



# MENTAL HEALTH BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

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SUBJECT

Transmittal of General Family-Based Mental Health Services Program Issues

BY

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## SCOPE:

This bulletin applies to all providers (Type 4B) enrolled in the Medical Assistance Program as Family Based Mental Health Service (FBMHS) providers.

## PURPOSE:

The purpose of this bulletin is to offer direction to assist FBMHS providers in following guidelines and/or procedures outlined in the proposed regulation in order to assure consistency of program delivery across the Commonwealth.

## BACKGROUND:

In April 1990, the Office of Mental Health (OMH) received federal approval of the State Medicaid Plan Amendment, allowing federal reimbursement on behalf of Medicaid-eligible clients for FBMHS services.

In June 1991, two technical assistance sessions were held to address many frequently recurring questions presented in this transmittal. In addition, quarterly FBMHS program director's meetings have been held to identify policy and procedural issues which require clarification.

## PROCEDURE:

Use this document as a reference to assist you in providing a service consistent with the intent of FBMHS.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

CENTRAL AREA DIRECTOR (DOROTHY FULTON, ACTG.) - (717) 257-7490  
WESTERN AREA DIRECTOR (SHIRLEY DUMPMAN) - (412) 257-6805  
EASTERN AREA DIRECTOR (GEORGE KOPCHICK) - (215) 740-3468

# PENNSYLVANIA FAMILY-BASED MENTAL HEALTH SERVICES

## QUESTIONS AND ANSWERS

### PROGRAM ISSUES

#### Target Population

1. I have heard the terms "child", "identified patient", IP, and consumer used interchangeably. Which is preferred?

The proposed regulations use the term consumer to identify the child/adolescent who is the primary recipient or identified patient of FBMHS in a family.

2. How many adolescents or children may be identified as consumers in one family?

There is one child or adolescent in the family who is identified as the primary consumer for record keeping and billing purposes. There may be other children/adolescents in the family who are eligible for the full range of Family-Based Mental Health Services.

#### Operational Issues

3. Why can't the "clinical consultant" provide direct services in the FBMHS program?

The clinical consultant's role is to supervise the program staff when the program director does not meet the supervisory qualifications as defined in the proposed regulations and contract addendum. The clinical consultant is not a team member.

4. When a provider is approved under a county plan and for some reason wishes to not enroll in the Medical Assistance Program, will it be permitted to provide services paid with 100% state funds?

No. The MH/MR Act of 1966 requires that all other sources of revenue be used prior to use of state funds. Medicaid (federal funds) must be sought for eligible persons.

5. Who are we designating as professionals qualified to evaluate and diagnose children and adolescents in the FBMHS draft proposed regulations?

Professionals who are qualified to evaluate and diagnose are those licensed individuals whose scope of practice includes that responsibility in the State of Pennsylvania. These individuals include: licensed physicians, licensed psychologists, certified registered nurse practitioners and a registered nurse with a masters degree in nursing with a major in psychiatric nursing.

6. How do medication goals relate to the FEMHS plan?

The FEMHS plan should include the identification of any known medications prescribed for the consumer and the physician who prescribed them.

7. How long can a child be in "placement" (hospital, residential) and have the FEMHS service continue?

The treatment plan must clearly articulate the FEMHS goals for working with the child and family during this time. The FEMHS Agency needs to develop a policy regarding this practice. All FEMHS services delivered during this time period can be billed utilizing the actual service dates only after the child returns home and continues to receive FEMHS. There is a 32 week period of eligibility. If services extend beyond this period, reauthorization is necessary.

8. What is the maximum and minimum number of families per team?

Eight families per team is maximum and there is no minimum. However, the provider's productivity will be reviewed during the rate setting process with the potential for the establishment of productivity standards in the future.

9. Must the treatment plan be completed in five days?

A treatment plan must be initiated within five days from the first day of service; however, a longer period of time may be required to complete the treatment plan.

10. When does the 32 week time limit begin for the child/adolescent enrolled in the FEMHS program?

The 32 week period begins on the first day of billable service. The agency needs to develop the policy of when the child and the family is enrolled in the program.

11. What is the composition of the Team?

Section 5260.21 of the proposed regulations state that the team consists of two child mental health professionals or a child mental health professional and a child mental health worker.

12. What percentage of team-delivered units to team-member-delivered units is recommended?

OMH is recommending the projects utilize a 60%/40% ratio of team-delivered units to team-member-delivered units.

Program Evaluation/Utilization Review/Quality Assurance

13. What is meant by cultural competence?

Cultural Competence is a set of behaviors, attitudes, and policies that come together in a system to empower agency, client, parents, and mental health professionals to work effectively in cross-cultural situations.

14. How can cultural competence in a program be evaluated through the UR process?

Cultural competence in a program can be evaluated through the UR process by assessing how the agency and its staff adhere to the principles of a culturally competent system which:

Recognize the family, as defined by each culture, as the primary system of support and point of intervention.

Recognize that minority populations are at least bicultural, creating a unique set of systems issues.

Recognize that cultural forces effect the choices made by families and individuals.

Recognize the need to include cultural knowledge in practice and policy-making.

Recognize that cultural competence includes working with natural, informal supports and helping networks within minority communities.

Recognize that minority participation is essential in planning, governing, administering and evaluating the development of services.

Recognize that staffing patterns must reflect the makeup of the client population to ensure the effective delivery of services.

Recognize that culturally competent services include the concept of responsive services matched to the client population.

The Office of Mental Health is in the process of developing a checklist which identifies these components.

#### Documentation Accountability/Issues

15. How can the requirements for documentation be met without having pages of confusing entries?

The provider must know and understand what the requirements are, as discussed in M.A. 1101.51(d) (1-6) and 1101.51(e)(1) (1-x) and in the proposed FBMS regulations. The provider must know and understand how to reflect the interaction, therapeutic or otherwise, in a complete concise manner. Notes must be written in clear and concise objective language detailing who, what, when, where, how and why.

16. Can a clerical person enter and initial or sign casenotes?

No. Only the person who delivers the service may enter and sign the casenote.

17. When may a signature stamp be used in clinical record keeping?

Never.

18. How can an adolescent be enrolled in a program and not have a parent signature on the treatment plan?

Section 201 of the MH/MR Procedures Act 1976 as amended permits individuals 14 and older to voluntarily consent to treatment or refuse treatment. Efforts need to be made to gain parental involvement.

19. Must we keep an inventory of equipment purchased by the FBMHS contract and who has access to the equipment?

Yes. The 4300 fiscal regulations, sections 4300.106, 4300.107 discusses the purchase of fixed assets and ownership responsibilities of the provider agency.

20. Must the clinical record include the documentation of the physician/licensed psychologist recommendation prior to the service initiation?

The clinical record must include the documentation that the FBMHS was recommended for the child and the family prior to billing.

21. What kind of documentation is needed on the clinical record of other children with severe emotional disturbance in the family who are also enrolled in the Base Service Unit (BSU)?

The agency needs to have a policy on the documentation of treatment activities when more than one child is a BSU client in the family. Suggestions may include:

writing one note and inserting copies in the other family member's charts;

document in the other family member's clinical records when dealing with an individual family member issue;

document in the other family member's clinical records if dealing with medication issues.

22. Must all services, telephone calls, etc. be documented in the notes and specifically tied to the treatment plan?

All contacts must be documented in the record and tied directly to the treatment plan goals.

### Legal Issues

23. Why is there no provision in the proposed regulations which addresses the provider's right of appeal for misuse of funds or abuse of consumers?

The provider's rights of appeal are described in the Medical Assistance Regulations Chapter 1101.84. The Medical Assistance 1101 regulations are the general provisions applicable to all Medical Assistance providers.

24. Why can't a licensed MSW recommend a child/adolescent for FEMHS?

The program decision is based on the fact that in Pennsylvania the MSW in the scope of their practice, may not render a diagnosis which is a prerequisite to all treatment services except crisis or emergency services.

25. Can we have a clear definition of what standards we must meet?

The proposed regulations (FEMHS) and the M.A. 1101 regulations provide clear definitions of standards to meet. In addition, the FEMHS Quality Assurance work group is developing proposed Quality Assurance standards.

26. Will a FEMHS provider have to be licensed?

Yes. An initial licensing survey will be scheduled after a provider is approved through the inclusion in the County Human Service Plan, has completed the application program packet with county approval, and is enrolled by OMH to receive federal reimbursement as a provider in the Medical Assistance Program.

27. How often are on site licensing surveys performed?

On site surveys will be conducted annually; however, when programs are not in compliance with licensing standards, site surveys are conducted more frequently.

28. What material needs to be available for a licensing survey?

Along with the notice of a scheduled licensing visit, the licensing surveyor will send a list of all information that must be available on the day of the survey. Some of the materials may include: staffing roster, operating policy & procedures, patient records, addendum to FEMHS contract, etc.

29. Why is a licensing survey needed?

The purpose of a visit is to evaluate the program's compliance with OMH/OMA program standards and to promote quality of the general program. Licensing also indicates compliance to the states minimum standards and is a requirement for participation in the Medicaid program.

30. When will the provider be informed of the licensing survey's findings?

The surveyor will include an exit meeting prior to completing the site visit. At this exit interview, all deficiencies will be discussed. The surveyor may also make recommendations and suggestions at this time.

31. When will the provider receive a License/Certificate of Compliance?

The provider will receive a License/Certificate of Compliance after the site survey within six to eight weeks if the program is in substantial compliance with the draft proposed regulations. A License/Certificate of Compliance will be processed through the Bureau of Regulatory Administration, Division of Licensing office. If the surveyor noted deficiencies, a "Notice of Deficiencies" will be sent to the provider within ten days of the visit. The provider will submit a "Plan of Correction" to the licensing surveyor. If accepted, a License/Certificate of Compliance will be issued. No License/Certificate of Compliance will be issued if the program does not substantially meet the OMH/OMA program proposed regulations.

32. Will OMH approve a team which consists of the Family-Based Mental Health Services Project Director and a mental health worker?

In small programs with less than a \$120,000 budget, it is permissible for the project director to act as a team member if the project director meets the qualifications for a child mental health professional.

33. What happens if a team is not comprised of either two child mental health professionals or a mental health professional and a mental health worker?

The Area Office will require a plan of correction to be submitted with time lines indicating how the agency plans to meet the requirements of the regulations. A provisional license will remain in effect.

System Issues

34. What is meant by service linkage in FBMHS? How is it different from the linking done by ICM?

The FBMHS is a comprehensive service which includes treatment, casework services, and family support services. Casework services include linking the family to those services in the community which are needed and promoting the service relationships which the family has already established. The FBMHS casework services component include similar activities as ICM. It is not the intent of OMH to have children served simultaneously in ICM & FBMHS. The proposed regulations limit the amount of ICM service time permitted while a family is receiving FBMHS.

35. How can we work with private insurers who are trying to get their families into the FEMHS?

Define carefully the contract for services for each child and the family with the private insurer.

Other

36. What constitutes a "current medical examination"?

A current medical examination under Early & Periodic Screening, Diagnosis and Treatment (EPSDT) is identified as the physical (screen) provided within the time lines established by the American Pediatric Society. A copy of the APS Periodicity Schedule is located in the FEMHS Handbook Insert.

37. If clinical records do not have the report of the medical examination, can we bill?

Yes. All attempts to meet the required standards must be documented. The documentation may include:

that a child had a physical within this periodicity schedule;

attempt was made to gain records from the most recent physical within the APS time framework;

attempts were made to gain the cooperation of the family to obtain a medical examination.

38. What are the implications of FEMHS being an Early and Periodic Screening Diagnosis and Treatment (EPSDT) service under Medicaid?

All Medicaid eligible individuals under 21 participating in a FEMHS program are eligible for services under the EPSDT program and FEMHS providers are required to inform eligible individuals and their families about the EPSDT program including the services available under EPSDT (which are more extensive than those under Medical Assistance), and the benefits of preventive health care. Applications and specific information may be obtained by calling the EPSDT hotline number 1-800-KIDS-MED (1-800-543-7633).

39. Can you help us to convince DPW/Personnel to allow MH Program Specialist I & II position classifications for these programs?

OMH staff will be reviewing all the personnel issues.

FISCAL ISSUES

Enrollment

40. What is included in an enrollment package?

A complete enrollment package consists of:

- One multi-category enrollment packet
- Two provider agreements each with original signatures
- A license number provided by the Department of Public Welfare,  
Office of Administration, Division of Licensing
- An approved rate from the Area Office of Mental Health

41. How does a provider obtain an enrollment package?

When a provider is accepted into the County's Human Service Plan, the county will provide an enrollment packet as supplied by the area Office of Mental Health.

42. Why must a provider submit an enrollment package?

The completed packet must be submitted to enroll the Family-Based Services provider into the Medical Assistance program which will permit the provider to bill Medical Assistance for the federal portion of the approved rate.

43. When will the provider receive a Family-Based handbook, billing rate information and billing forms?

After being enrolled in the MA program, the provider will receive a notice indicating:

- |                 |                            |
|-----------------|----------------------------|
| -provider name  | -FFP portion of total rate |
| -address        | -type of service           |
| -license number | -procedure codes allowed   |
| -effective date |                            |

The provider notice is sent along with a signed completed provider agreement and a FBMHS handbook insert addressing specific issues. Under separate cover the provider will also receive an initial packet of forms and the complete provider outpatient handbook. The handbook will provide instructions on how to order future forms and information concerning other general MA issues.

44. How do I know my provider type and provider number?

Once a provider is licensed and has a rate approved by the area Office of Mental Health, an enrollment package is submitted. The information contained in that packet is loaded onto the provider file that generates a provider identification number. All FBMHS providers are provider type 48.

45. If there is more than one eligible child in the family, how does this affect billing for services?

One eligible child/adolescent must be identified as the "consumer" for billing and record keeping purposes. However, all eligible children or adolescents in the family may receive a full range of FEMHS from the treatment team.

46. If individual team members are traveling from different places of origin or in individual cars to provide a team delivered service, how do you bill for this service?

Since salaries and mileage for all staff are items included in the development of the rate for FEMHS, invoicing should only be submitted to account for the one person who travelled the farthest. Travel time should be included in the total amount of time spent in a specific activity. You cannot bill for the travel of more than one team member per team delivered service contact with the same family.

47. If a client and/or their family is not available for a contact, can you bill?

If there is a documented, planned appointment, the team or team member traveling to that appointment may bill MA for the total amount of the travel time. No time is permitted reimbursable to sit and wait for the contact to arrive. The procedure code billed would be the code of the intended contact. If there is no scheduled appointment and the team or team member is "dropping by" when no one is home, you may not bill for services.

48. If a family group facilitated by the FEMHS team (member) consists of two or more families, how is the service billed?

Only one family per team represented can be billed for the service. Use codes W0871 (team member with family) or W0873 (team with family).

49. How can family support services be billed if family support money is in the county office?

There is no way to bill for it since it is not included in the development of the rate.

50. What FEMHS are not eligible for Medicaid reimbursement?

Concrete services and those not related to the treatment plan's therapeutic goals are not eligible for MA reimbursement. These services include:

Recreation	Clothing
Fuel Oil/Furnace Repairs	Piano Lessons
Furniture Repairs	Y.M.C.A.
Rental Assistance	Respite
Parents Without Partners Membership	Garbage Removal
Automobile Insurance Assistance	Housekeeping
Driver's License	Furniture
Telephone Bills/Telephone	Budget Classes
Food	Water Pumps

51. How are these services paid for?

These services are paid with 100% state funds if they are deemed necessary. Costs of non-FFP eligible services are not included in the rate.

52. Can County MH/MR Program Administrative Offices bill for MA administrative costs for FY 90-91 if the provider agency is not billing for FY 90-91 services?

No. The County MH/MR Program can only bill for MA administrative costs if the provider agency is billing for services in FY 90-91.

53. Why can't FEMHS "contractual services" providers bill against the FEMHS rate for their units of services?

The costs of the contracted FEMHS are already included in the approved rate. Only FEMHS team members may bill for units of services.

54. How can you provide for services for a child who has requested services when the parent refuses to sign a consent to treatment?

Services may not be provided to a child under 14 without a parent's consent (see definition of parent in these proposed regulations).

55. In invoicing Medical Assistant (MA), how do I account for the client's signature each time I submit an invoice?

Complete the "Encounter Form" found in the MA handbook by requiring each consumer to sign at least monthly. This signature certifies the consumer is actively involved in FMHS. In the event the consumer is under fourteen (14), the parent may sign instead. The encounter form may be client specific or it may be for a number of clients. In any event, when this is signed monthly, it allows invoices to be submitted with the words "SIGNATURE EXCEPTION" on the recipient's signature line.

56. When am I required to complete a State Match Verification Form (SMV)?

Each time an invoice is submitted to MA, it must have a corresponding SMV. The SMV must first be signed by the county authorizing agent whose responsibility it is to assure state funds are available for the service. Therefore, in completing the invoice, it is necessary to record a number 17 in field 41 of the invoice to indicate a SMV has been completed and is on file in the provider agency. Documentation of 100% state dollars paid services is also necessary; documentation procedure is at the discretion of the county authorizing agent.

57. Can we bill for travel time for an appointment with the family when the family does not show?

Yes, if the family had an appointment and the clinical record documents the amount of time spent in travel. Billing would be done under the procedure code intended for the purpose of the contact.

58. How do I identify services performed when completing an invoice?

There are five procedures available. They are listed by procedure code and name as follows:

- W0870 - team member with consumer
- W0871 - team member with family of consumer
- W0872 - team member with collaterals and/or other agencies
- W0873 - team of two or more with consumer and/or family
- W0874 - team of two or more with collaterals and/or other agencies

If a single date of service is billed it is recorded in the "Service End Date" field. Consecutive dates billed are done so by entering the first date of service in the "Service Begin Date" field and the last date of service in the "Service End Date" field. The type of service for Family-Based providers is "FB". Only two places of service are currently available. They are: 02-Patient's Home, and 11-Community/Other.

Units of service recorded on the invoice must be the total units provided for a specific client on a specific day in a specific place for a specific procedure. The usual charge is the approved annual rate multiplied by the number of units billed per line.

59. Who signs the provider's signature on the MA invoice?

The Program Director or a representative of the agency designated by the Program Director who assumes responsibility for all information contained in the invoice must sign the MA invoice. With the permission of the authorized designee, a signature stamp is accepted.

60. When must a consumer sign an invoice?

The consumer must sign the invoice each time an invoice is submitted, UNLESS the encounter form is signed monthly, in which case the phrase "SIGNATURE EXCEPTION" is accepted. See page 11, question #51.

61. Where do I submit current invoices?

Department of Public Welfare  
Office of Mental Health  
P.O. Box 8081  
Harrisburg, PA 17105

62. How long do I have to submit?

180 days from the date of service for initial submission. 365 days from the date of service for total resolution.

63. If I exceed the normal submission time frame, is there an exception?

Yes. There are three reasons acceptable for an exceptions:

- a. delay by the CAO in determination of eligibility
- b. payment being requested from a third party resource
- c. delay due to retroactive enrollment

In these cases, invoices must be sent to:

Laurie Michtich  
Department of Public Welfare-Office of Mental Health  
Division of Operations  
Health & Welfare Building - Room 502  
Harrisburg, PA 17120

64. When cost reconciliation for FBMHS providers occurs, will counties be able to utilize carryover money from the previous fiscal year to reimburse providers for underpayment of costs?

Due to the timing of the Family-Based reconciliation process, there is little, if any, probability that carryover dollars could be available to allow counties to reimburse providers for underpayment of costs. Therefore it becomes more important that counties negotiate rates effectively, monitor the FBMHS program, including reviewing of expenditures and units of service, and renegotiate rates if necessary to assure that there is very little discrepancy between rates negotiated and rates reconciled.

65. Who can bill for services at the FBMHS approved rate?

Only the FBMHS child mental health professionals and child mental health workers may bill.

Rates

66. What is Reconciliation?

Reconciliation is a process which requires the provider to cost settle budgeted expenditures to actual expenditures. An OMH Bulletin discussing the cost settlement process is being developed. Providers who are billing M.A. for services provided during FY 90-91 will be required to cost settle.

67. Can rates be negotiated? If so, how often?

Rates must be negotiated annually. All annual rates are effective 7/1 - 6/30. If a provider experiences an unanticipated change in costs, a new rate may be negotiated. Once calculated, if the rate change is determined by the provider to be "significant", it should be presented to the county for review and approval. The county then presents it to the Area Office of Mental Health for final approval. The negotiated interim rate is effective on the date it is activated by the Department of Public Welfare until 6/30.

68. If a program director also serves a family preservation program, how are salary and costs to be budgeted?

Salary and costs are to be pro-rated based on the percentage of time spent in each program.

69. May a county use funds other than OMH/FBMHS allocated funds to support FBMHS programs?

Yes. A county may use other MH funds, private or other public funds as state match for MA covered services; however, the county MH/MR Administrator is responsible for certifying that the funds for the match are available and are under the county MH/MR Administrator's administrative control.

70. If there is a "savings" as a result of FBMHS medicaid reimbursements, is there any restriction on how these "savings" may be used?

The provider bills MA which generates federal funds to pay for the service provided to eligible clients. The generated income offsets the amount of state dollars utilized by the FBMHS provider thereby increasing available dollars for the county to expand the FBMHS services. The county may use the state dollars to expand the current provider's FBMHS program or to create another FBMHS provider. These funds may not be used outside of FBMHS. In any event, any state dollars not expended by the end of a fiscal year are returned to the state as carryover. The money is returned to the fund not governed by the OMH and therefore will not come back to the counties.

71. What is the authority for this restriction on the use of state dollars?  
It is a state program decision and applies to each program for two full years beginning in FY 91-92.
72. What does OMH recommend as a percentage of the budget to be utilized in family support services?  
OMH is recommending a minimum of 5% of the budget to be utilized for family support services.
73. What is the allowable indirect administrative cost for a FEMHS program?  
The allowable indirect administrative cost for a county operated program is based on the approved county allocation plan. If the FEMHS provider is a private provider, the maximum allowable indirect administration cost is 15% of the budget.

Funding

74. What advantage is Medicaid billing to providers?  
There are no prospective new state dollars in the foreseeable future. FFP allows for program expansion. FEMHS is now a service recognized under an approved Medicaid State Plan Amendment. At the beginning of each fiscal year, a county is awarded a base allocation including categorical funds specifically for FEMHS programs. That money is awarded through a contract to providers identified in County Human Service Plans. Those providers use these state dollars to draw down federal dollars by billing MAMIS on a fee for service basis. Additionally, a provider's annual rate should include expansion and an accurate estimation of total costs. That rate is based on an estimate of federally eligible clients for which services can be billed. Therefore, a provider's total allowable costs are reimbursed by both state and federal dollars.
75. Will the start-up year be program funded? What if a provider starts up in the middle of a fiscal year?  
"Start-up" year for providers with existing programs is FY 90-91. That year was program funded and will continue to be for two additional years. The M.A. payment is reimbursed on a fee-for-service basis. If a provider starts up anytime during a FY, that year is their start-up year. A rate will be established for the provider to bill MA on a FFS basis to draw down federal funds for any portion of the start-up year. Two additional years of program funding is permitted. In conjunction with this, all counties which had FEMHS programs in FY 90-91 must account for that start-up year on an accrual basis. Due to required cost settlement all providers and counties must report FEMHS funds on an accrual basis.
76. Can Medicaid be billed if the agency is program funded?  
Yes. See question #74 & #75.

77. What is the difference between "cash" and "accrual" accounting?

The cash basis of accounting is the method by which revenue is reported in the fiscal year it is actually received. The accrual basis of accounting is the method by which revenue is reported in the fiscal year it is earned (meaning when the service is provided). FEMHS providers must account for their generated revenue on an accrual basis.

78. Which method of accounting will be used for FEMHS?

During the start-up year which is FY 90-91, all counties who currently have approved FEMHS providers must report on an accrual basis. While providers are permitted to bill retroactive to July 1, 1990, very few intend to do that. Therefore the money received during FY 91-92 will be for services provided in FY 91-92 thus reflective of a year of normal operation. Furthermore, a poll of counties planning on cash reporting revealed that most counties will be reporting on an accrual basis anyway.

79. What are Title 4A Funds? How do they relate to FEMHS?

Title 4A Funds are Emergency Assistance Funds which provide concrete emergency services for AFDC eligible children and their families. FEMHS may apply for these services for eligible FEMHS children and their families through the County Board of Assistance.

#### Automated Billing

80. Is Automated Billing available?

Automated Billing is not available from OMH although independent agencies may request an Electronic Media Contract from TCC (The Computer Co.) as instructed in the provider handbook. This will allow for automated billing to be received and processed under your new provider number. TCC will supply you with set-up specifications and require a test tape to be approved prior to the time billing starts. All automated billing must be completed within 180 days of the date of service. Service in excess of that time must be submitted on hard copy as instructed in the handbook.

MISCELLANEOUS QUESTIONS AND ANSWERS

1. Will providers be permitted to incorporate a profit, ex. 3% as permitted in the 4300 regulations, in their rates? ...

Yes. These rates are county negotiated fees which will be adjusted to audited actual costs that must comply with Chapter 4300.108 (relating to retained revenue) which is considered an allowable cost. Chapter 4300.108(b) specifically states "THE DEPARTMENT'S PARTICIPATION WILL BE LIMITED TO AN AMOUNT NOT TO EXCEED 3% OF THE TOTAL GROSS REVENUES APPLICABLE TO THE CONTRACT". Chapter 4300.108(c) continues by saying, "THE DEPARTMENT WILL PARTICIPATE IN AN ALLOWANCE FOR RETAINED REVENUE ONLY WHEN THE COUNTY EXPLICITLY APPROVES RETAINED REVENUE BY INCLUDING SPECIFIC PROVISIONS IN THE CONTRACT". The retained revenue is intended to be an incentive for agencies to operate efficiently and pursue third party revenues. It is an allowable budget item. Inclusion of this item in rate determination should be in non-personnel costs-other-identified as "retained revenue". On page 5 of the rate determination package the amount designated for retained revenue must be identified as "state reimbursable only" and not included in the final rate determination.