SCOPE

County Mental Health/Mental Retardation Program Administrators
Base Service Unit Directors
Targeted Service Management Provider Directors

PURPOSE

The purpose of this bulletin is to disseminate the Targeted Service Management Technical Assistance Packet prepared by the Office of Mental Retardation.

BACKGROUND

In 1987, the Office of Mental Retardation prepared an amendment to the State Plan under Title XIX of the Social Security Act. This amendment, approved in October, 1988, authorized Pennsylvania to initiate and fund Targeted Service Management for persons with mental retardation under the State Medical Assistance Program. Targeted Service Management offers locating, coordinating and monitoring of services for individuals with mental retardation who are eligible for Medical Assistance.

DISCUSSION

Since implementation of Targeted Service Management beginning in 1993, questions regarding service provision, billing of the Medical Assistance system, and other matters have been recorded and researched by the Office of Mental Retardation staff and are addressed in the attached Technical Assistance Packet. This material is categorized and presented in a manner that allows revision and/or addition through issuance of replacement pages by the Office of Mental Retardation as necessary. We recommend that this material be retained in a binder facilitating replacement of outdated material.

The responses contained in the attached Technical Assistance Packet are the most current and supersede any prior material. Recipients of this packet are encouraged to photocopy and distribute it to case management, fiscal and other staff participating in the Targeted Service Management initiative.

REFER COMMENTS AND QUESTIONS TO:

Office of Mental Retardation, Targeted Service Management Unit, Room 512
Health & Welfare Building, Harrisburg, PA 17120,
Telephone: (717) 783-2376; FAX: (717) 787-6583
OFFICE OF MENTAL RETARDATION TARGETED SERVICE MANAGEMENT

TECHNICAL ASSISTANCE PACKET

PROVIDERS' QUESTIONS . . . .

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INDIVIDUAL ELIGIBILITY

1) ARE THERE ANY AGE LIMITS FOR TARGETED SERVICE MANAGEMENT (TSM) RECIPIENTS?

ANSWER: No.

2) DOES OMR HAVE A DEFINITION OF MENTAL RETARDATION FOR TSM ELIGIBILITY?

ANSWER: OMR follows the definition under the MH/MR Act of 1966 which reads: "Mental Retardation means subaverage general intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following: (1) maturation, (2) learning and (3) social adjustment."

3) CAN AN INDIVIDUAL WHO IS DIAGNOSED WITH MENTAL RETARDATION AND MENTAL ILLNESS RECEIVE BOTH TARGETED SERVICE MANAGEMENT (TSM) AND INTENSIVE CASE MANAGEMENT (ICM)?

ANSWER: Yes, as long as each service is necessary.

4) IS AN INDIVIDUAL SERVED IN A PSYCHIATRIC OR GENERAL MEDICAL HOSPITAL ELIGIBLE FOR TSM?

ANSWER: Yes, provided the hospital stay is only of a short-term basis of thirty (30) days or less. If the stay is thirty-one (31) days or longer, the transitional planning rule will apply. Under this rule, TSM may be provided only during the final 30 days of hospital stay. TSM provided during this transition cannot be a duplication of the discharge planning provided by the hospital.

5) CAN TSM BE RECEIVED BY INDIVIDUALS IN PUBLIC AND PRIVATE ICFS/MR APART FROM THE 30-DAY TRANSITIONAL PLANNING PERIOD SPECIFIED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) (E.G., BILLING FOR ANNUAL PLAN VISITS BY SERVICE MANAGERS)?

ANSWER: No.

6) CAN THE THIRTY-DAY, TSM-BILLABLE TRANSITIONAL PLANNING PERIOD BE EXTENDED DUE TO UNFORESEEN DELAYS IN A PERSON LEAVING AN ICF/MR OR HOSPITAL?

ANSWER: No. The thirty (30) day transition period is strictly limited to TSM services provided during the final thirty (30) days of facility/hospital stay. The safest approach is to hold billings for transition planning until the discharge date is past, the move successfully completed, and the person's TSM eligibility status can be accurately pinpointed. A Claim Adjustment (MA 319A) may be filed by a provider who inadvertently submits a billing later identified as unacceptable due to delays an individual may encounter in making a move.
7) ARE NON-MA CERTIFIED FACILITIES, SUCH AS LARGE COMMUNITY HOMES, SUBJECT TO THE THIRTY-DAY TRANSITION RULE?

   ANSWER: No.

8) CAN AN INDIVIDUAL RECEIVING "ACCESS" SERVICES FROM THE PENNSYLVANIA DEPARTMENT OF EDUCATION ALSO RECEIVE TSM?

   ANSWER: Yes, as long as both services are needed and there is no duplication of services between ACCESS and TSM.

9) IS AN INDIVIDUAL ELIGIBLE FOR TSM FROM A TSM-PARTICIPATING COUNTY WHEN THE INDIVIDUAL'S OWN COUNTY-OF-RESIDENCE IS NOT ENROLLED IN TSM?

   ANSWER: Yes, as long as the participating County MH/MR Program agrees to provide the service and ensures that the state match is available for this service.

10) MAY A CHILD WHO IS RECEIVING EARLY INTERVENTION (EI) SERVICES RECEIVE TSM TO AID IN COORDINATION OF OTHER NON-EI SERVICES RECEIVED, SUCH AS RESpite OR SITTER SERVICES?

   ANSWER: Yes, as long as there is no duplication of service, the child may receive TSM to aid in the coordination of non-EI services such as respite.

11) IF AN INDIVIDUAL IS ELIGIBLE FOR MEDICAL ASSISTANCE (MA) DURING ANY PART OF A MONTH (I.E., INVOLVED IN MA "SPEND-DOWN" CIRCUMSTANCE OR FOR ANY OTHER REASON), IS THAT PERSON TSM-ELIGIBLE FOR THE ENTIRE MONTH?

   ANSWER: No. An individual must be eligible for MA on the actual date of any TSM service provision.

12) CAN AN INDIVIDUAL WHO IS INCARCERATED IN A LOCAL OR STATE CORRECTIONS FACILITY RECEIVE TSM?

   ANSWER: No. Since a person's MA is revoked upon incarceration, the individual would not be eligible for TSM during imprisonment.

13) IS IT POSSIBLE FOR AN MA-ELIGIBLE INDIVIDUAL WHO IS NOT EXCLUDED BY ANY OF THE ABOVE RESPONSES TO BE INELIGIBLE FOR TSM?

   ANSWER: Yes. The Office of Medical Assistance Programs (OMAP) has issued a provider resource titled "Health Care Benefit Package", MA 446 (5/93), which the OMR/TSM Unit has distributed to TSM providers. The OMAP document, MA 446, supersedes information regarding TSM eligibility appearing in Appendix D of the original TSM Provider Handbook (1/93), pending future revision. It lists the Provider Types covered under the various Benefit Packages comprising Medical Assistance Coverage in Pennsylvania. Some Benefit Packages do not currently cover Provider Type 32 (TSM).

   If the individual's MA category and program status results in assignment to a Health Care Benefit Package which precludes Provider Type 32, TSM is not a reimbursable MA service.
PREFACE

The Office of Mental Retardation Targeted Service Management Unit and other staff have collaborated on researching and responding to questions presented by County Mental Health/Mental Retardation offices and contracted providers of Targeted Service Management (TSM).

This Technical Assistance Packet is a result of these efforts. Its format allows revision and addition to questions by replacement of pages as need arises. The material has also been catalogued for ease of reference.

Information offered under each topic is most current and supersedes any prior material. These questions and answers address concerns emerging since TSM's pilot implementation and, in some instances, represent significant departures from instructions previously given or appearing in the first edition of the Targeted Service Management Handbook for Persons with Mental Retardation (1/93).

We encourage County and Provider staff to thoroughly review this material. Recipients of this Technical Assistance Packet are encouraged to photocopy and distribute it to case management, fiscal and other staff participating in the Targeted Service Management initiative.

We trust this resource will aid providers in TSM provision and reimbursement. Every effort has been made to be responsive, deliberate, and thorough in developing this technical assistance material.

We thank the many Targeted Service Management providers who challenged us with their inquiries or called attention to issues demanding resolution.

Contact the Targeted Service Management Unit of the Office of Mental Retardation for further assistance at (717) 783-2376.
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14) HOW WILL PROVIDERS ASCERTAIN INDIVIDUALS’ MA CATEGORIES AND PROGRAM STATUS CODES TO DETERMINE TSM ELIGIBILITY ONCE OMAP’S NEW "ACCESS CARD", LACKING SUCH CODING, IS IN PLACE?

ANSWER: Refer to the Data Systems Section of this packet for information on the Eligibility Verification System (EVS) developed by OMAP and their contractor, EDS. This system is operational and will aid providers in ascertaining individuals' Benefit Packages, MA Categories and Program Status Codes needed to determine TSM eligibility.

15) IS AN INDIVIDUAL WHO RECEIVES MANAGED CARE THROUGH AN HMO OR HIO ELIGIBLE FOR TSM?

ANSWER: Yes. Targeted Service Management is exempt from Managed Care. Therefore, the FFP portion for these individuals should be billed as TSM activity/units in the same manner as for other individuals who are not enrolled in an HMO OR HIO.
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7) Are non-MA certified facilities, such as large community homes, subject to the thirty-day transition rule?

Answer: No.

8) Can an individual receiving "Access" services from the Pennsylvania Department of Education also receive TSM?

Answer: Yes, as long as both services are needed and there is no duplication of services between Access and TSM.

9) Is an individual eligible for TSM from a TSM-participating county when the individual's own county-of-residence is not enrolled in TSM?

Answer: Yes, as long as the participating County MH/MR Program agrees to provide the service and ensures that the state match is available for this service.

10) May a child who is receiving Early Intervention (EI) services receive TSM to aid in coordination of other non-EI services received, such as respite or sitter services?

Answer: Yes, as long as there is no duplication of service, the child may receive TSM to aid in the coordination of non-EI services such as respite.

11) If an individual is eligible for Medical Assistance (MA) during any part of a month (i.e., involved in MA "spend-down" circumstance or for any other reason), is that person TSM-eligible for the entire month?

Answer: No. An individual must be eligible for MA on the actual date of any TSM service provision.

12) Can an individual who is incarcerated in a local or state corrections facility receive TSM?

Answer: No. Since a person's MA is revoked upon incarceration, the individual would not be eligible for TSM during imprisonment.

13) Is it possible for an MA-eligible individual who is not excluded by any of the above responses to be ineligible for TSM?

Answer: Yes. The Office of Medical Assistance Programs (OMAP) has issued a provider resource titled "Health Care Benefit Package", MA 446 (5/93), which the OMR/TSM Unit has distributed to TSM providers. The OMAP document, MA 446, supersedes information regarding TSM eligibility appearing in Appendix D of the original TSM Provider Handbook (1/93), pending future revision. It lists the Provider Types covered under the various Benefit Packages comprising Medical Assistance Coverage in Pennsylvania. Some Benefit Packages do not currently cover Provider Type 32 (TSM).

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SERVICE ELIGIBILITY

1) WHAT ARE CONSIDERED ELIGIBLE SERVICE FUNCTIONS?

ANSWER: Eligible service functions are identified on Attachment A. A brief list of ineligible functions is also included.

2) IS WORK PERFORMED BY A SERVICE MANAGER IN CONDUCTING A LIABILITY DETERMINATION AN ELIGIBLE SERVICE FUNCTION?

ANSWER: Generally, liability determination is an eligible service when the liability relates to and is required for services that are to be located and authorized for an individual. Determining Medical Assistance and/or Targeted Service Management eligibility would be eligible for federal reimbursement as a county administrative expense, but not as an eligible TSM service.

3) WHY IS OUTREACH AN INELIGIBLE FUNCTION?

ANSWER: Outreach occurs before an individual is determined to be part of the "target" population, and thus, ineligible for TSM.

4) WHY IS INTAKE EXCLUDED AS AN ELIGIBLE SERVICE FUNCTION?

ANSWER: The Health Care Financing Administration (HCFA) considers Intake to be an administrative function, not a service function. "Service management" assumes that the individual will already be enrolled in the county program and determined to have mental retardation. The determination of an individual's mental retardation and enrollment in the county program must occur prior to receiving TSM.

5) IS THE DEVELOPMENT OF A LIFE MANAGEMENT PLAN (LMP) OR AN INDIVIDUAL PROGRAM PLAN (IPP) AN ELIGIBLE SERVICE UNDER TSM?

ANSWER: Yes. The development of an LMP or an IPP is an eligible TSM activity. However, in the event the first such plan is completed at an intake meeting, counties/providers are cautioned to separate out billing time for this from a segment of time for intake. Intake is not a billable TSM activity; it is billable as a county Administrative Cost.

6) WHAT IS THE DISTINCTION BETWEEN TRANSITION PLANNING FOR INDIVIDUALS IN HOSPITALS, NURSING HOMES OR ICFs/MR AND DISCHARGE PLANNING?

ANSWER: Discharge planning is the preparation for an individual's departure from the facility and is the responsibility of the facility. Transition planning focuses on preparing the individual to live in his/her home and community, and is the responsibility of the TSM provider.
7) ARE TRAVEL AND TELEPHONE USAGE BY THE SERVICE MANAGER ELIGIBLE SERVICE FUNCTIONS?

ANSWER: Yes. If the activity is part of locating, coordinating, or monitoring of services for, with, or on behalf of an individual, the activity is an eligible service function.

8) CAN TRAVEL TIME OF THE SERVICE MANAGER BE Claimed WHEN THE INDIVIDUAL IS NOT HOME?

ANSWER: Yes. If the service manager has an appointment scheduled and the individual does not keep the scheduled appointment, the provider may bill for the travel time to and from the appointment.

9) WHY ARE MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH MENTAL RETARDATION EXCLUDED UNDER TSM?

ANSWER: Direct services, such as mental health services, are not considered locating, monitoring, or coordinating functions.

10) IF SOMEONE RECEIVES MEDICAID-FUNDED WAIVER SERVICES BUT NOT CASE MANAGEMENT FUNDED UNDER WAIVER, CAN THIS INDIVIDUAL RECEIVE TSM?

ANSWER: No. OMR requires that counties ensure that individuals receiving Waiver services receive Waiver funded case management by July 1, 1994. Counties may request additional federal funds to cover Waiver Case Management currently not funded through the rebudget process.

11) IS SERVING AS A REPRESENTATIVE PAYEE AN ELIGIBLE SERVICE?

ANSWER: No.

12) IS TIME SPENT ON DOCUMENTING SERVICES AN ELIGIBLE SERVICE?

ANSWER: Yes. Time spent on documenting services can be considered and billed as an eligible service activity. Time spent on documenting services can also be built into the provider's interim rate as a supporting cost. One method must be chosen and consistently applied.

13) IS MONITORING A SHORT TERM HOSPITAL STAY FOR MENTAL HEALTH NEEDS AN ELIGIBLE SERVICE?

ANSWER: Yes, but only for thirty (30) days of hospitalization prior to discharge.

14) IS ADVOCACY FOR ACCESS TO SERVICES IN GENERAL, AS OPPOSED TO ADVOCACY ON BEHALF OF ONE INDIVIDUAL, AN ELIGIBLE SERVICE FUNCTION?

ANSWER: No.

15) WHAT ARE SOME EXAMPLES OF PREVENTION SERVICES EXCLUDED AS INELIGIBLE FOR PAYMENT UNDER TSM?

ANSWER: Examples include: prenatal screenings; lead poison screening/abatement program; maternal health offerings; etc.
16) ARE THE TSM SERVICES COMPARABLE TO REGULAR CASE MANAGEMENT SERVICES?

ANSWER: Generally, they are. State regulations 55 PA Code 6201, applicable to all case management, provide for the locating, coordinating, and monitoring service functions that are standard case management practice and are also reimbursable by Medical Assistance (MA) as eligible TSM activity. However, providers are reminded that HCFA prohibits billing of MA for certain activities commonly undertaken by Case Managers; eg., intake; assisting application for Medicaid; outreach; prevention services (#15).
PROVIDER ELIGIBILITY AND ENROLLMENT

1) WHO ARE ELIGIBLE SERVICE PROVIDERS FOR TARGETED SERVICE MANAGEMENT?

ANSWER: Eligible providers of service must be enrolled in the Medical Assistance Program. In addition, eligible providers are:

   1) County MH/MR Programs which provide Targeted Service Management directly; or

   2) Private providers of service management under contract with County MH/MR Programs and not also direct providers of other services for individuals with mental retardation. For purposes of this program, providers who contract for or coordinate family support services, home based services, early intervention services or supported living services are not considered to be "direct" providers of other services for individuals with mental retardation; or

   3) Private providers of service management under contract with County MH/MR Programs who are also providers of other direct services for individuals with mental retardation when the following criteria are met:

      a) The County MH/MR program develops a monitoring system to ensure that the contractor who provides Targeted Service Management offers the individual access to his/her choice of services apart from those provided directly by the contractor; and

      b) The County MH/MR program assures that the expansion of Service Management positions through the use of TSM funding shall only be designated for providers who do not also provide other direct services for persons with mental retardation.

2) IS THERE A PRESCRIBED RATIO BETWEEN SERVICE MANAGERS AND NUMBER OF INDIVIDUALS SERVED BY THE TSM INITIATIVE?

ANSWER: No.

3) MUST A PROVIDER OFFER A MINIMUM NUMBER OF TSM UNITS OF SERVICE PER MONTH PER INDIVIDUAL?

ANSWER: No.

4) CAN A PRIVATE PROVIDER OF TSM WHO ALSO OFFERS DIRECT SERVICES INCREASE THEIR NUMBER OF CASE MANAGERS OFFERING TSM?

ANSWER: Yes, as long as the provider does not exceed their complement of full-time equivalent case managers which was in place on the effective date of enrollment as a TSM provider.
5) DOES A CASEWORKER TRAINEE MEET THE QUALIFICATIONS FOR PROVIDING TSM?

**ANSWER:** No. As of January 1, 1993, there is no longer a Caseworker Trainee classification for counties. That job title has been eliminated and replaced by a new "entry level" job title of County Caseworker 1 with more stringent qualifications. The minimum requirements for the new County Caseworker 1 classification (Class Code L0623) meet the qualifications. See Attachment B.

6) WHAT ARE THE SPECIFIC MINIMUM REQUIREMENTS THAT SERVICE MANAGERS WHO ARE COUNTY EMPLOYEES MUST MEET IN CONFORMANCE WITH THE COUNTY MH/MR PROGRAM SUPPLEMENTAL AGREEMENT SIGNED BY THEIR PROGRAM ADMINISTRATOR?

**ANSWER:** The minimum Civil Service requirement for "County Caseworker 1" (Rev. 1/28/93) is a bachelor's degree, which includes or is supplemented by twelve (12) college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social services.

7) CAN SOMEONE QUALIFY FOR COUNTY CASEWORKER 1 AND BECOME AN ELIGIBLE TSM PROVIDER ON A COUNTY STAFF BY SUBSTITUTING EXPERIENCE FOR THE SPECIFIED BACHELOR'S DEGREE?

**ANSWER:** Yes. The current equivalency policy requires at least 12 acceptable college credits and experience limited to service for the duration and in the specific paraprofessional social services job title which appears on the above cited specification.

8) MUST SERVICE MANAGERS ON THE PAYROLL OF AGENCIES CONTRACTED BY COUNTIES TO PROVIDE TSM MEET THE CIVIL SERVICE REQUIREMENTS REFERRED TO ABOVE?

**ANSWER:** No, not at this time. The county will be responsible for insuring that contracted providers' employees meet the requirements designated by the county's Personnel Action Plan (PAP) or the Modified Classification Review (MCR) Program approved by the Department of Public Welfare. Contact the Department's Division of Personnel Planning and Staff Development at (717) 783-9302 for further information.

9) CAN STAFF OTHER THAN TRADITIONAL CASE MANAGERS—SUCH AS SUPPORTED LIVING PROGRAM ADVISORS—BE ELIGIBLE TO PROVIDE AND BILL FOR TSM?

**ANSWER:** Yes, but all of the following provisions must be met:

1) The individual served may not have any other Mental Retardation Case Manager;

2) Staff must be employed by the enrolled TSM provider;

3) Staff must meet or exceed the minimum Civil Service, PAP, or MCR requirements for an entry level Case Manager;

4) Only eligible TSM functions are billed for MA reimbursement.

Counties/Providers that develop TSM provision in this way must notify the OMR, TSM Unit prior to engaging staff in this capacity.
10) CAN ANY AGENCY WHICH MEETS THE PROVIDER ELIGIBILITY CRITERIA PROVIDE TSM?

   ANSWER: No. The County MH/MR Program is responsible for selecting and contracting with providers for a particular geographic area.

11) CAN A COUNTY SELECT ONE PROVIDER TO BE THE TSM PROVIDER FOR THE ENTIRE COUNTY OR JOINDER?

   ANSWER: Yes. A County MH/MR Program may contract with a single provider, for TSM, if appropriate.

12) CAN A COUNTY SELECT MORE THAN ONE PROVIDER TO PROVIDE TSM WITHIN A GEOGRAPHICAL AREA?

   ANSWER: Yes.

13) DOES EACH PROVIDER HAVE A DIFFERENT PROVIDER NUMBER?

   ANSWER: Yes.

14) HOW DOES A PROVIDER ACQUIRE A MEDICAL ASSISTANCE MANAGEMENT INFORMATION SYSTEM (MAMIS) PROVIDER NUMBER, NECESSARY FOR PARTICIPATION IN TSM AND AUTHORIZING BILLING OF THE MA SYSTEM FOR SERVICE RENDERED?

   ANSWER: The following steps summarize the process:

   1) A County MH/MR Program, new to participation in TSM, is sent an Enrollment Package which contains materials requiring completion and signature.

      2a) If the County Program directly provides this service, the County completes the Enrollment Information Form providing data necessary for payment, and the County Program administrator reviews and signs other documents of an agreement nature.

      b) In the event the County contracts for TSM provision, the County makes the necessary number of copies of the Enrollment Package and forwards them to such agencies for completion.

   3) The completed Enrollment Package documents are submitted by the County to OMR, reviewed in the TSM Unit, and routed to the Deputy Secretary and others for signature and approval before enrollment can proceed.

   4) Upon return of the signed agreements, the TSM Unit performs the data entry of a provider's information into MAMIS which automatically assigns a Provider Number.

   5) MAMIS produces "hard copies" of provider information called Provider Notices, which detail the providers' identifying, mailing, and rate schedule information.

   6) MAMIS generated Provider Notices are received and reviewed in the TSM Unit upon receipt from the Office of Medical Assistance and are subsequently forwarded to the enrolled provider. The provider may begin using the Provider Number appearing on the Notice for billing of MAMIS.
15) WILL THE PROVIDER NUMBER CHANGE WITH EACH NEW YEAR OF TSM PARTICIPATION?

ANSWER: No. The Provider Number initially assigned to a provider upon acceptance into the TSM program will continue in use as a permanent identifier.

16) WHAT IS CONSIDERED ADEQUATE DOCUMENTATION OF CHOICE BY ENROLLED TSM PROVIDERS WHO OFFER OTHER DIRECT SERVICES?

ANSWER: When options for service are available, the options must be listed in the person's case records along with documentation that the services were identified and offered to the individual and documentation of the individual's response(s) to choices offered.
COUNTY PROGRAM/FISCAL ISSUES

1) ARE THERE RESTRICTIONS ON WHERE TSM FUNDS CAN BE REALLOCATED WITHIN THE COUNTY PROGRAM?

ANSWER: Yes. The funds generated from Targeted Service Management must be used to enhance the provision of case management services or augment the county administrative capacity to administer case management activity.

2) IS THERE ANY CONSIDERATION BEING GIVEN TO ALLOWING COUNTIES TO MAINTAIN FUNDS WHICH HAVE NOT BEEN EXPENDED AS OF THE END OF THE FISCAL YEAR?

ANSWER: No. Funds unexpended as of the last day of the fiscal year will be treated as carry-over through the Income and Expenditure (I & E) Report.

3) HOW CAN RURAL COUNTIES WITH SMALL TSM ELIGIBLE POPULATIONS RECEIVE THE NECESSARY ADDITIONAL ADMINISTRATIVE SUPPORT TO IMPLEMENT TSM?

ANSWER: The needs based budgeting process is the means by which counties can identify additional fiscal needs in this area. In addition, federal funding for administrative costs is also available for participating counties.

4) CAN COUNTIES ADVANCE STATE FUNDING TO ASSURE ADEQUATE PROVIDER CASH FLOW?

ANSWER: Yes.

5) WHAT INCENTIVES DO COUNTIES HAVE TO CONTROL EXPENDITURES AND MONITOR UTILIZATION?

ANSWER: County incentives to control expenditures and monitor utilization include:

   a) Proper management of funding made available through TSM enables the county to enhance case management services;

   b) The potential for audit exception by State and Federal government for misuse of funds;

   c) The Department's expectations that the County will fulfill its administrative functions in an appropriate manner. Federal funds will also be used to support the County for these administrative services.

IV-1
(2/94)
6) WILL THERE CONTINUE TO BE A LIMIT ON THE FEDERAL DOLLARS IN THE COUNTIES' ANNUAL ALLOCATION LETTERS?

ANSWER: Yes. The limit on federal funding is based on the amount of federal dollars appropriated by the State Legislature.

7) CAN SERVICE PROVIDERS RETAIN REVENUES, ACCRUING AT THE CLOSE OF THE CONTRACT PERIOD, IN EXCESS OF ELIGIBLE EXPENSES REALIZED UNDER THE CONTRACT?

ANSWER: In accordance with the County Mental Health and Mental Retardation Program Fiscal Manual, 55 PA Code CH 4300.18, a county may authorize a contracted provider to retain revenue to an amount not to exceed 3% of the total gross revenue applicable to the contract.

8) MAY AN INDIVIDUAL CHOOSE TO RECEIVE TSM FROM AN ENROLLED PROVIDER IN A COUNTY OTHER THAN THE ONE IN WHICH THE INDIVIDUAL RESIDES?

ANSWER: Yes.

9) IS A COUNTY/PROVIDER SELECTED FOR TSM PROVISION BY AN INDIVIDUAL WHO IS ELIGIBLE FOR TSM OBLIGATED TO PROVIDE TSM TO THAT PERSON?

ANSWER: Yes.
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**ANSWER:** Yes.
RATE SETTING

1) HOW WILL RATES BE ESTABLISHED?

ANSWER: Each County MH/ MR Program calculates and forwards a TSM interim rate to OMR for consideration each year of participation. OMR must review these individual interim rates annually. A County which contracts for TSM provision may establish this interim rate as the rate for all of its TSM providers or may negotiate individual rates which may not exceed the County's approved interim rate. Rates are to be negotiated between the County and Provider in accordance with the County Mental Health and Mental Retardation Fiscal Manual, 55 PA Code CH 4300.

2) MUST COUNTIES WHICH CONTRACT FOR AGENCIES FOR TSM PROVISION INFORM OMR OF RATES NEGOTIATED FOR TSM UNITS OF SERVICE? IF SO, WHEN AND HOW?

ANSWER: A declaration of the TSM rate a county agrees to pay a contracted provider (or several) signed by both the County Administrator and the private provider Executive Director (or legal representative) must be submitted to the Office of Mental Retardation, TSM Unit. This may be in statement or letter form and should accompany the provider's Enrollment Package, so that the rate may be entered on the MAMIS file allowing payment to occur.

3) HOW CAN A PROVIDER BE REIMBURSED FOR INDIRECT SERVICE FUNCTIONS WHICH SUPPORT ELIGIBLE SERVICE ACTIVITY?

ANSWER: Indirect functions that are necessary to support eligible service activity can be included in determining the interim rate. When the provider is the County program, the County has the option of requesting reimbursement as an administrative cost.

4) MAY COSTS ASSOCIATED WITH INELIGIBLE SERVICE FUNCTIONS, SUCH AS OUTREACH AND INTAKE, BE BUILT INTO THE INTERIM RATE?

ANSWER: No. Costs of ineligible service functions are not reimbursable under TSM. They may be reimbursable with 90/10 categorical case management funds or, in some instances, as TSM County Administrative Costs.

5) MAY TSM OFFICE SPACE, PHONE, AND UTILITY COSTS BE BUILT INTO THE INTERIM RATE, AS OPPOSED TO COUNTY ADMINISTRATION?

ANSWER: Yes. Space, phone, and utility costs which are necessary to support eligible service activity associated with TSM can be built into the rate.
6) WHAT ADJUSTMENTS CAN BE MADE AT THE END OF THE FISCAL YEAR IF
TSM EXPENSES WERE HIGHER THAN ANTICIPATED?

ANSWER: Total costs including adjustments cannot exceed the
County's allocation. Such year's end requests will be closely scrutinized.
An end-of-year adjustment may be made only if the actual TSM costs of a
County or its contracted provider are higher than the approved interim rate
times (x) the number of units that were provided. A County anticipating
such an adjustment should make a written request offering justification to
the appropriate Regional Program Manager. Counties which contract for TSM
provision will be expected to monitor their contractors' billings and
reimbursements to conform to allocation limits defined in their contracts.

7) CAN A COUNTY'S INTERIM RATE BE CHANGED (INCREASED) DURING THE
FISCAL YEAR?

ANSWER: Yes. This may occur based upon OMR's approval of a
written County request which justifies the rate increase. Although the rate
may be changed, there can be no increase in the County's total federal
funding (FFP) without a change in the County's allocation. An increase in
federal funds can be requested through the county rebudget process and may
be applied retroactively to July 1 if justified as necessary and
appropriate.

8) CAN ACTIVITIES ASSOCIATED WITH MAINTAINING PROVIDER
ELIGIBILITY BE BUILT INTO THE INTERIM RATE?

ANSWER: Yes. Activities or elements related to maintenance as an
eligible TSM provider may contribute to interim rate calculation.
Eligibility requirements for providers are established in the Department's
approved TSM State Plan Amendment. For example, costs associated with the
provider serving as "a fixed point of referral and information for persons
with mental retardation and their families" should be included in this
calculation.

9) WHY DOES THE FEDERAL FINANCIAL PARTICIPATION (FFP) AMOUNT OF
THE INTERIM RATE ROUTINELY CHANGE (DECREASE) DURING THE FISCAL YEAR, NOTABLY
ON OCTOBER 1?

ANSWER: The federal government establishes the FFP amount of the
interim rate based on an annual formula which may cause the FFP rate to
fluctuate with each new federal fiscal year. The federal fiscal year begins
on October 1, not July 1 as does the state fiscal year.

As a result, one FFP reimbursement rate is entered on each
provider's MAMIS file for the first quarter of the state fiscal year
(July 1 - September 30) and a second rate is entered for the 2nd thru 4th
quarters of the state/county fiscal year (October 1 - June 30). The two
rates will appear on the Provider Enrollment Notice and annual updates.
TSM ADMINISTRATION

1) HOW DOES COUNTY ADMINISTRATION DIFFER FROM ADMINISTRATIVE COSTS CHARGED BY A PROVIDER OF TSM?

ANSWER: County Administration Costs may be charged for certain functions of the County MH/MR Program and receive 50% Federal reimbursement. County Administrative Costs are for the proper and efficient operation of the State Plan and cannot duplicate case management service furnished under TSM. Provider Administrative Costs are for functions which directly support eligible TSM service activity. Provider's Administrative Costs are therefore built into the TSM service rate which is subject to Federal Financial Participation, which is currently 54.61% of total costs (for period 10/1/93 - 9/31/94).

2) WHAT CAN BE BILLED AS COUNTY ADMINISTRATIVE COSTS?

ANSWER: County Administrative Costs can be billed for expenditures associated with certain activities related to service management, such as intake into the County MH/MR Program, which are not eligible service activities. County Administrative Costs can also be billed for contract monitoring of service management providers and other related administrative expenses of the County Office.

The full range of activities for which County Administrative Costs can be billed and the procedures for billing are contained in instructions by QMR titled "INSTRUCTIONS TO COUNTY MH/MR PROGRAMS CLAIMING FEDERAL REIMBURSEMENT ON TARGETED SERVICE MANAGEMENT ADMINISTRATIVE COSTS".

3) WHEN A COUNTY MH/MR PROGRAM IS A PROVIDER OF SERVICE, CAN THE COUNTY BILL SOME TSM ADMINISTRATIVE COSTS AS A PROVIDER EXPENSE AND OTHERS AS A COUNTY ADMINISTRATIVE COST?

ANSWER: Yes. As long as the County can document that there is no duplication of billing and County Administrative Costs are included in the County's approved Cost Allocation Plan, this dual method may be used.

4) WHAT PERCENTAGE OF COUNTY ADMINISTRATIVE COSTS ARE REIMBURSED THROUGH MEDICAL ASSISTANCE?

ANSWER: 50%.

5) IS OUTREACH TO LOCATE INDIVIDUALS WHO MIGHT BE MENTALLY RETARDED REIMBURSED AS AN ELIGIBLE SERVICE FOR TSM OR IN ANOTHER MANNER?

ANSWER: No. Outreach is not a reimbursable function under TSM, but it is a County Administrative Cost eligible for 50% federal reimbursement.

6) MUST THE "ADMINISTRATIVE COST REPORT" BE SUBMITTED WITHIN 14 WORKING DAYS AFTER END OF QUARTER?

ANSWER: Yes. This time frame is necessary to accommodate federal claiming and reporting requirements at the Department level.
7) WHEN COMPUTING ADMINISTRATIVE COSTS, CAN A COUNTY INCLUDE ADMINISTRATIVE EXPENSES INCURRED BY A CONTRACTED PROVIDER OF TSM?

ANSWER: No.

8) ON WHICH INCOME AND EXPENDITURE (I AND E) REPORT WILL THE 4TH QUARTER COUNTY ADMINISTRATIVE COSTS APPEAR?

ANSWER: Fourth quarter County Administrative Costs should be indicated on the I and E Report for the year in which the costs are incurred even though reimbursement for 4th quarter costs will not occur until the next fiscal year.
TSM SERVICE DOCUMENTATION REQUIREMENTS

1) WHAT IS THE DEFINITION OF A UNIT OF SERVICE?

ANSWER: A unit of service is defined as 15 minutes of eligible activity or a major portion thereof.

2) ARE THERE ANY LIMITS ON SERVICE PROVISION?

ANSWER: Yes. The maximum number of allowable units per month is 480 units per eligible individual. An edit inquiry will occur at 160 units per month per individual.

3) HOW ARE SERVICE UNITS DOCUMENTED?

ANSWER: Eligible service units are documented on an Activity Log issued or approved by OMR.

4) WHAT MUST BE INCLUDED ON AN ACCEPTABLE ACTIVITY LOG?

ANSWER: Providers must maintain individual records to include:

1) TSM Recipient's Name;
2) Date of Service;
3) Place of Service;
4) Duration of Eligible TSM Service Activity (Hours and/or Minutes);
5) Nature of Service/Contact (Descriptors Supporting Billing);
6) Name of the Service Manager and Provider Agency;
7) Signature of Service Manager.

The following additional documentation elements required by OMR may appear on the Log or be maintained in accessible and regularly updated cross reference(s) for purposes of Utilization Review:

1) Recipient # (formerly MAID #);
2) ICF/MR or nursing facility discharge information and date, as applicable.
3) TSM units billing information.

The TSM provider agency name and MA provider number may be printed on the form as standard information. The BSU# assigned by the county or provider and other variables may be maintained on the log at the discretion of the provider designing this documentation form.

5) DOES THE SERVICE MANAGER HAVE TO SIGN FOR EACH SERVICE ENTRY?

ANSWER: No. If multiple dated entries appear on an Activity Log or other OMR approved form, the Service Manager may sign once for all services rendered and documented on that form.
6) **MAY A SIGNATURE STAMP BE USED ON THE ACTIVITY LOG?**

**ANSWER:** Though not preferable, this is acceptable if the signature replicates that of the actual Service Manager who provided and documented the service. The provider will be held accountable for any service that is billed to the Department.

7) **WHAT ARE THE MINIMUM ACCEPTABLE SERVICE NOTES DOCUMENTED ON THE ACTIVITY LOG FOR PURPOSES OF JUSTIFYING FEDERAL CLAIMS?**

**ANSWER:** To qualify as supporting documentation for Federal Financial Participation (FFP), the notes must reflect service management activity falling within the parameters of "locating, coordinating and monitoring of services." (See "Eligible Services" Section and Attachment A.) Detailed checklist formats for logging activity and related descriptors are acceptable documentation that may alleviate some note maintenance.

Specific citations regarding the setting, nature of the contact (phone, person-to-person, correspondence, etc.), names and roles or titles of persons contacted, agency names, etc., which validate the billing data elements and support the eligibility of the activity are recommended.

8) **CAN THE ACTIVITY LOG BE PLACED AND MAINTAINED ON COMPUTER DISK?**

**ANSWER:** Yes. Providers which supply Service Managers with laptop or personal computers for maintenance of service delivery records should require the Service Manager to print out hard copy records which are then hand-signed to authenticate TSM provision.

9) **IS IT NECESSARY TO DOCUMENT THE LENGTH OF TIME (MINUTES OR HOURS) ASSOCIATED WITH A PARTICULAR SERVICE MANAGEMENT ACTIVITY?**

**ANSWER:** Yes. While recording of To/From "clock time" is not required, duration in minutes/hours must be recorded.

10) **CAN THE NUMBER OF MINUTES BE ADDED TOGETHER TO DETERMINE NUMBER OF BILLABLE UNITS FOR AN INDIVIDUAL?**

**ANSWER:** Yes. This is acceptable as long as: 1) the minutes of service are provided on the same day or consecutive calendar days; 2) the number of units computed equal or exceed the number of service dates documented (i.e., Minutes added together on two consecutive days must total at least two units.); and 3) the place of service is the same. Note that minutes of service occurring on the same day at the same place must be added together for billing purposes. (See X-1, #1).

11) **MUST AN INDIVIDUAL'S PROGRAM PLAN (IPP)—ALSO REFERRED TO AS A PERSON-CENTERED PLAN (PCP), LIFE MANAGEMENT PLAN (LMP), OR INDIVIDUAL EDUCATIONAL PLAN (IEP)—REFLECT THE PROVISION OF TSM AS A SERVICE?**

**ANSWER:** Yes. The IPP must include a statement that the individual chooses to receive TSM during the period services are provided. If the timing of the annual IPP development, review, and presentation does not allow this, the provider may draft an IPP addendum which the individual or his/her representative must sign.

VII-2

(2/94)
STATE MATCH VERIFICATION

OMR/TSM Unit is currently exploring several issues associated with the purpose, necessity, and manner of completion of this form.

We are attempting to address concerns presented by providers while continuing to satisfy the Commonwealth's and Health Care Financing Administration's (HCFA's) fiscal accountability and documentation requirements.

Pending resolution, providers should continue to complete and retain the State Match Verification Form and document this on each invoice (MA 319 10/90) submitted to MAMIS, coding "17" in Section 41 of the MA 319.
THIRD PARTY RESOURCES

1) IF AN INDIVIDUAL HAS A THIRD PARTY RESOURCE, DOES THAT RESOURCE HAVE TO BE BILLED FIRST BEFORE AN INVOICE IS SENT TO MA?

ANSWER: Effective immediately, TSM providers should discontinue submitting claims to third party insurers or seeking broader Third Party Liability statements of denial prior to billing MA. This applies only to TSM provision and will be retroactive to the provider's enrollment in TSM.

References to third party resource billing and associated procedures in TSM documents (Medical Assistance/TSM Provider Handbook, Training Material, etc.) will be updated to reflect this change through the release of a Mental Retardation Bulletin on this topic. In the meantime, please disregard prior Third Party Liability advisement and make pen and ink changes as needed.

2) HOW ARE INVOICING ITEMS RELATED TO THIRD PARTY LIABILITY TO BE TREATED IN VIEW OF THE ABOVE RELEASE OF OBLIGATION TO BILL THIRD PARTY INSURERS FOR TSM?

ANSWER: When completing a Physician's Invoice/Medical Services/Supplies Invoice (MA319) or the Claim Adjustment (MA319A), items which relate to resource information should be left blank, regardless of an individual's specific insurance coverage.

<table>
<thead>
<tr>
<th>Item</th>
<th>Resource Code</th>
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<td>Item 7.</td>
<td>Health Insurance</td>
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<td>Item 8.</td>
<td>Name and Address</td>
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<td>Item 9A.</td>
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INVOICE COMPLETION/BILLING ISSUES

1) HOW DO SERVICES PROVIDED IN DIFFERENT PLACES BUT ON THE SAME
DAY NEED TO BE REPORTED ON THE INVOICE?

ANSWER: Services provided in different places on the same day are
recorded on different lines of the invoice. Combine all units for the same
day/same place on one line.

2) ON THE INVOICE, SHOULD THE USUAL CHARGE BE THE NUMBER OF UNITS
TIMES (X) THE PROVIDER'S INTERIM RATE OR THE NUMBER OF UNITS TIMES (X) THE
FFP AMOUNT OF THE PROVIDER'S INTERIM RATE?

ANSWER: Either amount can be entered, but the system will only pay
the FFP portion of the provider's interim rate. Unless a third party payer
is involved, the Department prefers the provider enter the FFP amount.

3) DOES ITEM #40 (NO. OF ATTACHMENTS) ON THE PHYSICIAN'S INVOICE
NEED TO BE COMPLETED?

ANSWER: Generally, providers should leave item #40 blank or fill
in a zero excepting the few special circumstances requiring attachments to
be submitted.

Providers are reminded that they currently must complete items #41
and #42, Attachment Type, as appropriate to document any "attachments"
required to be on file, such as the State Match Verification Form.

4) DOES THE INDIVIDUAL HAVE TO SIGN THE INVOICE, AS INDICATED IN
THE TSM PROVIDER HANDBOOK (1/93), IN ORDER FOR THE PROVIDER TO RECEIVE
PAYMENT?

ANSWER: No. This has been waived for TSM providers. The
individual must only sign his/her current program plan or addendum to the
plan which states the individual chooses to receive Targeted Service
Management.

5) HAS USE OF THE ENCOUNTER FORM IN THE TSM PROVIDER HANDBOOK
(1/93) BEEN WAIVED?

ANSWER: Yes.

6) CAN A PROVIDER USE A SIGNATURE STAMP TO AUTHORIZE A TSM CLAIM?

ANSWER: Yes.
7) IS IT TRUE THE PAPER MA ID CARD IS BEING REPLACED? IF SO, HOW/WHEN WILL TSM BILLING BE AFFECTED?

ANSWER: A new ID, the ACCESS Card (plastic card with a 10-digit "Recipient Number"), is being phased in throughout the state by the Office of Medical Assistance Programs as a corollary to the Eligibility Verification System (EVS). MA recipients throughout the Commonwealth will be provided with ACCESS Cards over the course of five (5) stages or "phase-ins". TSM providers in counties where the ACCESS Cards have been distributed should be using the new 10-digit recipient number for invoicing.

Until all ACCESS Cards are issued, Providers are permitted to use the standard MA ID number. Since June 1, 1993, however, the new 10-digit "Recipient Number" has appeared on the paper MA ID card. Though not mandatory, providers should begin use of that simplified ID number as soon as it is obtained, even prior to full ACCESS Card implementation. Such use is likely to reduce invoice error and rejection since this single identifier replaces the more cumbersome record number and several other codes. This new number also is used in verifying eligibility, obtaining other information relevant to serving individuals, and receiving proper reimbursement.

Bulletins, detailing the phase-in periods and other specifics, have been issued by the Office of Medical Assistance Programs to enrolled Providers to aid the transition to ACCESS and EVS. Counties or Providers which have failed to receive these OMAP bulletins may contact the Office of Mental Retardation, TSM Unit for copies at (717) 783-2376.

8) CAN A SERVICE MANAGER BILL FOR UNITS OF SERVICE IN EXCESS OF THE TOTAL NUMBER OF HOURS WORKED IN A DAY?

ANSWER: No. Billing in excess of the actual hours worked is not allowed.

The total workday hours multiplied by four (4) units is the maximum number of units for which the service manager may bill. Providers may, of course, bill for TSM units occurring during compensable "overtime".

9) FOR WHOM DOES THE SERVICE MANAGER BILL TSM UNITS WHEN SERVING MORE THAN ONE ELIGIBLE PERSON AT A TIME?

ANSWER: The Service Manager may either split the units between the individuals or bill the total time/units under one individual's MA ID number. If billing under several names, the Service Manager must document contact/activity in each record.

A Service Manager may not bill for service to more than one person during any fifteen (15) minute unit of service.

10) WHAT DATES ARE USED IN BILLING FOR CONSECUTIVE DAYS?

ANSWER: The beginning date will be the date the first service was provided, and the end date will be the date the last service was provided.
11) WHAT EVENTS OCCUR IF A PROVIDER BILLS OVER 160 TSM UNITS IN A MONTH FOR A SINGLE INDIVIDUAL?

ANSWER: The payment will be made, and a follow-up inquiry by OMR staff will occur to determine the appropriateness of such service provision.

12) CAN PROVIDERS ABBREVIATE TO "TSM" AS THE INVOICE ENTRY FOR PROCEDURE NAME, ITEM 29A?

ANSWER: Yes.

13) CAN TWO SERVICE MANAGERS BILL FOR THE SAME INDIVIDUAL FOR THE SAME SERVICE AT THE SAME TIME?

ANSWER: No. Two Service Managers representing the same MA Provider Type and Type of Service may not routinely bill for the same individual for the same service (activity) at the same time. For example, if a Service Manager is terminating employment and, in transferring responsibilities, is explaining the individual's service activity to the new Service Manager, only one Service Manager may bill.

However, OMR recognizes that extraordinary circumstances such as crisis intervention and/or emergency placement may warrant two Service Managers simultaneously working on behalf of an individual. Such invoices must be directed to the appropriate Regional Office with written justification for approval. Submission of such invoice program exceptions directly to MAMIS will result in rejected claims.

This policy will not prohibit multiple "same day/same place" billings by case managers from distinct disciplines—representing distinct providers (eg. TSM, ICM, D & A, etc.) and coordinating unique services—who meet collaboratively with or on behalf of the same individual in an interdisciplinary encounter or planning session.

14) IF AN MA CLAIM IS REJECTED, HOW DOES A PROVIDER RECEIVE FULL PAYMENT?

ANSWER: If a claim is rejected, the provider can generally resubmit a new claim based on correcting errors or supplying new information as indicated by the edit codes appearing on the Remittance Advice Notice transmitted by MAMIS. A resubmission requires that the Claim Reference Number (CRN) and the Remittance Advice (RA) Number of the original rejected claim be documented on the invoice. If the individual is not eligible for MA on the date of service or coverage does not include TSM, the service management may be funded as non-MA case management program.

Providers should follow the resubmission instructions in the TSM Provider Handbook to ensure proper payment.

15) HOW SOON MAY A PENDED INVOICE BE RESUBMITTED FOR PAYMENT?

ANSWER: If a pended invoice does not appear on a subsequent RA as approved or rejected, it may be resubmitted forty-five (45) days after the Process Date appearing on the RA pending the original invoice.
DATA SYSTEMS

1) IS A COMPUTERIZED BILLING PROCESS OFFERED BY THE STATE?

ANSWER: Yes. Enrolled providers may contact EDS Federal Corporation, contracted with OMAP/MAMIS, at (717) 975-6045 for more information concerning the magnetic tape invoicing option.

2) CAN A PROVIDER BILL TAPE-TO-TAPE IMMEDIATELY OR WILL THERE BE SOME DELAY?

EDS Federal Corporation has indicated that there should be no delay in billing tape-to-tape as long as the provider is enrolled and tape-to-tape is indicated in their MAMIS file.

This entry on the provider's file, allowing electronic billing (magnetic tape invoicing), initially results from information appearing on the provider's completed Enrollment Information Form and the signing of a contract with DPW supporting the provider’s intent. The contract, the "Supplemental Provider Agreement for Electronic Media Claims Invoicing", is sent to each provider as part of the original enrollment package. Once returned to the Department, and processed through officials there, a signed copy is returned to the provider thereby authorizing tape-to-tape billing.

A provider which initially enrolls as a TSM provider prepared to bill only by manual invoice completion may later contact OMR to complete the authorization process.

3) WHERE CAN A PROVIDER LOCATE THE REQUIRED "SIGNATURE TRANSMITTAL FORM" (MA 307), AN INVOICE SUBMISSION FORM WITH HANDWRITTEN SIGNATURE, WHICH MUST ACCOMPANY 1) MAGNETIC TAPE BILLING, 2) DISKETTE BILLING, OR 3) MACHINE-PRINTED CONTINUOUS FORM INVOICES?

ANSWER: The MA 307 form referred to in the TSM Provider Handbook will be added in a future revision. The "Encounter Form," in the Handbook, requiring recipient signatures is NOT the form providers are to use for this purpose. A copy of the appropriate form (MA 307) appears in the Appendix of this Packet. (Attachment D.) Use of a photocopied form is acceptable.

Also, providers may order this and other forms needed by completing and submitting a Medical Assistance Provider Order form, MA 300X 4/92, sent to them upon enrollment with their supply of invoices, etc.

4) HOW CAN A PROVIDER ASCERTAIN AN INDIVIDUAL'S HEALTH CARE BENEFIT PACKAGE CODE, PROGRAM STATUS CODE, AND CATEGORY OF ASSISTANCE ONCE THE PAPER MA ID CARD INDICATING SUCH CODES IS REPLACED BY THE NEW PLASTIC MA ACCESS CARD WHICH DOES NOT?

ANSWER: Via the on-line recipient Eligibility Verification System (EVS) implemented by DPW and its contractor EDS. See the EVS Provider Manual, PUB 261 (4/93) which can be obtained by contacting EDS at (717) 975-6045.

XI-1
(2/94)
UTILIZATION REVIEW (UR)

Office of Mental Retardation staff are in the process of developing Utilization Review methodology and procedures.

TSM Providers are reminded to:

1) Seek OMR approval for their TSM documentation forms (individualized Activity Logs) prior to use;

   and

2) Comply with all requirements and policies relating to service provision, documentation, and invoicing contained in this Technical Assistance Packet and other materials provided by the Department.
ATTACHMENTS

A. Eligible Service Functions/Ineligible Functions

B. County Caseworker 1 (L0623) Class Specification

C. Medicare Denial Letter

D. Signature Transmittal Form (MA 307)
ELIGIBLE SERVICE FUNCTIONS

Locating Services:

Assistance to individual and family in linking, arranging for, and obtaining services specified in the individual's plan including medical, social, habilitation, education, or other community service which the individual needs to live at home and in the community.

Activities consist of:

Assessment of strengths/needs for the purposes of receiving services.

Arranging to develop plans and agreements for the provision of services.

Development of the individual's plan.

Referral to generic, informal, and specialized services and supports.

Ensuring providers are appropriately qualified to provide services.

Making contacts with prospective service providers on behalf of the individual.

Problem resolution to ensure access to services including consultations.

Finding home and community services for individuals residing in Medicaid institutions. Transitional assistance up to 30 days prior to an individual's discharge from a Medicaid institution is permitted under current Federal policy.

Assisting the individual in obtaining Food Stamps, energy assistance, housing, financial assistance, employment, medical services, legal services or other necessary services and benefits.

Identifying individuals in the community including family, friends, groups, or organizations who may be available to provide services and support.

Securing information relating to obtaining services.

Service manager travel time relating to linking, arranging for, and or obtaining services with and on behalf of the individual.
Coordinating Services

Ongoing management of services and support stipulated in the individual's plan in cooperation with the individual, family, and providers of service.

Activities consists of:

Assuring that the individual's plan is appropriately organized and implemented.

Maintaining contact with the individual's family, friends and others to ensure that the individual's support network is appropriately utilized in the provision of services.

Organizing activities around planning and service delivery.

Resolution of barriers related to the above activities.

Maintaining collaboration with generic services, informal supports, specialized agencies and others concerned with services for the individual and family service needs.

Ensuring appropriate persons and agencies are involved in program planning and decision making relating to the individual's services.

Arranging for modifications in service delivery.

Making necessary arrangements to assure that the individuals and families continue to have access to needed services.

Enabling the individual to continue to receive financial and other resources he/she is eligible for.

Dissemination of information and support to individuals and others responsible for planning and the implementation of services.

Ensuring consistency in service delivery among providers.

Service manager travel time relating to ongoing management of services, with and on behalf of the individual.
Monitoring Services

Establishment and implementation of means to assure that the individual is receiving the appropriate quality, type, duration and frequency of services and benefits.

Activities consist of:

Assuring that the individual's plan is implemented and reviewed via meetings, visits, and phone contact with providers, family, and others that are concerned with the individual.

Assessments of service outcomes at regular intervals.

Assessments of individual/family and provider satisfaction with services provided for the individual.

Advocacy to ensure continuity of services, system flexibility, access and proper utilization of resources, and individual rights.

Ensuring individual health and well-being.

Ensuring that services are appropriately authorized and documented.

Ensuring that service objectives and outcomes are consistent with the individual's needs and goals.

Ensuring the individual's eligibility for continued benefits.

Ensuring that services are cost effective.

Service manager travel time relating to monitoring of services with and on behalf of the individual.
SERVICE FUNCTIONS INELIGIBLE FOR FEDERAL FINANCIAL PARTICIPATION UNDER TARGETED SERVICES MANAGEMENT

Intake to the County Program for purposes of determining whether an individual has mental retardation and qualifies for Medical Assistance.

Prevention Services

General information to individuals, families, and the public which is not on behalf of the individual.

Travel expenses of the service manager outside of eligible service functions.

Services otherwise available under Medicaid through 2176 Waiver and Early Intervention.

Medical treatment and other specialized services including physical or psychological examinations or evaluations.

Actual cost of the provision of the service which the service manager links, arranges, or obtains on behalf of the individual.

Assistance provided to individuals regarding:
  a. Medicaid eligibility determinations or redeterminations
  b. Medicaid intake processing
  c. Medicaid preadmission screening for inpatient care
  d. Prior authorization for Medicaid services and utilization review
  e. Medicaid outreach (methods to inform or persuade individuals to enter into care through the Medicaid system)

Institutional discharge planning from a hospital, nursing home or ICF/MR
 COUNTY CASEWORKER I

**Definition:** This is entry level professional social service work in a County Children and Youth, Mental Health/Mental Retardation, or Human Services Agency.

Employees in this class participate in formal and informal county agency training programs which provide knowledge of the methods, procedures, rules and regulations necessary to perform social service and case management supportive services to children, youth, and families, people who are mentally disabled, people who are physically challenged, and others to assist them in attaining a more satisfactory social, economic, emotional, or physical adjustment. The work assigned is limited in scope and difficulty, and is performed under close supervision, but as knowledges and skills are acquired, more latitude in judgment and decision making is permitted. Work is performed under the close supervision of a professional social service or administrative supervisor and is reviewed through individual and group conferences, assignment of professional reading, attendance at training programs, and the reading of records and reports.

**Examples of Work:** Participates in formal and informal training programs which provide basic knowledge relative to agency purpose, services provided, client population characteristics, and applicable laws, methods, procedures, rules and regulations governing the operation of the agency.

Learns about the network of available community resources by reviewing resource files, site visits, and working with and observing higher level caseworker staff.

Receives instruction regarding the reason for and proper completion of applicable forms and paperwork.

Performs a variety of entry level social services and case management duties designed to provide supportive services to children, youth and families, people who are mentally disabled, people who are physically challenged, and others.

Assists clients and their families in developing and using their own potential for more adequately resolving their social, health, emotional and economic problems.

Provides or assists in the provision of social services, such as placement of children and adults in foster or adoptive homes, day care centers, domiciliary care facilities, or institutions.

Guides clients in home and budget management, housing, child care and parenting skills, employment, recreation and living arrangements.

Schedules and conducts interviews and follow-up visits to provide service and counseling.

Prepares and provides testimony in court under supervision.

Makes referrals to other public and private social services and community agencies and resources to meet client needs; assists clients and their families in understanding and utilizing these resources.

Attends and participates in case reviews and supervisory conferences and is exposed to a variety of learning experiences, including formal and on-the-job training programs, designed to develop professional and technical skills.
Documents activities and services using designated agency methods and procedures, including social service summaries, correspondence and reports.

Performs related work as required.

Required Knowledges, Skills, and Abilities: Knowledge of the basic principles of economics, sociology, psychology, and other social sciences.

Knowledge of current social, economic, and health problems and their impact on the growth and development of people.

Knowledge of human development and behavior including the individual, family, and group.

Ability to understand and accept the needs and rights of others and to work with adults and children who are physically challenged, mentally disabled, emotionally troubled, and economically disadvantaged.

Ability to learn, interpret, and apply relevant laws, regulations, and policies governing agency services.

Ability to learn how to conduct individual and family interviews and to use them to identify individual and family problems.

Ability to learn how to effectively interact with individuals, families, and as a member of a treatment team.

Ability to plan and organize work, prepare adequate records and reports, set priorities, and learn to maintain a caseload in an effective and timely manner.

Ability to adequately express ideas orally and in writing.

Minimum Experience and Training: A Bachelor's Degree which includes or is supplemented by successful completion of 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social sciences;

or

Two years of experience as a County Social Services Aide 3 and two years of college level course work which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social sciences;

or

Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social sciences and one year of experience as a County Social Services Aide 3.

10-20-92
Rev. 01-28-93
Ms. Kathy Montag  
TSM Coordinator  
Commonwealth of Pennsylvania  
Department of Public Welfare  
Post Office Box 2675  
Harrisburg, Pennsylvania 17105-2675  

Dear Ms. Montag:  

This is in reference to your letter of May 14, 1993 to Pat Antrobus concerning Medicare coverage and reimbursement of Targeted Service Management (TSM).

Sections 2303 of the Medicare Carriers Manual and 3151 of the Medicare Intermediary Manual, copies of which are enclosed for your convenience, each state that unless items and services are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member they are not covered under the Medicare program. Since you described the TSM program as not being primarily medical in nature and it does not meet the criteria listed above, no coverage can be offered under the program.

Should you have any questions regarding this letter, please contact Barbara Cerbone on (215) 596-0583.

Sincerely,

[Signature]

Nancy Bolton O'Connor, Chief  
Carrier Operations Branch  
Division of Medicare  

Enclosure
General Exclusions From Coverage

3150. GENERAL EXCLUSIONS.

No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services.

A. Not reasonable and necessary (§ 3151);
B. No legal obligation to pay for or provide (§ 3152);
C. Paid for by a governmental entity (§ 3153);
D. Not provided within United States (§ 3154);
E. Resulting from war (§ 3155);
F. Personal comfort (§ 3156);
G. Routine services and appliances (§ 3157);
H. Excluded foot care services and supportive devices for feet (§ 3158);
I. Custodial care (§ 3159);
J. Cosmetic surgery (§ 3160);
K. Charges by immediate relatives or members of household (§ 3161);
L. Dental services (§ 3162);
M. Paid or expected to be paid under workers' compensation (§ 3163).

N. Nonphysician services provided to a hospital inpatient which were not provided directly or arranged for by the hospital (§ 3164).

3151. SERVICES NOT REASONABLE AND NECESSARY.

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

3151.1 Devices Not Approved by FDA.—Medical devices which have not been approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures or services performed using devices which have not been approved for marketing by FDA.
B. Identify which services are related to noncovered services and which are not. Following are some examples of services "related to" and "not related to" noncovered services while the beneficiary is an inpatient:

1. A beneficiary was hospitalized for a noncovered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear cut example of "not related to" services and are covered under Medicare.

2. A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a noncovered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a noncovered transplant or implant, the services related to the admitting condition would be covered.

3. A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the noncovered transplant, the services would be "related to" noncovered services and would also be noncovered.

C. After a beneficiary has been discharged from the hospital stay in which he received noncovered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior noncovered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous noncovered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, repair of complications from transsexual surgery or from cosmetic surgery, removal of a noncovered bladder stimulator, or treatment of any infection at the surgical site of a noncovered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee should be denied. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits should be denied.

(See Intermediary Manual, § 3637.15 and Hospital Manual, § 415.18 for billing procedures.)

2303. SERVICES NOT REASONABLE AND NECESSARY.

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member; e.g., payment cannot be made for the rental of a special hospital bed to be used by the patient in his home unless it was a reasonable and necessary part of the patient's treatment. See also § 2318.
SIGNATURE TRANSMITTAL FORM (MA 307)

Commonwealth of Pennsylvania
Medical Assistance Program

SIGNATURE TRANSMITTAL FORM
FOR DISKETTE/TAPE/CONTINUOUS-FED INVOICES

I am hereby submitting the enclosed invoices, diskettes or magnetic tapes as an approved Service Bureau/Provider.

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I certify that the information on the enclosed invoices, diskettes or tapes is accurate and complete as submitted.

I understand that payment and satisfaction of these claims will be from Federal and State funds and that I may be prosecuted for false claims, statements or documents, or concealment of material facts.

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V-5 DATE APRIL 1, 1990