

# Office of Developmental Disability Services (ODDS) eXPRS-Plan of Care FAQ

## Introduction

This Frequently Asked Questions (FAQ) document is being distributed to answer questions raised in conference calls between CDDP/Brokerages and ODDS. The answers provided in this document are meant to serve as a guide and are up-to-date as of 10/28/2015. All are subject to change based on policy and rule changes.

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# Billing and Payments

## Timesheets/Time Entry

**Question:** How do we learn about timesheet entry process?

**Answer:**

- Go to the “Help” menu and select the How-To Guide for guidance
- <https://apps.state.or.us/exprsDocs/HowToCreateServiceDeliveryPSWIC.pdf>

**Question:** When a PSW does not give us written authorization to enter hours into eXPRS via the eXPRS Plan of Care Services Delivered Report Form checkbox, are we allowed to enter their time?

**Answer: No, the timesheet is not properly completed the PSW will need to resubmit a properly completed timesheet. Any overages will suspend automatically and those can be edited or deleted later.**

**Question:** Can other (non-agency, CDDP, brokerage representatives) enter SE time for / and on behalf of PSW?

**Answer: No. This is a breach of security and confidentiality. If a PSW is not able to enter their own SD, they need to work with their CDDP or brokerage for appropriate entry.**

**Question:** If someone puts in dates of service for March (in this case March 1st) should we approve this? In the past, TNT would not process service dates in the current month if it was prior to the first billing period in that month. Will eXPRS track this OR should we not approve this time?

**Answer: Yes, you can approve time once you receive a timecard and verify services. Approved PSW payments are aggregated and transmitted to TNT following the Contract Payroll Calendar for CDDP’s/Brokerages 2015. Approved service delivery lines beyond the current submission period are automatically held for the next cycle.**

**This is only for submissions to eXPRS, NOT for submissions via a Manual Rates & Units file. If you are submitting a Manual file please follow the policies procedures from before POC.**

**Question:** Is eXPRS POC set up to restrict providers from entering more than half of their time in the first half of the month, rather than a monthly total? What happens if someone provides more than half the 1st-15th? Would they then bill for the hours they provided in the second half of the month?

**Answer:** Time entries are not restricted by the system. The system does not restrict the amount of authorized hours within the authorized frequency.

If someone provides more hours in the first half of the service period, they will have less hours available in the second half. SC/PA's should pay attention to this upon approving as they are most familiar with what services are authorized and when.

**Question:** If a PSW does not check the box, on the enrollment form, allowing the CDDP to make their time entries can we do so anyway?

**Answer:** No, if the box is not checked you are not authorized to enter their time. Only the PSW may enter their time. If you think they did not check the box by error and they are requesting you submit the time please have them either sign a document or submit an email to your office requesting you do so.

**\*NEW\* QUESTION:** Can the deadline to submit time sheets be extended when eXPRS is down or there is a holiday?

**ANSWER:** No.

**\*NEW\* QUESTION:** What is the process for payment of timesheets for PSWs who pass away?

**ANSWER:** If the timesheet is signed by the PSW then payment should be issued. If the PSW passes away before being able to sign it, as long as the employer of record authorizes the services they can be paid for up to 365 days afterwards. If there are concerns around the estate or survivorship please notify ODDS for guidance.

## Paychecks/Pay Stubs

**Question:** Does the check have the client name on it and/or identifying information about whether it is from a County or a Brokerage? We are hearing from behavior consultants that they are receiving checks without identifying information which makes it difficult for them to track what services have been paid and which are outstanding. We've directed them to go into eXPRS to view service delivered entries & look for the "invoice number" on the check. -- the question is whether each client paid through eXPRS is issued a separate run ID/invoice number, so that providers can track what is actually being paid to them.

**Answer:**

- **The PSW / PSW-IC paychecks are issued by TNT and they control what is on the check stub.**
- **The Behavior Consultants paychecks are issued by SFMA. If an individual is serving in both capacities they will be paid separately.**

**Question:** Do we have access to an itemized list or report that connects the service payment with the customer receiving the service instead of the provider? It would be helpful if the provider number was included in the results (both eXPRS # and SPD #)

**Answer: Yes, this data can be found using the view services search. How to guide is available on the help menu.**

**\*NEW\* QUESTION:** According to: APD-IM-15-057 states the following: Homecare Workers (HCWs) receive either a check stub or an Electronic Funds Transfer (EFT) stub each time they are paid. Recently, these stubs have displayed language reminding HCWs to be aware of when their provider enrollment credentials expire so that they can renew them before they expire. (Specific Language included in the APD) Can you confirm that this information is included on the pay stubs of our PSW's when they receive payment from TNT?

**ANSWER:** This IM was specifically directed to Homecare workers working for APD. It does not apply to DD providers at this time. If a HCW is also a provider of SPPC they most likely received the reminder on their pay stub.

## Provider Organization Payments

**Question:** Can agencies pro rate their 1:1 attendant care rate?

**Answer: No. Use the tier rate. 1:1 attendant care is a specific procedure code with a specific modifier. Group attendant care is a different procedure code using a different modifier, tier rates apply.**

**\*NEW\* QUESTION:** Are provider Organizations required to record the “Time in, Time out” of service on their invoices? Some PO’s do, and others simply record the hours provided.

**ANSWER:** eXPRS requires time in/out on all hourly services billings, regardless of provider type or data entry method (manual or SD import by agency). Whether time in, time out is required on the invoice would depend on the service. All hourly services require time in, time out.

## Payment Review

**Question:** Can Service Deliveries (SD’s) be reviewed prior to submission by a supervisor or manager?

**Answer:**

- **Yes, depending on how your processes work in your CDDP/Brokerage. If you are reviewing items that have already been entered into POC by an agency or PSW, the SC/PA would review but not submit the SD’s. The reviewer would then review their work and submit.**
- **If you are entering PSW time into the system then the SC/PA would save the time entry but not submit it which will place it into draft. The reviewer could then submit the SD for approval by searching for Draft SD’s.**

## EOR Review

**\*NEW\* QUESTION:** A question about employer paperwork. We have had a few cases where a child with a K plan funded DD151 plan was removed from the parents' home and placed into foster care by child welfare. The plan was to continue K plan funded DD151 supports in the child welfare funded foster home. The PSWs would like to continue to work but paperwork is slowing everything down. We are realizing that new employer paperwork is needed which then requires additional employee paperwork. Is there any way that we can document what is transpiring and simply have the new foster parent sign off on the time sheets for the month or two it takes to switch over all the paperwork? It is making continuity of care quite cumbersome.

**ANSWER:** The person reviewing the timesheet should note on the timesheet and in progress notes the circumstances that led to the current Employer not being available to sign the timesheet. If possible, verify that the services were provided through contact with the individual or others who would have knowledge (in this case the Foster Parent) and approve the Service Delivered. No one besides the PSW should sign that timesheet. This can only be done for one payroll period without an approved exception from ODDS. By the next payroll period a new Employer needs to be established. CDDP and brokerages must follow the requirements in OARs regarding termination of an employer of record.

## Payment Denial/Suspensions

**Question:** Is there a plan to allow hours to be entered to the limit of the plan rather than "suspending" the entire entry? For example, if a service has a limit of 250 hours and PSW's have entered 245 hours and then go in and enter another line of 8 hours, the entire 8 hours is suspended, rather than the 3 hours they would actually be over.

**Answer:** You can break the entry into multiple parts. Those that fall within authorized hours will be approved, those that exceed authorized hours will suspend.

**Question:** What is the CDDP and brokerages role in resolving “suspended” service deliveries? Does it differ if the CDDP entered the PSW time vs. the PSW entering their own time? It will consume a significant amount of staff time to resolve all suspended service deliveries. We currently have over 130 lines in “suspension”. The majority are related to times claimed that are overlapping other service deliveries and most of those are due to employment/day programs entering service deliveries during the same time period.

**Answer:** There is no difference between CDDP/Brokerages. You will need to review the suspended deliveries, which will show you why they are suspended. Once you have written permission from the submitting PSW you can correct the errors. Note: these are time sheet errors not a system error. It is the ultimate responsibility of the authorizing entity to ensure that time is correctly and accurately entered this include reviewing any lines that have suspended in the system.

**Question:** We had a few PSWs who recorded time when their customer was at work. The overlaps may only have been by 15 minutes, but nevertheless it prevented the service agency provider from submitting claims as the PSW claims had already been approved, but do have questions. Is there anything we can do to “fix” this?

**Answer:** One of the providers needs to adjust their billing entries. You will need to correct the Service Delivery entry and start over. The correction will be updated on the next aggregation cycle. You will need to notify the agency when the correction is done. You will also need to notify the PSW to have them correct and sign their time sheet.

## Group Payments (PSW Only)

**Question:** How do we enter / prorate group services in eXPRS?

**Answer:** For PSW & IC-PSW providers to use the “group” claiming, they would enter a Service Delivered billing entry for each client they saw, with the start/end times that applied to each AND check the “group” box on that SD entry line for each client who was part of that group at that time. eXPRS will then pro-rate the amount billed in the claims for each client in the group during the claims aggregation process.

**Question:** If a provider uses the group designation in an SDE and the two customers he's supporting for the hours on that SDE are from different brokerages, will the claim that shows up in a paid claims report pulled by a brokerage include the full amount paid to the provider (i.e. the payment for both customers) or will it show only the payment for the customer attached to the brokerage who is viewing the claims report?

**Answer:** Yes it will only show the pro-rated data for your client.

**Question:** What POC service codes are enabled for "group" pro-rated billing for PSW & IC-PSW providers?

**Answer:**The below POC procedure codes are enabled with the "group" check box (for pro-rated billing calculation) when entering Service Delivered entries for DE-PSW (type 84-803) and IC-PSW (type 74-734) providers:

- OR101 – Attendant Care – IADL
- OR324 – Assistive Technology Skills Training
- OR507 – Relief Care – Daily
- OR508 – Relief Care – Hourly
- OR526 – Attendant Care, Home or Community (ADL + IADL combined)
- OR529/W7 – Skills Training for K-Plan services
- OR541/W2 – Employment Path – Community

## Overpayments

**Question:** Who can the PSW's contact if they are overpaid?

**Answer:** They can contact ODDS at:

PSW/IC-PSW User Support

Phone: (844) 874-2788

Email: [technical.triage@state.or.us](mailto:technical.triage@state.or.us)

**\*NEW\* QUESTION:** What is the plan for reporting Provider Liability Deductions to providers? We are getting an increasing number of Providers (especially ICs and those that work with multiple customers and through multiple brokerages) contacting us very frustrated because they are getting checks for

different amounts than expected. It appears that these issues are due to Liability deductions. However, providers currently have no way in eXPRS to view their liabilities, when a liability deduction is made against a claim, the source of the liability deduction, etc. It sounds as though deductions are also not clearly reported in paychecks. When a provider receives a check for a seemingly random amount, they have no way to know if this is due to a legitimate deduction or a systems error, and have no means to reconcile their books. This seems to be a very large oversight with the eXPRS system. What is the plan for clear and transparent reporting of payments and liabilities, and is there someone who inquiring providers can be directed to other than the technical.triage contact until functionality is improved?

**ANSWER:** The issue is complicated for PSW/IC-PSW providers because TNT issues paychecks (not eXPRS directly), and liabilities for PSW/IC-PSW providers are complicated to explain/manage because of the restrictions of recovery amounts stipulated in the CBA.

CDDPs and Brokerage employees should contact the technical triage unit with questions.

**\*NEW\* QUESTION:** Recovering PSW Overpayment. Is it possible for the PSW pay stub to show the actual number of hours that a PSW worked and then a line with the overpayment adjustment on it? It is currently just showing the adjusted hours. For example, one individual worked 6.5 hours but with their overpayment they had .32 hours withheld to capture the 5% payback so their pay stub shows that they were paid for 6.18 hours. This is causing quite a few questions from PSWs regarding their pay stubs being incorrect.

**ANSWER:** We are working with TNT to change this.

**\*NEW\* QUESTION:** Is there a location within eXPRS for a PSW to see what the status of overpayment is and how much still needs to be paid back?

**ANSWER:** PSW's don't have this access and should reach out to CDDP/Brokerage for this information. Or they can send an email to [technical.triage@state.or.us](mailto:technical.triage@state.or.us).

CDDP/Brokerages can send inquiry emails to [psw.paymentissues@state.or.us](mailto:psw.paymentissues@state.or.us)

If a PSW's check is entirely incorrect they can write VOID on it and return it to TNT (Attention Kim Brady) who will then inform us.

If a PSW wants to increase their overpayment liability they can by emailing LeaAnn Stutheit, not TNT.

## Out of Cycle Payments

**Question:** Can we or PSW's be informed of when an out of cycle check run will occur?

**Answer:** We are running them all on the published calendar on the ODDS website and provider tools page. It is marked with a \* and the check date is marked with a diamond.

**Question:** Is it possible when doing an out of cycle check run that it doesn't encompass everything in eXPRS but only those that need to be?

**Answer:** Not at this time. In the future we are talking about this- but right now due to the high demand and use of the OOC runs, we are running everything authorized to be paid.

## Final Payments

**Question:** Are PSWs who have been terminated or who have quit paid differently? Prior to POC, timesheets were submitted to TNT 'out of cycle' with checks cut within 48 hours.

**Answer:** When a PSW stops working for a client (for whatever reason) but is not barred from working for other clients then they are not "Terminated". They are still approved to work. We know this is important and we are working with Labor Relations on this matter. Communication to the field is forth coming. Otherwise, PSW's no longer working for a specific client is still being paid on the regular schedule.

## eXPRS Payment Reports

**Question:** Are we able to run reports from eXPRS for the payment support details?

**Answer:** Yes, the Payment Details Report.

## Authorizations in POC

### New/Renewing/Transfer Plans

**\*NEW\* QUESTION:** We have a few POCs that were entered with incorrect start dates. This is problematic because when we try to use the actual end date of the ISP then POC believes that the plan is for more than 12 months. Is there a way for us to edit the start dates? Or someone that can do this for us so that we don't have to void months of SDs in order to fix this.

**ANSWER:** End the current POC, create a new – smaller POC to bridge the gap to the new POC date. If this does not work, send in an example for review.

**\*NEW\* Question:** How do we enter 24 hour services for 31 day months?

**Answer:** ODDS policy has approved for true 24/7 services, to enter 744 as the monthly ANA limit, and then authorize accordingly. Months with fewer than 31 days should never hit the 744 limit.

**Question:** Now that we are in eXPRS and the ANAs/CNAs are attached to the plans in eXPRS can we stop the duplicative submission of emailing the ANA/CNA to the ANA/CNA mailbox?

**Answer:** Not at this time. Please continue with your present process.

**Question:** Currently ANA hours are only able to start in POC on the first day of the month. Can this be changed? If not, what is the policy decision about when to start when an ANA changes mid-month?

## Answer

- For individuals who have had new ANA/CNA results with an INCREASE in attendant care hours, you may adjust the plan mid-month by editing the POC back to the 1st of the existing/current month. The total hours of attendant care provided during the month must not exceed the new total of monthly assessed hours. It would be anticipated that if the new assessment that increases the available hours occurs towards the end of the present month, that the full new amount of plan hours would not likely be used for the existing/current month. The newly available hours of support must only be used as needed to meet identified needs, and only in an amount that is necessary to meet them, as determined through the person centered planning process (see p.1 of the Expenditure Guidelines).
- For individuals who have had a new ANA/CNA results with a DECREASE in hours, a Notification of Planned Action (SDS0947) must be issued with an effective date at the end of the existing month or the following month (follow OAR 411-318-0020).
- There will be a future eXPRS/POC edit around this topic and more information will be released at that time.

**Question:** ISPs for individuals living in comprehensive services currently operate on a potentially 13 month cycle. Case managers renew the individuals ISP and LOC every year with in the same ISP month as the previous year. This cycle does not match up with the 365 days of funding that is written into EXPRS. The new ISP requires a variety of meetings to build the ISP and people have been questioning the exact start date. If the current ISP month is June 2015 the team will be meeting in April and May in preparation. Can the team meet in May with an ISP effective date of June 1st 2015 or is the effective date of the ISP the day the team meets? Does this mean the DD54 funding runs from June 1st 2015 - May 31, 2016 or from the date in May that team met through 365 days from that date? This may sound silly but it is confusing case managers as we embark on the new ISP and try to match it up to the 365 day funding cycle for DD54.

**Answer:** Please refer to transmittal APD-PT-15-014

**Question:** Does POC have a way to prevent field staff from entering POCs for individuals turning 18 within their ISP year so that we don't accidentally miss completing their adult planning and plan implementation?

**Answer:** At this time POC for children transitioning from child services to adult services must have an entirely new POC created. POC will not restrict a service element based on age.

**Question:** When a client is transferred from a brokerage to a CDDP we are wondering if we take over the current plan or do we do a new plan now that client is at the county. If we take over the current plan are we responsible for approving that all expenditures fall w/in expenditure guidelines and the ANA was properly answered or do we implement what is already in process and complete new documents at the end of the plan year.

**Answer:** Generally you should be able to continue the same plan, as long as the service needs have not changed. If you see a discrepancy with the plan or assessment you can make the changes as necessary. If this decreases services you will need to issue a NOPA. You must also ensure that you are able to provide the same services that are outlined in the plan.

**There is no system functionality to view other POC'S. We recommend the sending entity send a printed copy of the POC as part of the referral packet.**

**Question:** Can providers be authorized twice on a plan?

**Answer:** Providers can be authorized more than once in a POC plan, as long as their authorizations are not for the same service with the same/overlapping dates. Having providers authorized under the same service with overlapping/concurrent date ranges is not currently allowed.

**Question:** With county transfers, when a person transfers and the plan line is closed, can a provider still bill for appropriate time prior to closure?

**Answer:** Yes

**Question:** Are we still to use a formula to calculate ANA Daily Support Activities? Do we modify ANA hours to account for use of day support activities?

**Answer:** No, all attendant care services will roll up to the ANA hours.

**Question:** If a client is in crisis and their preferred provider is not enrolled, then what?

**Answer:** Any approved provider can be utilized per rule to provide supports.

**Question:** When starting a prior authorization line after the first of the month the PSW available hours are automatically pro-rated. What is the formula for that pro ration?

**Answer:** The available hours for all Attendant Care codes should not pro-rate. ISPs that begin mid-month present a situation where an individual may have a monthly amount of support hours, based on an assessment, which can be utilized in a partial month.

How supports are utilized during the partial month is a conversation topic during the person-centered-planning. It is foreseeable that in the first partial month of the plan some needs have gone unmet during the first part of the month where there may be catch up or a more time intensive support needed for that shortened duration in order to adequately meet the needs that were identified on the assessment. Supports must be available and utilized only when they are needed and only in the amounts that are necessary to accomplish goals described in the ISP. ODDS would expect to see documentation of this discussion within the ISP or progress notes.

**Question:** Currently in POC we enter the total of approved Provider Service Prior Authorizations (SPA) as the units of each Plan Line. We are considering changing our process to instead enter the total approved ANA hours for the units of each Plan line. This would allow us more flexibility with revisions. Will this approach cause problems in the system?

**Answer:**

- **The system will allow this. It is permitted as long as the customer approves.**
- **Follow up question, will this affect any reports generated by the system. Answer; this should not be a problem.**

**Question:** How do we account for supports when a person does not go to their regular non-residential program during the day, but instead stays home due to illness or other factors requiring attendant care for those days? Do they simply have to utilize only the hours available within the in-home ISP or can they flex the hours between the program and home? When we say flex, can we allow them to have the max at both home and the program and they bill the appropriate hours?

**Answer:** The ANA is meant to provide sufficient resources to meet known support needs. When the day time services are attendant care (likely either Facility Based Attendant Care OR542 (WF) or Group Attendant Care OR542 (WH)), Attendant care support (OR100, 101, 526) can be simultaneously authorized and the individual can utilize either depending on the circumstance. All of these services will draw down on the ANA hours, the combined total of which may not exceed the total ANA hours available to the individual in the month.

When the day time activities are employment services, the person centered planning process must account for the possibility that the individual will not work on some days and will require in home attendant care at those times. Employment services, which are funded through the waiver, do not draw down from the total ANA hours available to the individual.

**Question:** If the financial part of the plan is delayed for a month or two is it OK to have a client enrolled in K-plan as of April 1st 2015 even if the plan of care is not built into eXPRS until May 1st 2015 or maybe even June 1st 2015?

**Answer:**

- **This is okay IF the customer meets eligibility requirements and at least one service (say, case management) is being delivered.**
- **PSW's can be entered on the TBD line until you know who they will actually be.**

- It depends on the reason you re unable to put the plan into place. If financial eligibility has not been determined then the individual is not eligible for K plan services. If this is an urgent situation you can request a General Fund Exception through the exception process.
- The individual must be receiving a service within the timelines outlined in OAR 411-320 or OAR 411-340. If the individual is eligible for the service, the individual needs to have a completed LOC and ANA within 45 days of completed application and a service plan/service enrolled in POC within 90 days of the completed application (45 days of the LOC).

**\*NEW\* QUESTION:** When a new ANA reduces the overall hours allotted, how do we make that change in POC?

**ANSWER:** This can be tricky, send an example to Julie Harrison

## Hour Limitations

**Question:** Can a PSW work 40 hours for one customer then 40 hours for another customer, so on and so on?

**Answer:** Please refer to

<http://www.dhs.state.or.us/policy/spd/transmit/pt/2015/pt15021.pdf> for information around limitations on PSW hours

**\*NEW\* Question:** What is the responsibility of the CDDP/Brokerage in monitoring the 50 hour work week limitation in eXPRS? What tools can we use in eXPRS?

**Answer:** At this time, CDDP/Brokerages should not use the weekly hour limitations to control for 50 hour work weeks in eXPRS. It has come to our attention that the way this calculation works does not have enough flexibility if the assessed hours are fewer than 221.5 a month.

The CDDP/Brokerages responsibility to maintain the 50 hour cap is two-fold:

- To ensure that no more than 221.5 hours are allocated in a one provider to one individual relationship. Any monthly allocation over 221.5 will need to be addressed by either the local exceptions process or by submitting an exception to ODDS.
- To monitor the delivery of services to ensure that a 50 hour cap per week is not being exceeded. It is the responsibility of the employer of record to set a weekly schedule. Please work with them to ensure they are not authorizing the PSW from working more than 50 hours a week. The CDDP/Brokerage should monitor incoming timesheets for hours that seem excessive; however, we do not expect for you to review each timesheet in detail to ensure this.

**\*NEW\* QUESTION:** It is my understanding that if a provider goes over 50 hrs. /week that they still get paid for the excess hours. How do we pay for PSW's who exceed their authorizations?

**ANSWER:** ODDS is focusing the role of the CDDP or Brokerage to not authorize more than 50 hours per week per PSW within an individual's ISP. PSWs should not be working beyond their authorization, however, should this be occurring, this is something that should to be addressed with the Employer. ODDS does not require that POCs be created with weekly limits. ODDS is continuing to explore enhancements to POC that will assist with managing the limit. If a Service Prior Authorization line has been set to have a limit of 221.5 a month when a PSW submits SDs that exceed the authorized hours, those authorizations will suspend and cannot be overridden. The SC/PA must take the follow up actions described in the FAQs and document all efforts made to prevent the over authorization of hours in the future. The CDDP/Brokerage staff will need to either:

- Edit the SD billing so it falls w/in the allowed limit available for the service being billed, save & resubmit, or
- Request an update to the POC authorization (use the update request spreadsheet sent by ODDS recently) to increase the units authorized, then re-submit the suspended SD billing.

## Attendant Care

**Question:** Why won't the OR526 Attendant Care code work for more than one person receiving attendant care from a provider organization?

**Answer:**

- The Attendant Care code OR526 is for 1:1 care. If additional individuals are also receiving attendant care it becomes Group Care and should be authorized as OR542 (WH). You can authorize any combination of attendant care services (OR526, 100, 101, 542) in a POC up to the maximum available ANA hours. Providers may then bill the amount of each that was actually delivered during the month which, combined, cannot exceed the total monthly ANA hours.
- The ANA/CNA monthly hourly limit no longer needs to be inflated to accommodate the variety of attendant care/DSA services authorized. The different attendant care service procedure codes can be authorized simultaneously, as long as each individual service plan line itself does not exceed the ANA/CNA limit established for a date range. Then, the ANA/CNA monthly limit will be applied to SD entries submitted against all attendant care/DSA services authorized, enforcing the monthly limit for the total SD entries submitted. This will allow greater flexibility in services received, allowing for a variety of services from day to day/week to week/month to month, but still stay within the ANA/CNA assessed service hour's limit.

## Employment

**\*NEW\* QUESTION:** POC is still requiring us to start/stop a weekly service on a Sunday/Saturday. This is not always possible. How do we enter, or edit, these SPA lines when the services need to start or change on a day other than Sunday?

**ANSWER:** When entering the Weekly Employment Hours limit you do have to start / stop on Sat. / Sun., you cannot adjust the weekly limit. You can, however, adjust the authorization under that line which don't have to end on a Sat. / Sun.

## Discovery

**Question:** When putting Discovery into POC it will only move to approved status if the time lines are within 90 days. PA's can authorize up to 6 months if needed but when we put the POC in for that time period it stays in pending status. How can we fix this?

**Answer: SC/PA can authorize up to 180 days and anything over will pend for FAC approval.**

## Transportation

**Question:** Which transportation drop down option are we supposed to use for PSW mileage. We have been selecting OR-004 because it allows you to put in “community” and not only “to and from work”

**Answer: OR004 is the correct POC service code for mileage. It can be used with either modifier. If clients have mileage that applies under both modifiers, then they can have a service line set up using each modifier for code OR004.**

**\*NEW\*Question:** On the Expenditure guideline, for the last two revisions (Nov14 & Aug15), there is no longer a modifier code (WE/WD) listed for Mileage (OR004). However, eXPRS still lists both WE & WD (Community & Work-related, respectively) as required modifiers when entering the Plan Line. So, do we still need to write the modifiers into plans and track community vs. work-related mileage separately (in which case the expenditure guideline should be updated to reflect the necessity of the modifiers, still), or does eXPRS need to be updated to do away with the modifiers entirely (if the distinction is no longer required)? This has been a reported eXPRS issue since the Nov2014 guidelines, but doesn't seem to have been dealt with yet? Same issue with OR005 (though we don't generally utilize that code).

**Answer: We are exploring doing away with the WE/WD codes. For now, continue as you have been doing.**

**\*NEW\*Question:** Do you have an update on removing the rounding for mileage?

**Answer: We are working on it.**

**\*NEW\* QUESTION:** How do we handle multiple rides in 1 day? We are entering one generic SPA line with an estimate rate per trip that will encompass all of the rates the individual might use. However, given that this number is high at times, the number of rides an individual might need multiplied by the rate is going over the \$500 limit. Example: we have individuals that may take more than 1 taxi ride per day. To and from work for example. When we attempt to enter each ride individually into eXPRS we are given an error. We are only allowed to enter 1 unit of transportation per day.

**ANSWER:** This is because the service is set up as an ‘event’ in POC. Which entails only one entry allowed per day. One work around is to enter one billing for the total costs of all rides in one day. Then when the funds are received you can distribute as needed.

## Taxis

**Question:** Taxis – we are unsure how to put in cab service for our customers who use this. We can’t put it in on a per mile basis because the cost isn’t a straight – 1 mile = a certain dollar amount. I believe that if we put it in at a certain rate (say \$50 per trip) but a trip costs more or less, we could only get reimbursed at the \$50 level – creating a situation where we are likely to get under or over paid for each trip.

**Answer:**

**In POC, taxi and similar services are not entered using a monetary limit (e.g. \$350 per year), instead, the CDDP/Brokerage will authorize the number of trips that a person will take via taxi. The unit type for procedure code OR003 (Transportation, Commercial) is “each”. One trip = 1 “each”. This trip (each unit) number can be entered in daily, weekly, monthly, or yearly frequency increments. Taxis and similar services all use POC code OR003.**

**CDDP/Brokerages have two ways they can enter this information. Under both methods the CDDP/Brokerage will start by entering a plan line that includes the number of trips (units = each) that the person will take, the frequency of that number, and the date range. There is a realization that some estimating may occur around this unit number.**

After the service plan line has been created, the CDDP/Brokerage has two options on creating the “generic” service provider authorization (SPA) line. For the first, CDDP/Brokerages will enter a new generic SPA line each time the service is used. For example, if the individual took a cab on 4/2/2015 and paid \$7.23 for the trip, the CDDP/Brokerage would enter a generic SPA with the provider, 1 unit, the rate of \$7.23 and set the time period as 4/2/2015 for both the start and end date, and submit that SPA to “accepted” status. Under this method this needs to be done each time a trip is taken. The CDDP/Brokerage would then create an SD entry for that service, receive payment and route to the Taxi vendor (or reimburse the CDDP/Brokerage if payment was made prior to billing).

Under the second method, the CDDP/Brokerage will enter one generic SPA line with an estimated rate per trip which encompasses the entire plan line period. We understand that this is an estimate and that it might be inflated in order to capture unexpected billing. Once this line is accepted, the CDDP/Brokerage will then bill as they normally would for a generic provider, making sure to only put the actual cost in the “actual rate” field when creating the SD billing entry for the service. See example below:

**Provider:** {Generic} Broadway Cabs      **Dates:** 11/4/2014 - 11/4/2014  
**Client Name:**      **Client Prime:**  
**CM Organization:**  
**Service:** SE149/OR003 - Comm Transp, Commercial/NA - Not Applicable  
**Rate:** \$7.95      **Review Req:** Yes  
**Units:** 1 per Month     

Select	Date	Actual Rate	Total Items	Total Amount	Status
<input type="checkbox"/>			0.00	\$0.00	

    

For items checked above           

While both methods are available, we recommend using the first method if the individual does not use taxi services often or if the rates are unable to be estimated. The second method is recommend for those individuals who use taxis on a set schedule and have roughly the same amount billed each time.

We understand that this is a different way of looking at these services. We are looking at future functionality that may allow for other ways of entering them; however, for now this will allow for you to pay for these services through POC. Because there may be some inflating with rate and rate totals, your POC lines may go to pending. If this occurs please notify your FAC.

## Behavior Support Providers

**Question:** Can behavioral consultation timeframes could be written as “annual” timeframes for added flexibility.

**Answer:** Yes PT-15-008. And remaining consistent with expenditure guidelines.

**Question:** Does a DDPSW require a separate BC SPD provider number and PEA to also be a Behavioral Consultant?

**Answer:** Yes, a Beh Consultant is a different type of provider than a PSW or an IC-PSW, therefore they require a separate PEAA, provider enrollment/record & assigned a separate SPD provider ID number. Information has been provided on this topic in [AR 14-068 Consultant Provider Enrollment Agreement](#)

**Question:** How do I get a Behavioral Consultant who is marked incorrectly as a DDPSW in eXPRS corrected to the right credential?

**Answer:**

- Please send the provider name and number to [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us)
- Information has been provided on this topic in [AR 14-068 Consultant Provider Enrollment Agreement](#)
- <http://www.dhs.state.or.us/policy/spd/transmit/ar/2014/ar14068.pdf>

**Question:** Behavior Consultation (570) supports for development of FA/BSP are paid in one lump sum, once documents received. How do we address situations in which a provider is started but stops providing these services for some reason? Typical scenarios.....1. Client not satisfied with supports being provided prior to any documentation received (sometime prior to

development of FA) 2. Provider completed FA but client choosing to switch providers because dissatisfied with services up to that point. 3. Client started with provider prior to transferring counties, and now needs a new provider in area. In situations like this can we pay out the 1st consultant and reissue 27 hours of consultation or does the new consultant have to start at the diminished hours that remain?

**Answer: This is currently being discussed in the Behavior Consultation Workgroup. After receiving the work that was completed prior to the termination of the first Behavioral Consultant, determine the appropriate number of hours pay the consultant based on the invoice and any discussions held during the time of the termination discussion. The next behavioral consultant will most likely be able to pick up where the first behavioral consultant left off. This is a case manager decision and discussion to be had at this point. If the full 27 hours were paid to the first consultant, it would not be accepted that the 2<sup>nd</sup> behavioral consultant would also be authorized to work for 27 hours as it would appear most of the work had been completed. This is subject to change.**

**Bill the first consultant on a line under OR570. Then bill for the second consultant on a separate line also under OR570. You do not have to change the authorization amount line.**

**Question:** If PPI is needed in a BSP, there can be up to 3 hours after the development of the BSP to address this. Should these extra 3 hours be coded as OR570 or OR310?

**Answer: Please read the expenditure guidelines as to the distinguishing difference between the OR570 and OR310; how they are authorized and what services they authorize.**

**Question:** If 27 hours are allocated for OR570, but the FA/BSP are completed in less time, can the remaining hours be converted to OR310 hours, for continued support around the BSP during that plan year?

**Answer: No. These are separate services and not interchangeable. You are not allocating hours in POC for OR570, the units should be 1 as it is an outcome/event payment. The Behavior Consultants can submit an invoice for the hours it took to complete and the payment amount and as long as the amount is within the expenditure guideline they can bill for the service.**

**\*NEW\* QUESTION:** Can we get a list of all of the agencies and Behavioral Consultants who have SPD #S & get a new list as they are added? I had not heard about Kiwanis and we use them.

**ANSWER:** Dan Boyd sends and updated Behavioral Consultants list every Friday. ODDS will begin sending a similar list for In-Home provider agencies. You can look specific providers such as Mt. Hood Kiwanis Camp, up in POC. From the home screen go to “Provider”, then “View Provider” which will take you to the “Find Provider” page. Once there go to the “Provider Type & Specialty” section and enter the provider name.

## Relief Care

**\*NEW\* QUESTION:** Is the process for authorizing foster home providers in POC changing? Currently, we enter these folks as a generic business in POC.

**ANSWER:** Generic providers should not continue to be used when authorizing a foster care provider to deliver relief care to a consumer enrolled in in-home services.

When a foster care provider is selected to provide relief care service, email Chelas Kronenberg ([Chelas.a.kronenberg@state.or.us](mailto:Chelas.a.kronenberg@state.or.us)) with the foster care providers name, physical address and Medicaid provider number. The foster care provider’s PEA for foster care is used to authorize them as a relief care provider in eXPRS. Please allow up to 2 weeks for enrollment.

**Question:** OR507 – Daily Relief. Expenditure guidelines say, “Daily care is a 24 hour unit (one day) of service. No other ADL/IADL support can be paid during that 24 hour period.” Given this, can vocational supports be provided during the same 24hour time period as OR507 – Daily Relief?

**Answer: Per Policy, Yes - for waiver funded employment services are allowed for 507, if they suspend, contact your FAC.**

**Question:** How do we enter respite care across multiple calendar days?

**Answer: To bill for daily respite OR507, the provider would list the date the service started, and the start time & end time. The 24hr period is calculated**

from the start time. So, 6pm on Fri to 6pm on Sat = 1st day, then 6pm Sat to 6pm Sun = 2nd day, for the 2 full days of relief care provided. The billing entries would look like this:

Date	Start	End	Units	Service Hours
4/10/15 (Fri)	6pm	6pm	1 day	24 hrs.
4/11/15 (sat)	6pm	6pm	1 day	24 hrs.

Remember that there can be no other billed Attendant Care during these periods and the provider is responsible for customer's care for the full 24 hours.

**Question:** In relief care, sometimes providers report that someone will be picked up early. If they are picked up before 4:00 pm, they cannot bill for a day of services because it is for less than 16 hours. However, they cannot bill for hourly relief services because that is not a code they are authorized to bill under

**Answer:** 24 hour Relief Care is a flat rate regardless of the amount of hours provided. See the Provider Services FAQ regarding this scenario

**Question:** How can we authorize payment for daily relief care to adult foster home provider?

**Answer:** Currently you can utilize the "generic" provider option & route the payments paid to you, back to the provider. CDDP/ Brokerages are responsible for verifying the license(s) of the provider.

## Job Coaching

**Question:** How do we address an issue wherein a PSW transports a customer to and from a meeting with a job coach, assists with communication and understanding at the meeting, and then submits claims for that service with the provider agency (job coach) also claims for that meeting time?

**Answer:** Continue to enter both and email to your FAC for review.

## Skills Training

**Question:** What codes do would skill training classes fall under?

**Answer:** Information about classes can be found under the Skills Training service in the [Expenditure Guidelines](#). It is important to note that any class must be consistent with that description, including that “Training must be designed to increase the individual’s skills in completing a specific ADL/IADL activity and not be a general educational or recreational activity.”

Classes will most typically be authorized under OR542 and the reimbursement rate subject to an amount not to exceed the appropriate tier rate for ‘Skills Training – Facility’ found in the expenditure guidelines. The units of service do count against the hours determined to be necessary by the ANA to meet identified support.

They could use code OR529/W7 for this as well. That’s the hourly attendant care code specific for Skills Training.

## Environmental Modifications/Assistive Technology/Assistive Devices

**Question:** How do we get an Environmental Accessibility Adaptations (S5165) service paid for in Plan of Care if a general business provides this service? Do we select a “generic provider” in POC as the provider or does the Brokerage pay the general business/vendor and then get reimbursed? Exactly how does this work?

**Answer:** Yes, select a “generic provider” in the POC service prior authorization (SPA), and then list the general business in the text field provided. This text field is just for information and is not used by the system.

Once the “generic” provider SPA has been submitted to “accepted” status, and the service provided (example: the modifications completed), the authorizing CDDP/Brokerage will create & submit the SD billing entry for that service SPA.

Payment will be generated back to the CDDP/Brokerage to forward to the business/vendor.

**Question:** In a Foster home, when needed equipment is not covered by OHP do we need to do a new CNA?

**Answer:** No. See the Provider FAQ on the DHS staff tools page for information on billing for k-plan ancillary items when an individual is enrolled in foster care or residential services:

<http://www.dhs.state.or.us/spd/tools/dd/Provider%20Services%20FAQ%20March%202015.pdf>

## Generic Providers

**Question:** Are we the pay to general business under the Generic option and how do we assure that in eXPRS?

**Answer:** Using the “generic” provider authorization option involves several steps start to finish. As the service authorizing entity, the CDDP or Brokerage would:

1. Authorize the service needed using “generic” provider, then entering the specific provider/business/vendor in the text field provided in the POC SPA.
2. Since its “generic” and no actual provider is linked in the system to that SPA, the authorizing CDDP or Brokerage must create & submit the Services Delivered entry to bill for the “generic” service.
3. Once those Service Delivered entry (ies) have been created/submitted by the CDDP or Brokerage for the “generic” authorized service, the system will aggregate the SD entries into claims for payment. The funds for those paid claims will be routed back to the authorizing CDDP or Brokerage as the “pay to” provider.
4. The CDDP/Brokerage then pass the funds on to the provider/business/vendor you used the “generic” option for, as payment for the service/item authorized.

**Question:** Do we enter the name of the business?

**Answer:** Yes, for auditing purposes. Use the supplied text field.

**Question:** Will any submissions made for generic provider need to be CPMS’ed the old way or will it be taken care of since it was billed through eXPRS?

**Answer:** It will be taken care of since it was billed through eXPRS.

**Question:** There was a release about a 90 day limit for attendant care with generic providers. Is this option available to use for PSW’s or Provider Orgs

who are authorized to provide service, but are not set up in eXPRS yet?? This would allow new providers to get paid in the initial set up period so that there is no lapse in service for our customers.

**Answer: Using the generic option is not allowed for PSW'S or new provider organizations; however, it is permitted for approved provider organizations while we await their provider record creation.**

**Question:** Is there a reason why we would be unable to utilize the date upload feature to input large amounts of data for General Businesses (such as RVTD for bus pass orders)? We are essentially acting as a provider on their behalf, and it would save us time we don't have inputting repetitive data.

**Answer: This functionality has only been developed for direct service provider agency organizations.**

**\*NEW\* QUESTION:** For services entered as generic provider, how long till the CDDP can expect to receive the funds for these services from the state?

**ANSWER:** Should get aggregated the following morning and receive payment in 2-3 business days after claim is approved by SFMA.

**Question:** What is listed on the report that is generated and sent to the county regarding the funds being sent to the county for these generic providers? Who will the reports/funds be sent to?

**Answer: Reports are not distributed. Information is available in eXPRS standard payment reports.**

**Question:** Is it possible to submit a payment prior to the date of service for General Businesses? We usually order our bus passes the month before and mail them out so that our customers have them available for use on the first of the month.

**Answer: EXPRS does not allow billing for future service dates.**

**Question:** In regards to General Business payments, once the bill has been entered into eXPRS who is making the payment to that general business? Is TNT making the payment to the general business, or is the brokerage making the payment and the state reimbursing the brokerage? If this is going to be a reimbursement to the brokerage, why?

**Answer:**

- **TNT does not make payments to businesses, only individuals.**
- **The CDDP's or Brokerages can choose to make the payment to the business either before or after receiving reimbursement from the state.**

**\*NEW\* QUESTION:** Will purchases remain as generic provider or will we be moving to have them set up with an SPD #? Example: Wal-Mart, Costco, etc.

**ANSWER:** At present the priority is to get providers of attendant care type services off the generic list. Entities such as Wal-Mart, Costco etc. may continue to be set up as generic providers until further notice.

**\*NEW\* QUESTION:** Are there any updates on the credentials for in-home agencies that are currently having to be entered as generic businesses?

**ANSWER:** PEAA's have been sent out all IHCA's known to be providing services, but not all have been returned, hence the reason some of these providers don't have a number yet.

**\*NEW\* QUESTION:** Follow up: Should we remind the providers to complete / submit their PEAA paperwork? And can we be emailed a copy of the PEAA form.

**ANSWER:** Yes, remind them. And yes, a copy of the PEAA form will be emailed to you.

## Authorization Limits

**Question:** Will the system enforce both 3 hours per month and 18 hours per year?

**Answer:** The POC must be built following the person centered plan and ISP which must be in compliance with expenditure guidelines.

**The system will enforce only the limit set on the service line/SPA. If they set it as hours per year, then no monthly limit will be enforced.**

**Question:** What can be done about eXPRS not allowing a third person to share mileage because it goes over the \$500.00?

**Answer: Authorizations will pend for FAC review. Make sure to let them know when this occurs.**

## General Fund Authorizations

**Question:** How do we pay folks who are not Medicaid eligible but approved for a general fund payment? Do we use the rates and unit file?

**Answer: No, you would set up their service authorizations for POC & bill accordingly, like anyone else. The system will read the client's eligibility for the service, and bill accordingly. If the client is only eligible to have their services paid with GF, the system will know this & fund the claims that way. Authorizations should pend for FAC approval.**

## Hold Harmless Provisions

**Question:** Attendant Care, Relief Care – Hourly, and “Ongoing” Job Coaching were the service categories and each was “held harmless” separately, as I understand it, according to whatever the highest rate the provider was making for that specific service prior to the CBA.

The question then is: what do we do if a provider has been making different rates between Attendant Care and Relief Care? For instance, if they were being paid at \$13.75 for relief care by one family and \$15.24/hr. for Attendant Care by another. Each would have been “held harmless” separately.

With Relief Care-Hourly being phased out and now only utilizing Attendant Care, which rate takes precedence if they differ? If the relief care rate was higher, would that rate simply disappear and they'd use the lower Attendant Care rate? Or would we simply select the highest rate they'd been paid between the two services, so as not to “reduce” their rate (per the usual language in the CBA “grandfathering” clause)?

I'm assuming the latter is the case (select the higher of the two rates, and that is the new "combined" rate going forward) but wanted to verify whether this is the correct interpretation. Also, if that is the correct interpretation, as of what date should such "re-grandfathering" take place, or have taken place?

**Answer: APD-IM 14-077 addresses this in the Hold Harmless explanation "3. Personal support workers will maintain their highest service payment rate for services in the same category. Service category for our purposes means tasks provided under a program and the tasks provided in the program or the actual task.**

**Relief care is a service that provides ADL/IADL supports. Therefore the rate for hourly relief care should not be lower than the highest hourly rate for other ADL/IADL supports such as Attendant Care services. Correct the rate to the highest service payment rate that the PSW has been receiving for ADL/IADL supports. This is not "re-grandfathering" this is assigning the correct pay rate. Please do not retroactively correct rates paid prior.**

**The only difference is that employment services provided by a PSW are not considered ADL/IADL supports and there should be a different rate for employment services than ADL/IADL services**

## PSW Rate Increases

**Question:** How is the expected rate increase going to be handled in POC?

**Answer: eXPRS is being updated to accommodate this prior to 1/1/2016. We will release more information as we get closer.**

## Technical Support

### PSW Technical Support

**Question:** Who does a PSW contact when they need their secure email with their log in credentials resent? Who does the PSW contact if they concerns with their pay that we are unable to answer?

**Answer: Have them contact technical triage at: [technical.triage@state.or.us](mailto:technical.triage@state.or.us)**

**\*NEW\* QUESTION:** What is the difference between the Triage # and PSW Enrollment in their responsibilities responding to provider questions/issues?

**ANSWER: Technical Triage** is the primary point of contact for PSW's for issues other than provider enrollment. They should be the **only** information given to PSW's to resolve any issues. The technical triage team then forwards those requests to the appropriate person internally.

CDDP/Brokerages' may report a PSW issue to Technical Triage if they are unaware of where something needs to go. If they are reporting a payment issue for a PSW it should always be reported to Technical Triage first.

**PSW Enrollment** resolves issues around the PEAA. They should also be notified when a new CHC is completed or updated ([SPD – AR-14-062](#)). Lastly, they are the point of contact if determining if a provider has been enrolled and the status of their enrollment.

## Searching

**Question:** Assuming that there isn't going to be a rollover mechanism for Provider SPAs upon re-credentialing, is there a way to search for Provider SPAs within POC?

**Answer: Yes, use the Finds SPA page to search for specific SPA authorizations w/out having to go through individual POCs. User guide for this work is available on the eXPRS Help Menu under CDDP/Brokerage → Plan of Care → POC Plan Mgmt.**

<https://apps.state.or.us/exprsDocs/HowToFindProviderSPAsInPOC.pdf>

**Question:** Can a functionality be added to POC to be able to search all POCs by provider, specifically for DD54? Can a functionality be added to POC to search by service within a service? Example; within DD54, being able to search for all plans with 542. ?

**Answer: These can be done if you have the claims manager role on the claims delivery page. Adding this functionality to the POC search page will be added to the white board for future enhancement consideration.**

## Voiding Payments

**Question:** Is there a way for us to void POC claims as we do for all other claims if there are some that are approved in error or prematurely by CDDP/Brokerage staff? There can be things that get through that should not have been paid and if we realize after the fact it appears impossible to correct prior to submission. It is more of a challenge to fix issues on the back end then it is to fix prior to CDDP/Brokerage submission.

**Answer:** Currently Brokerage/CDDP staff can void SERVICE DELIVERED entries, but not claims. Remember, these are different features in eXPRS. Once a SERVICE DELIVERED entry (ies) are voided, the system will automatically void the claim the SDs are contained within in the next claims aggregation cycle for that provider. Agencies - the aggregation cycle runs every business day. PSW/IC-PSW – the aggregation cycle runs 2x/month for the pay periods. If you need claims voided before the aggregation cycle runs, you can submit a request to the DHS service desk.

**Question:** If there is an error on how Attendant Care or other hours are authorized in POC, how do we go about fixing this?

**Answer:** Depending on the error you would either need to void the incorrect lines, or if the error is such that you don't feel like you need to make a correction, just have it corrected moving forward, you can end date the current Plan Line and begin a new one with the correct information.

**Question:** Are PSWs able to void their own service delivery claims? If not, can they?

**Answer:** No, they cannot due to collective bargaining agreements. However, users with the "POC Claim Manager" role at the CDDP or Brokerage can void Service Delivered entries for PSW/IC-PSW providers. If the SD has yet to be processed into a claim, voiding the SD entry is all that is needed. If the SD entry is "approved" and has been paid in a claim, the voiding is a two-step process; first void the service delivery (ies) and second void the claim. The claim will be voided automatically in the next claims aggregation cycle. If the claim needs to be voided sooner, please contact the DHS Service desk and request assistance.

## POC Provider Technical Troubleshooting

**Question:** I have a number of PSWs that are showing up on my provider panel, but they are not an option on the drop down box as a PSW to be selected even though they are not showing up with expiring credentials on the CHC and PEA Expiring Report. How do I know why they are not showing up as an option to select on service line providers?

**Answer:** Please use the appropriate Troubleshooting guide provided in the online [eXPRS documentation](#). The POC Provider Troubleshooting guide is found here:

<http://apps.state.or.us/exprsDocs/TroubleshootingAddingProviderPOC.pdf>

Please inform us of any of these issues which cannot be resolved using these online guides

**\*NEW\* QUESTION:** One of our PSWs who was on our provider panel at one point is now gone, and it appears that his entire provider record has disappeared because I can't find it in a search. He completed his credentials in June, so none of them have expired. What are some of the potential reasons that this occurred so that I can trouble-shoot this?

**ANSWER:** Do a search for "inactive" providers. Commonly this is the reason why they would 'disappear.' If that is not the case, then contact PRU at [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us) to request more information on if the provider is enrolled.

## eXPRS User Roles

**Question:** How do CDDP's get the time in if they were unable to get the "management role" as indicated?

**Answer:** The CDDP will need to request to have the "Local Auth POC Claims Manager" role assigned to whomever at the CDDP needs to do that time entry work.

A spreadsheet ("POC user enroll worksheet") has been distributed to help you identify any staff with existing eXPRS accounts who will need this or other role changes. Please complete and return these spreadsheets, ASAP.

For any additional staff not enrolled previously enrolled in eXPRS, full enrollment forms must be completed and sent in. For additional assistance or to request a copy of the spreadsheet, please email [info.exprs@state.or.us](mailto:info.exprs@state.or.us)

## Reports

**Question:** What does the “date” field mean, next to the PSW name, on the Provider Service Report?

**Answer:** That shows the last login date of that PSW. If a PSW shows as in eXPRS but this field is empty it means they have yet to log in.

**\*NEW\* QUESTION:** There is an issue with the Provider Status Report providing expiration dates that do not match CRIMS or the Provider Credentials listed on the View Provider page. For example, a provider has an expiration date of 4/30/15 in CRIMS, the eXPRS View Provider page (under Credentials) has it as 4/30/16, but the report says that it expires 7/31/15. I have found this exact case with one provider and similar cases with others.

**ANSWER:** Send a specific example to Julie Harrison. Keep in mind that there will often be different dates for CRIMS, CHC and PEAA if they were entered on different dates.

**\*NEW\* QUESTION:** How are we able to narrow our search for expiring CHC/PEAA’s ending on a specific date? The Provider Status Report says end date, but it does not allow you to choose what the end date is for, CHC or PEAA.

**ANSWER:** Send an example of the report to Julie Harrison. Its true there is no way to enter the end date here. But, if you run the Provider Status Report and in the Search Criteria field enter Show Valid and then export the report to Excel then you will be able to see those end dates and filter them as needed.

**\*NEW\* QUESTION:** The Provider Payment Summary indicates that we have a Provider Liability and what the amount of the liability is, but it does not have further information. It would be helpful if the Remittance Advice Monthly would include the lines for the liabilities. That would allow us to track them and to balance our deposits.

**ANSWER:** The Payment Detail Report will provide that information.

## Providers

### New Provider Enrollment

**Question:** We are trying to set up an efficient way for new providers to get set up in eXPRS for payment. I have been told that a new provider cannot be input into eXPRS without an initial EOR relationship. From there, a PEAA cannot be input into eXPRS without an initial CHC approval. Is this correct? Should the paperwork be staggered, pending each approval, rather than sending all of their paperwork up at once?

**Answer:** PEA, CHC, FI information and eXPRS user request can all be submitted together, they don't have to be staggered.

Receiving a provider number is not dependent on establishing an EOR, add a draft authorization in POC for a provider does not require an EOR. Moving that authorization out of draft to accepted status dose require that EOR relationship.

**Question:** Should we hold PEAs until the CHC is complete? When do you want CHC and PEA? Same time or in batches?

**Answer:** Either way. It is ok to send the PEAA as 'pending' CHC approval, or to email it to [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us) once the CHC is complete.

**Question:** PSWs providing care with CHC for CIIS or PC20 for approval line. How long will it take to get approval for new type of care?

**Answer:** This is dependent on present workflow. However, the approval will be back dated to the date of application signature or the CHC approval, whichever is later.

**Question:** Do the EFT enrollment forms for the PSWs in EXPRS get submitted to TNT or to ODDS? If they go to ODDS, who should they be submitted to?

**Answer:** These go to TNT directly; PSWs and IC-PSWs need to use TNT's direct deposit form

**Question:** What is the usual turnaround time for TNT to process documents?

**Answer:** If all is correct on the documents, about 10 business days. If anything is incorrect in the documents they will be rejected and have to be corrected first.

**\*NEW\* QUESTION:** If a PEAA has not been processed in over three weeks, can the field process it manually with a rates and unit file?

**ANSWER:** If paying a PSW on a manual rates and units file the authorization in POC needs to be adjusted to capture this. This may only occur for PSW's with an existing relationship with the individual served. If this is a new PSW or a new relationship you must wait until the provider is fully authorized to authorize services. Once a rates and units file has been submitted and approved by ODDS make the following adjustments:

End date the active authorization, for example if the last day that could be paid was 8/31/2015 end date the authorization on this date. Authorizations should end on the last day of the month. If there are suspended service delivery lines beyond this date you should void those (they should not have paid out).

Once the record is corrected re-create the SD line to start on the first day of the next authorization period. For example, if the provider became active as of 9/13/2015 you would create a new SD line to start on 9/16/2015. It is very important that SD authorizations don't cross service periods in these cases. They should always start on the 1st or the 16th. Once an authorization period is paid via the manual rates and units process any future payments for that period will always be through manual rates and units. Use error code: "Rates and Units only period"

Progress note that the gap in authorization is due to payment being made via a Rates and Units file

## Employment Checks

**Question:** It is becoming more and more difficult for us to manage employment verification for PSWs since all of this information isn't captured in eXPRS. Is this something that can be referred to TNT given that they are the ones processing the payroll?

**Answer: Employment verification is the task of the employer of record, not the state or TNT.**

## Provider Panel in POC

**\*NEW\* Question:** What is the difference between removing and terminating a provider off of the provider panel?

**Answer: Providers should only be end dated at this time. Removing a provider will prevent them from being paid moving forward. Terminating a provider on the panel will result in ALL payments being prohibited from moving forward. We are working on a technical solution to ‘de-clutter’ the provider panel.**

## Personal Support Worker Credentials

**\*NEW\* QUESTION:** We have been asked by TNT to communicate things such as SSN mismatches so that they can be corrected in eXPRS. How is this to be managed? Is there a way that TNT and eXPRS can manage that and cut us out as the middle-man? TNT is requesting a copy of the PSW’s SSN card.

### **ANSWER:**

- You will need to manage this as you have in the past. eXPRS does not manage this.
- The TNT procedure on this is to first contact the provider for the SSN. Failing that, TNT will contact the CDDP.
- Once the correct SSN has been determined, you should notify the eXPRS team of it as well.

**\*NEW\* Question:** We frequently run into provider enrollment issues wherein there is an expiring or an expired CHC or PEAA, and we submit the new PEAA or CHC approval or both. The part(s) of the Provider record where it lists the CHC or PEAA dates gets updated, but the “Approved to Work” date remains cut off at one of the “old” expiry dates, despite the necessary PEAA/CHC items apparently being in order. Is it NOT an automatic process that, once a CHC or PEAA credential/date gets updated in the system, the “Approved to Work”

date gets updated to the latest date whereat all credentials are met (as long as all criteria are indeed “good to go”)? If not, should it be? One would think that once the necessary credential (be it a CHC or PEAA) gets updated, the providers “Approved to Work” status should automatically get updated accordingly, rather than having to wait for someone to notice that some switch in the system never got flipped, or having to send repeated inquiries in order to get it flipped.

**Answer: The provider enrollment process is handled in steps and the final step cannot be automated due to Affordable Care Act (ACA) federal requirements for provider enrollment screenings.**

**After the PEAA is entered on the eXPRS provider record, Provider Relations Unit is required to complete new ACA Validations prior to approving and extending the PSWs approved to work credential period. New CHCs may or may not require new ACAs depending upon the status of the provider record.**

**If, after two weeks, you verify in eXPRS that the provider credential remains in pending status, you can email [PSW.Enrollment@dhsosha.state.or.us](mailto:PSW.Enrollment@dhsosha.state.or.us) to request a status.**

### **Question**

Some of our criminal background check dates seem to differ from what is in eXPRS. What can be done about this?

**Answer: Use the PSW update information form and email it to [PSW.enrollment@state.or.us](mailto:PSW.enrollment@state.or.us).**

**Question: If eXPRS is showing a CHC is expired but I have proof it’s been updated, who and how am I sending it to ODDS to get this updated?**

**Answer: Please use the appropriate Troubleshooting guide provided in the online eXPRS documentation (<http://apps.state.or.us/exprsDocs/>)**

**Send CHC update information to [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us)**

**There is a transmittal on this subject, APD-AR-14-062**

**<http://www.dhs.state.or.us/policy/spd/transmit/ar/2014/ar14062.pdf>**

**Question:** Is there a mechanism yet for ODDS and BCU to collaborate on CHCs or are CDDP/Brokerages still needing to forward the CHC info to PSW enrollment email?

**Answer: No. This is being considered for future enhancements. For now, CDDP/Brokerages still need to forward the information.**

**Question:** A long-time PSW resubmitted her background check for the 2 year review 3/24/15. It had to be redone by 3/31/15. The approval did not come back until 4/4/15. Can she still get paid for the work she did between 4/1/15 & 4/3/15? If so, how? I am not able to approve the provider line due to the CHC re-submit.

**Answer: Per rule, Providers must meet all qualification criteria to be approved.**

**Question:** Why are there 2 CHC dates or PEA dates sometimes? Which one do I need to consider or worry about or should I focus on the “approved to work” and proceeding date instead?

**Answer: The overlap of those two date ranges is to be considered the active date range. Users can learn more about how to view a PSW provider record by using the assistance guide here:**

**<http://apps.state.or.us/exprsDocs/HowToFindViewPSWProvider.pdf>**

**\*NEW\* QUESTION:** We have noticed that providers’ CHC dates in CRIMS do not match what eXPRS has on record for that provider. For example, a providers CRIMS record has a start date of 4/13/2013, so the end date would be 4/30/16, but eXPRS has 06/30/2017.

**ANSWER:** This can happen when more than one check was done by more than one entity. If you see discrepancies send Deb Satterfield an email or complete a PSW Information update form.

**Question:** If a PSW is coded as a CIIS provider, seniors, or something other than DDPSW, how to we ensure they are changed so that we can select them from a drop down on a person’s POC service line?

**Answer: PSWs must have a valid PEAA by service type. The Provider Enrollment unit will use the PEAA to create or update a PSW’s provider record ID in the DHS Provider Database. If you have any question regarding which PEAA to use, please contact [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us)**

**Question:** If a PSW has had a criminal background check, but the approval date is listed as the start date AND the end date in EXPRS for the CHC, is this just a data entry error, or is this some type of code for a problem? We've had a few entered this way.

**Answer:** This indicates an error with the CHC, please send the PSW CHC approval dates, name and provider number to [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us)

**Question:** Will eXPRS notify PSWs when their credentials are expiring, or is it left up to the PSW to look at their credentials in eXPRS for this information?

**Answer:** eXPRS has not been set up to send those notifications or letters to providers about expiring credentials at this time. CDDPS & Brokerages have access to view the PSW or IC-PSW provider's record to determine their credential expiration date, as well as the CHC/PEAA Expire report and the new Provider Status Report.

## Provider Organizations Credentials

**Question:** What is the brokerage's role in coordinating PEAA's for Provider Organizations? Which services require a PEAA? How would the brokerage know which PEAA's are on file and current for specific providers? This question is relevant to a couple of different scenarios:

**Answer:** We are putting together a matrix of the different provider types & the corresponding PEAA's that are required. To be released soon.

**Question:** Is there a specific PEAA for Provider Agencies to fill out for eXPRS?

**Answer:** This depends on the type of business being enrolled. A list of PEAA's for Provider Agencies will be created, and posted or distributed in the near future. For now, please email any specific questions to [mike.parr@state.or.us](mailto:mike.parr@state.or.us).

## Personal Support Worker Updates

**Question:** We have the DHS individual provider change of information request form that is to be submitted to the Provider Relations Unit. Does the Provider

Relations Unit notify TNT about provider information changes or are we supposed to also submit the TNT change form that we had previous to going live in EXPRS?

**Answer:: Send the Change of Information request for to the Provider Relations Unit. [Psw.enrollment@state.or.us](mailto:Psw.enrollment@state.or.us). Provider relation enters the information and then notifies TNT.**

## Independent Contractors

**Question:** How will an Independent Contractor who is not a PSW going to be issued a 1099?

**Answer: This is handled through SFMA and they will issue the 1099.**

**Question:** We know that SFMA will issue the 1099 for Independent Contractors. We have made payments out in 2015 for dates of service that were in 2014. Who should we send this information to so that it can be included on 1099s?

**Answer: 1099 forms are based on payment date, not service delivery date. If you made the payment, you issue the 1099. There is a \$600.00 threshold for reporting. SFMA will only issue 1099 for payments they made.**

## Legacy/Transition Items

*Note: These questions are being included for reference only. The issue they addressed has either been corrected or the time period in question has passed. This also includes any 'whiteboard'/enhancement items.*

### Implementation

#### Question

How does someone get a provider enrollment number without a PEAA?

#### Answer

- **The mainframe system didn't use to require PEAs**
- **It would be good to email [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us) once you receive a CHC approval. We check on these, but otherwise we are not notified.**

#### Question

Will we be able to submit a rates & units file in March for dates of service thru 2/28/15?

#### Answer

- **Yes. The 02/16/15 to 02/28/15 payment period will follow the same rules as previously circulated. This applies to January and February POC participants only.**

#### Question

Is eXPRS still doing a nightly update from TNT? This is specific to the relationship link for Employers and PSWs.

#### Answer

- **Yes, as files are received from TNT.**

#### Question

We are getting many calls from people waiting on their EXPRS passwords. Some providers are saying they submitted enrollment forms weeks ago and

haven't heard back and other providers are jumping into eXPRS and ending up with.....Your account has been locked. Contact your systems administrator. I think this means they entered an erroneous password too many times and they are now locked out. Who resets their accounts? I think we're losing potential PSW eXPRS users since their first entry into eXPRS isn't going well and then they are giving up. Is there an easier way to reset their password besides leaving a message at the help desk? (Note: during the call, Coos Bay and Community Pathways stated they had the same problem... getting a "Financial" error message.)

### **Answer**

- **“Mark” stated they had the same problem and found it occurs when a user role is not assigned to a provider number. Doing so corrects the problem.**

### **Question**

Foster home providers – the current workaround for these folks is that we’ve been told to enter them as a generic business. There is not an option for generic business on the OR526 dropdown.

### **Answer**

- **If Foster care is providing attendant care outside of their home they need to obtain a new provider # and enroll in eXPRS.**

### **Question**

Will PSWs that have a current Criminal History and PEAA but are not approved to work in eXPRS going to be able to be paid from the date they completed these documents or do they need to not work until they are approved?

### **Answer**

- **Per transmittal APD-AR-15-003 all PSW’s must be in eXPRS and approved before they can work. We cannot issue payment if they are not.**
- **PSW enrollments are to be sent to:  
[psw.enrollment@dhsosha.state.or.us](mailto:psw.enrollment@dhsosha.state.or.us)**

- **The system will allow them to be paid back to the first date of their credential was approved to work status.**

### **Question**

Trying to be proactive, I created & submitted POCs with an effective date of 1/1/15. My county isn't going live until April. Is there a way to edit the start date for these POCs or do I need to start all over?

### **Answer**

- **We are not moving POC dates for service, only the service authorized date for PSW providers.**
- **They can manually adjust those as needed. If the service authorization is still in draft status, it can be edited to change the start date. If it's been submitted & moved out of draft – yes, you need to start over (void / withdraw & create a new line / authorization with the new start date.**
- **Follow up question; if they don't get moved, will there be any harm? Answer; no.**
- **Going forward, attempts to enter a start date which is prior to your going live date will cause an error message to pop up.**

### **Question**

We had originally planned on having the PSWs start entering their SD's on 2/1/15 and entered our POCs accordingly. However, it became clear that 3/1/15 was a better start date. We cannot change the start dates on POCs without voiding them out and re-entering everything. Below is Brande's response when we asked her about changing start dates and it sounds like we do not have to manually do anything - just make sure we do not approve any time prior to 3/1/15. Is this correct?

### **Answer:**

- **The overall POC date range and the service line date range do not need to be changed/edited if the provider service prior authorization (SPA) under the service line have been**

moved forward to align with your agency's "go live" date for POC.

- Any SDs entered by the provider PRIOR to their SPA start date being pushed forward (example: SDs entered for Feb before the start date of their SPA was moved to 3/1/15) should be rejected if in "pending" or voided if moved to "accepted", and payments handled outside of eXPRS.

### Question

Is it possible to get detailed instructions for PSW's on what to expect when they are attempting to get their user log in from eXPRS? We are fielding a lot of calls around this. We are happy to help but it would be good to have some instructions around: Timeframes for generally how long it will take to get the first email, what that email looks like, additional follow up steps that will be needed, how they will know when they are done, etc. This would give us something we can share with providers and also help alleviate staff anxiety when they get these calls.

### Answer:

- It is generally taking 3-10 days to get a user enrolled. Once enrolled, a secure email is sent from [info.exprs@state.or.us](mailto:info.exprs@state.or.us) with the user's login information.
- The new "Provider Status" report will show counties and brokerages if members of their provider panel have an eXPRS account. The number under "User Login" indicates the number of user accounts associated to that provider. For PSWs, there should always be a 1. For agencies, there could be 1 to many users associated to the agency.
- Some of the email notifications sent to PSW's are bouncing back as "undeliverable."
- The notification emails (which expire after 30 days) are mandated to be secure emails which requires the PSW to

create a user name and password to view the email. It has come to our attention that some are mistaking this as their eXPRS log in user name and password which it is not.

- Another discovered issue is that sometimes the notification email to the PSW is landing in their “spam” or “junk” folders.
- These initial emails also include an attachment with more detailed information.

### Question

If we need to make a correction to a payroll to add hours for a PSW from a month before we went live in eXPRS, but now are in eXPRS what is the correct way to proceed for an out of cycle check to make the correction?

#### Answer:

- Use the pre POC system. Rates and Units File to TNT. See APD-AR-15-003

### Question

How are we getting reimbursed for FI fees for TNT to write those vendor checks for those generic payments?

#### Answer:

- The state is not reimbursing for this as it has to do with the contract between the county and TNT.

## 2015-2017 Roll-over

### Question

It seems we are not able to enter plan lines for services that begin in the new contract year. When I'm entering plan lines for an entire year-long ISP, this means I cannot enter the entire plan even though we're able to identify the plan runs from 6/1/15 through 5/31/16. I

thought I was able to do this before. For 151 plans summer and school year OR526 monthly amounts are different. I am not able to enter 9/1/15-05/31/16 hours. It gives me an error message saying “Your request could not be completed because: Plan lines for same service cannot overlap.”

**Answer:**

The overall POC date range & the service plan line date range can extend into the new biennium/contract period w/out issue. Since the service funding is associated with the SPA, the SPAs under a plan line must end on 6/30/15, to align w/the funding in the current contract period. CDDPs/Brokerages may not be able to view new SPAs for dates 7/1/15 → in a current POCs until the biennial roll over process is completed. Additional clarification may be provided with biennial rollover details.

Service lines for 07/01/15 on are saved, but not visible to you.

Allowing you to see and authorize those entries is an enhancement that could be available as soon as June 11th.

**Question**

Does this mean we have to go in again at the new contract year and enter the remainder of all these services on the same person?

**Answer:**

To be determined, based on the how roll-over for POC is to be handled. There are still meetings occurring about this.

**Question**

How will supports that are allocated annually (i.e. anything that has a frequency of *per year*) be rolled over at the biennium?

- a. Example: Customer has a plan that starts April 1<sup>st</sup> and has chosen to allocate 14 hours of day relief care during the plan year. We don't know how

many of those 14 days he will use between April 1<sup>st</sup> and July 1<sup>st</sup> and how many he'll use after. So, reflecting the ISP goal and as directed by the customer, we allocate the 14 days on a per year frequency. What happens when July 1<sup>st</sup> comes? Will eXPRS roll over all 14 days? Will it roll over no days? Will it know how many days have been used and roll only the remaining days over?

- b. This issue applies to any support that isn't allocated monthly or weekly: behavior supports, mileage, bus passes, assistive devices, environmental modifications, etc. How will these annual supports be carried over to the new biennium POCs?

**I would like to clarify that I the question here is two-pronged:**

1. How will things roll on the plan line?
2. How will things roll on the service (provider) line?

**Answer:**

**Additional information will be coming separately regarding rollover.**

**Question**

When we change the plan end dates in POC will we also need to change the Plan Line end dates to coincide or will there be a mechanism in the roll-over process to address these?

**Answer:**

**Part of the roll over, more information coming.**

## Question

A recent eXPRS patch/release allowed for POC dates to cross contract dates in order to reflect actual ISP dates (e.g. doesn't need to end 6/30/15). Though the overall POC end date and POC plan lines are allowing actual end dates beyond 6/30/15, provider lines are not allowing end dates to exceed the contract date and be submitted for the actual ISP end date. Is this an issue that will be corrected?

## Answer:

- **The extension of the Plan Date to match the ISP date is valid. This will not allow service lines or provider lines to cross the contracted dates, the Plan Date will provide a reference to ISP dates as well as provide ODDS information to roll the plan lines forward.**

**\*NEW\* QUESTION:** Now that all the SPAs have rolled and have been created in draft status with a 7/1/15 start date, we are wondering how to handle lines with an annual allocation, specifically services such as mileage and daily relief care. If there is only 1 provider authorized for the service, we understand that eXPRS won't allow them to bill more than what was authorized in the plan line, so there should be no issues in that scenario. However, if there are multiple providers, it seems that eXPRS will allow "overpayment" of one provider (as long as it's within the amount authorized in the plan). If providers have access to the full number of units both pre-6/30 and after 7/1, it will be impossible for PAs to track how many miles are actually being used during the plan year and whether or not a given provider exceeds the limits of their service agreement. When there are multiple providers involved, should we wait to submit the provider line until after the provider submits all bills through June? Then we would edit the total units to include only the total remaining units starting 7/1. Not sure if we are being expected to do this for all customers/providers who have annual allocations and multiple providers. We are concerned about the workload but are also concerned about not being able to track/monitor to ensure that providers are not paid beyond the limits of their individual service agreements. How would the State like for us to handle this?

Examples: DAILY RELIEF: Let's say the plan line is set up for 14 days of Daily Relief, which is assigned to 2 different providers (each provider has a service agreement with a cap of 7 days). After the roll, each provider will have an SPA for 7 days pre-6/30 and an SPA for 7 days after 7/1.

If Provider A used 1 day pre-6/30, they "should" have 6 days left.

If Provider B used 5 days pre-6/30, they "should" only have 2 days left (but their rolled SPA will show they have 7 days). If Provider B tries to bill for anything over the 2 days that are actually "left" in their Service Agreement, eXPRS will process the payment because it is within the 14-day cap at the plan line.

Then when Provider A goes in and tries to bill for the number of days that are actually in their Service Agreement, their service delivered entries will suspend/deny because all 14 days have already been claimed by another provider.

Same issue for mileage, in that if one of the providers bills for more than what's in their contract (but within the plan line amount), there is no way for the PA to catch that when reviewing and paying bills, and we won't realize the issue until the provider who's short-changed tries to bill for their services and runs up against the plan line cap.

These examples just illustrate pretty basic scenarios, with 2 providers having an even split of the units. As you can imagine, it gets further complicated when there are more than 2 providers, each with a different number of units allocated to them. (And customers are definitely not keeping track of how their providers use their annual allocations.)

The way we got around this when we went "live" in POC April 1st is that for any service that was approved as an annual allocation, we waited until all services were paid (out of TRACS) through March 31st, and then we built a SPA for the provider in POC for the remaining balance of units. It's pretty cumbersome, but we're just not aware of any other way for PAs to help ensure that Service Agreements are not overspent.

**ANSWER:** If a Service Plan Authorization line is created under an old Service Plan line (say... 06/30/15) it will continue under the new Service Plan line (say... 07/01/15.) But the approved service amount (miles, hours, etc.) WILL cap out at the maximum amount for the entire plan year taking into account pre 6/30/15 totals for this example.

Unless the Service Plan line was manually ended on 06/30/15 then then the new one manually started on 07/01/15. Then you will have to make the year-end calculations yourself.

## Behavior Support's

### **Question**

At this time Providers who are currently authorized for Behavior supports do not show up in the drop down box in eXPRS for OR570. Will they, or are we going to be paying them as Generic providers indefinitely?

### **Answer:**

**The functionality is currently working correctly. If you are missing someone please add them to your panel. If this does not work submit a support request.**

**We are still in the process of setting up consultation records for DD comprehensive agencies.**

### **Question**

We have a behavior support specialist who claims they have spoken with people at the state and have all of their credentials up to date but are still not in eXPRS. Is there anything we can or need to be doing? Who do we refer them to for support?

### **Answer:**

**If they are not on the approved spread sheets (sent out weekly) by Dan Boyd and Chelas Kronenberg then they are not approved. Only Behavioral Consultant Independent Contractors can be found in eXPRS. Agency providers do not yet have a specialty built in eXPRS and can only be found on the weekly issued spreadsheet. Agency providers who are 'approved' can be authorized as generic providers in eXPRS up to 90 days.**

### **Question**

Extra credentials for PSW-ICs to complete behavior support plans. What are those and how are they listed in eXPRS so that we can know the individual is credentialed?

### **Answer**

- **They must enroll as a Behavioral Consultant PEAA. This process can be found in transmittal AR-14-068. They must be approved before they can be authorized to begin work**

### **Question**

Extra credentials for PSW-IC's to complete behavior support plans. How are these listed in eXPRS so that we can know the PSW is credentialed?

### **Answer**

- **Behavior consultants will have a separate provider # in eXPRS. Reference transmittal APD-AR-14-068**

### **Question**

How will we know when Behavior Consultants have been added?

### **Answer:**

- **Weekly emails are sent out, from Chelas Kronenberg or Dan Boyd, listing credentialed consultants. Both individuals and agencies. They may or may not show as available in eXPRS.**
- **Enter any approved provider from that list as a generic provider for now.**

## **7/2015 Backlog Concerns**

**\*NEW\* QUESTION:** We continue to have issues with our PEAA's and CHC updates reaching PRU. We wait 4 weeks to send the spreadsheet asking for an update and receive the response that she hasn't received a PEAA. We know Michelle is on the other end of the email that we submit these forms to and have started asking her to confirm that she's received the number of attachments we know we've sent. But we haven't heard a resolution to how

paperwork is getting lost. Especially since providers have to wait till they have an SPD # to start working. CHCs can take 4-6 weeks but with an additional 4 weeks or more for the SPD # to show up which is extended when Jessica hasn't received the paperwork, we have a lot of unhappy PSWs and employers. In the beginning we were sending them to [SPD.ProviderNumbers@dhsosha.state.or.us](mailto:SPD.ProviderNumbers@dhsosha.state.or.us).

The issue of missing PEAA's came up and we emailed this address to ask about it and received a direct response from Michelle James. Michelle suggested that we send the paperwork directly to her email address instead. We started doing that but have continued to notice issues with our paperwork ever arriving to Jessica Orwick. We decided to go back to sending them to the [SPD.ProviderNumbers@dhsosha.state.or.us](mailto:SPD.ProviderNumbers@dhsosha.state.or.us) instead. A couple of weeks ago, per a call in, we started asking Michelle to respond that she has received the number of attachments, but she is not writing back to confirm. My concern is the paperwork is getting lost somewhere between Michelle and Jessica. One of my coworkers was talking to Michelle on the phone and mentioned that paperwork is not getting to Jessica and we only find out once we send the spreadsheet for updates after waiting 4 weeks. Michelle told us we didn't need to do that spreadsheet, we could just ask her. We told her we would not be doing that, we would continue to follow the protocol per Lea Ann. I sent several follow ups to Jessica a week ago and Jessica sent back an email to let us know she didn't have PEAA's for them and to send them. These were PEAA's that we had sent as far back as April and this wasn't the first time we had followed up for them. As you can imagine, this has gotten very frustrating.

**ANSWER:** With the 06/30/15 registration date, we've received a tremendous amount of PEAA's causing a lot of backlog.

It's difficult to track incoming PEAA as they come in via multiple avenues when they should only come in via [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us) or the fax # of 1-503-947-9357.

Other issues slowing the process are; submission of incomplete PEAA's, submissions via external secure email systems which can be difficult or impossible to open, multiple re submissions or PEAA form... please send

updated spread sheets instead, and receiving forms other than PEAA, CHC or change of PSW Address forms.

We also ask that multiple PEAA forms not be lumped together into one scanned submission as we then have to print and rescan the individual PEAA forms. This also delays the process.

To help expedite the process you can send the PEAA in without waiting for the CHC form to be completed. Then send in the CHC form when it is completed. Please email the PSW enrollment box to advise us the CHC has been completed since we don't receive that report.

## Whiteboard/Future Enhancements

### **Question**

Is there a timeline for when PSW's will have access to their own profiles? This access would help them to be more accountable and maintain their own credentials, in addition to ensuring that the information in eXPRS is correct. Also, is it possible to add a section into PSW profiles for expiring ODL's and Insurance, as eXPRS does still restrict payment when these things expire?

### **Answer:**

**These items are on the whiteboard for future enhancement considerations.**

### **Question**

Mileage in eXPRS is being rounded to the nearest quarter of a mile (.25, .5, .75) and PSWs are submitting it as tenths of a mile. When the rounding occurs it is causing some PSWs to go over on their mileage even though they provided the correct amount of miles and this will incorrectly suspend a day of mileage. Is this a system 'glitch'? Are we able to change this without written permission from the PSW?

### **Answer:**

The system currently rounds to the quarter mile. A future enhancement to the system is being considered for this. At this time, please enter data as accurately entered on the time sheet unless otherwise directed. You can break the entry into multiple parts. Those that fall within authorized hours will be approved, those that exceed authorized hours will suspend.

### Question

Is it possible to have TNT add the claim number to PSW paystubs? Being able to track a payment back to the claim in eXPRS will save us a lot of time while trying to problem-solve issues with PSW checks.

**Answer:**

**We are looking at options to optimize this. Future system enhancements are being considered to address this issue.**

### Question

Is it possible to edit the SPA from the Find SPA page?

**Answer:**

**No. But that will be added to the white board for future enhancements.**

### Question

Is there a way to tell which eXPRS profile entered/submitted SD billings for a provider?

**Answer:**

**This has been added for future enhancement consideration.**

### Question

Do voided plan lines disappear after any period of time? If so, when? If not, could they?

**Answer:**

**This has been added for future enhancement consideration.**

## Question

We were not successful putting 2 provider's lines at TBD in anticipation of adding 2 PSWs to a client's service line. Is there a reason for this and how do we ensure we can add multiple providers?

### Answer

- **Only one TBD provider authorization line is currently allowed. This request has been added to our "whiteboard" list of potential future changes. However, it is not presently prioritized for any action.**

## Question

Ability to increase hours on a POC Plan line without having to end the plan line and then start a new one.

### Answer

- **This has been added to the white boarded for future consideration. UPDATE: Addressed by 'split' functionality.**

## Question

CHC/PEAA expiration reports with PSW mailing address and phone number

### Answer

- **This has been added to the white boarded for future consideration.**

## Question

Can we show the name of the generic business that we put into POC on the Claims View Page?

### Answer

- **This has been added to the whiteboard for future consideration**

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## Question

Can we have a Claims report that shows the name of the generic provider that we listed in POC? This is essential for us to be able to reconcile payments that we are receiving on behalf of clients for the generic business payments.

#### **Answer**

- **This has been added to the whiteboard for future consideration**

#### **Question**

Can we remove the “/” from the date field on the Create Service Delivered Entries page? Ex: instead of 3/4/2015 we would enter 030415 or 03042015

#### **Answer**

- **This has will be added to the whiteboard for future deployments.**

#### **Question**

Is there a report that connects the direct deposit amount back to claims payments? If not, can there be?

#### **Answer:**

- **No. This will be added to the whiteboard for future development.**
- **Any payments from SFMA are outside of express.**

#### **Question**

Prorated mileage – proper way to enter?

- Half the miles on each client (if in a group of 2)
- All the miles on one client – if so, do we alternate which client is using the miles?

#### **Answer**

- **The system does not allow prorating miles at this time. Please enter a separately calculated prorated amount of miles for the day.**

#### **Question**

Are electronic signatures for timesheets being considered?

**Answer:**

- **On the whiteboard for future development.**

### **Question**

When will we have the ability to change plan lines?

**Answer:**

- **This on the whiteboard for future enhancement considerations.**

### **Question**

Is there any chance of reformatting the time sheet?

**Answer:**

- **Not at this time.**

### **Question**

When a customer transitions (one CDDP to another, Brokerage to CDDP, CDDP to Brokerage) the new location cannot start a new and / or update POC for them until the previous location closes the current POC. Is a “draft” POC capability on the white board for such situations? This would save time when the new / update POC can be done.

**Answer:**

- **This currently is not on the whiteboard, but it is a good suggestion and we will try have this added to the whiteboard.**

**\*NEW\* Question:** Can you add the Group Setting column on the Review Pending Services Delivered Screen?

**Answer:** This has been added to the enhancement request list.

**\*NEW\* QUESTION:** Is there a way to create a split ability in eXPRS to set up weekly and monthly hour restrictions?

**ANSWER:** No.

**\*NEW\* QUESTION:** I would like to address the need for an alternative method of generic businesses providing OR004, specifically taxi. We are requesting that there be a third method which is a monthly allocation with each invoice being one unit, and the rate being the monthly amount. The rate per ride does not allow those users that use taxi from various destinations (i.e. varying rates per ride), with varying needs on one given date.

**ANSWER:** OR004 is Mileage, and would not be used for Taxi rides.

We are aware that use of taxis is an ongoing issue which we are working on. Please review previous guidance on this issue.

**\*NEW\* QUESTION:** Is there discussion about allowing more than 1 plan line per procedure code? This would be especially helpful for the 50 hour per week max. We will have to limit these Plan Lines on a weekly frequency. This means that all other SPAs providing that support will also have to be limited to weekly.

**ANSWER:**

- More than one plan line is on the white board for future enhancements consideration.
- The 50 hours per week / per client is NOT managed in eXPRS

**\*NEW\* QUESTION:** May we have the contact information for PSWs included on the Provider Status report? This will make things so much easier for us when trying to coordinate updating credentials with PSWs.

**ANSWER:** Also on the white board but will not happen soon. What contact information do you want?

**\*NEW\* QUESTION:** The “Month” is wrong on the PSW time sheet.

**ANSWER:** We have already removed that from the time sheet.