COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
HEAD INJURY PROGRAM
HEAD INJURY REHABILITATION SERVICES

PARTICIPATING PROVIDER AGREEMENT

I, the undersigned (hereinafter referred to as "Provider" or "Contractor"), in consideration of being registered by the Pennsylvania Department of Health, Head Injury Program (hereinafter referred to as "Department" or "HIP"), as a participating provider, do hereby agree to be legally bound as follows: I offer to and shall provide special health services (as listed in Appendix C) for the Department to HIP-eligible individuals in accordance with the restrictions indicated in this Agreement and on the individual's HIP funding approval letter, and shall make reports to the Department concerning such services, and shall accept compensation therefore in accordance with reimbursement policies and rates established in Appendix C by the Department and with the terms and conditions incorporated in and made a part of this Agreement. This Agreement is effective as of _____ and is made pursuant to 35 P.S. 6934 (e), and shall continue in effect, unless otherwise terminated according to the terms and conditions of this Agreement, until _____.

The following appendices are incorporated as part of this Agreement:

(1) Appendix A - Contractual Conditions and Attachments 1, 2, 3, 4 and 5
(2) Appendix B - Payment Provisions and Attachments 1, 2, 3, and 4
(3) Appendix C - Fee Schedule

The following documents are incorporated by reference into and made a part of this Agreement. The Provider acknowledges having reviewed a copy of the following documents, which are available at http://www.health.pa.gov/vendors. The Provider agrees to comply with the terms of these documents:

(1) Standard General Terms and Conditions (Rev. 3/15)
(2) HIPAA Business Associate Agreement and Attachment 1 (Rev. 5/13)
(3) Commonwealth Travel and Subsistence Rates (Rev. 4/15)

The parties, intending to be legally bound to the provisions set forth herein, hereby affix their signatures to this Agreement:

APPROVAL FOR DEPARTMENT OF HEALTH:

By:_____
Agency Head (or designee) Date
Pennsylvania Department of Health

APPROVED AS TO FORM AND LEGALITY:

By:_____
Office of Legal Counsel Date
Pennsylvania Department of Health

By:_____
Office of General Counsel Date
Commonwealth of Pennsylvania

By:_____
Office of Attorney General Date
Commonwealth of Pennsylvania

CONTRACTOR:

Provider's Name

Office Address

City State Zip

County

Area Code – Telephone Number

Billing Address (if different from above)

Street

City State Zip

TYPE LICENSE

_____

LICENSE NO.

_____

FID. I.D. #/SS #

_____

SAP Vendor #

_____

(If the contractor is a corporate entity, please have either the president or vice-president and either the secretary/assistant secretary or treasurer/ assistant treasurer of the corporation sign. In lieu thereof, please enclose documentation, e.g., bylaws, board minutes, etc., designating what authority, the signatory has to execute contracts on behalf of the corporation.)

Signed _____

Print Name _____

Title _____

Date _____

AND

Signed _____

Print Name _____

Title _____

Date _____

APPENDIX A

CONTRACTUAL CONDITIONS

I. SERVICES

1. The Department agrees to reimburse the Contractor for the provision of post-acute traumatic head injury rehabilitation services the Department deems to have been provided to the satisfaction of the Department and in accordance with standards set forth in this Agreement. Any changes to this Agreement must be in written amendments that are signed by both the Contractor and the Department. The Contractor shall provide the services as defined in this Appendix A and listed in the Fee Schedule (Appendix C).

2. This Agreement is funded by an appropriation pursuant to 35 P.S.§ 6934 (e) which established the Catastrophic Medical and Rehabilitation Fund.

3. The Contractor acknowledges by execution of this Agreement that the Contractor is a "provider" as defined in the Department's Head Injury Program regulations (28 Pa. Code § 4.1, et seq.), and the contractor agrees to abide by these and any other regulations the Department may promulgate pursuant to 35 P.S. § 6934(e), and by any policy guidelines which may be issued by the Department.

4. Funding/Time Limits - The Contractor shall provide inpatient services, outpatient, day, or home-based services, routine case management services, and transitional case management services, in a combination as may be indicated in the rehabilitation service plan and the discharge plan, for up to a maximum period of time or up to a maximum dollar amount or both, as set forth and as updated in the Pennsylvania Bulletin.

5. Assessment Period - Services as defined below may be provided by the Contractor, and billed according to the Assessment Fee Schedule, for applicants who are both determined to be eligible for assessment by the Department or its specifically authorized agents, and are referred to the Contractor by the Department or its specifically authorized agents. A Pre-admission Assessment is typically conducted for all applicants, the outcome of which may or may not include a recommendation for a Comprehensive Neuropsychological Evaluation. There may be situations when the Contractor performs only a Comprehensive Neuropsychological Evaluation. Routine Case Management Services (Section #8, below) and Transportation (Section #9, below) may also be charged by the Contractor during the Assessment Period.

    a. Pre-admission Assessment (and Other Assessment) – An assessment performed by a qualified clinician or a team of clinicians with experience in cognitive, vocational, and behavioral rehabilitation. This assessment will take place during a face-to-face meeting with the client during which information must be gathered to sufficiently complete:

        1) The Pre-admission Assessment form (Appendix A, Attachment 1).
        2) A Mayo Portland Adaptability Inventory (Appendix A, Attachment 2).
        3) A comprehensive rehabilitation service plan (Appendix A, Attachment 3).
        4) A monthly charge estimate (Appendix A, Attachment 4)
        5) The Client-Provider Agreement (Appendix A, Attachment 5).

b. Comprehensive Neuropsychological Evaluation – A comprehensive assessment of cognitive and behavioral functions conducted with an applicant by a Neuropsychologist using a set of standardized tests and procedures. Various mental functions are systematically tested, including, but not limited to: intelligence, problem solving and conceptualization, planning and organization, attention, memory and learning, language, academic skills, perceptual and motor abilities, emotions, behavior and personality. This type of evaluation determines the nature and extent of behavioral changes due to an individual's traumatic brain injury and determines necessary treatment. The information gathered during a Neuropsychological Evaluation must be incorporated in the required documentation (Appendix A, Attachments 1 through 4).

6. Rehabilitation Period / Outpatient Services Billable - Rehabilitation services as defined below may be provided by the Contractor on an outpatient, day, or home-based basis and billed according to the Rehabilitation Period / Outpatient Fee Schedule for clients whose rehabilitation service plan has been approved in writing by the Department. These services may be provided only for rehabilitation purposes related to the client's brain injury and consistent with the rehabilitation service plan. Routine Case Management Services (Section #8, below) and Transportation (Section #9, below) may also be charged by the Contractor during the Rehabilitation Period.

    a. Behavioral Management - Services that focus on the development of a comprehensive behavior plan which integrates therapy evaluations, physiatric and neuropsychiatric recommendations that focus on the elimination or minimization of target behaviors and the development of replacement behaviors. The structure and support necessary to maintain these skills is identified so that the individual is able to move on to a less intensive environment. For mood instability, the focus of treatment may include medication management, behavioral interventions, therapy assessments and treatment to develop the structure and support necessary to maintain stability so that the person is able to move on to a less intensive environment.

    b. Cognitive Rehabilitation Therapy (CRT) - Services that focus on the (re) attainment of cognitive skills lost or altered because of neurological trauma. The aim of treatment is the enhancement of the client's functional competence in real-world situations. The process includes (re) attainment of skills through direct retraining, use of compensatory strategies, and use of cognitive orthotics and prostheses. CRT is provided to neurologically impaired individuals who indicate a sufficient level of recovery to benefit from such services and is carried out through direct services to clients to assess cognitive areas, target goals, select tasks and strategies, and monitor progress.

    c. Life-Skills Training – Services including, but not limited to: medication management; money management; maintenance of the living environment; social skills training; appropriate use of community services; community mobility; and maintenance of health. Life-skills training must be consistent with the goals of the rehabilitation plan.

    d. Occupational Therapy - Services that help individuals to overcome the physical, cognitive and perceptual problems that limit their ability to perform functional

activities. A client's ability to use upper limbs, perform fine motor skills, coordinate eye-hand movements, and use skills of cognitive function needed for self-care or activities of daily living is evaluated through occupational therapy. Occupational therapy may include exercise and education as well as functional tasks.

e. Personal Care - Services include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service includes meals. This service may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual. These services may only occur as necessary during the provision of other approved outpatient rehabilitative services.

f. Physical Therapy - Services that maintain and improve the movement of joints and limbs and provides treatment of these areas. A client's muscle tone, muscle strength, coordination, endurance and general mobility is evaluated through physical therapy. From this evaluation, an individualized program is developed to improve functional skills.

g. Psychology - Services that focus on understanding the interrelationship between the brain and how individuals think and act. Psychology helps to coordinate the rehabilitation process for clients with brain injuries. These services also focus on the redevelopment of cognitive and social skills, as well as coping and adjustment counseling to deal with the impact of the traumatic brain injury.

h. Physiatry - Medical services that specialize in the area of physical medicine and rehabilitation. Physiatry strives to treat the whole patient, not just the specific injury or condition which improves overall recovery. The goal of treatment is always to restore normal function and improve quality of life for patients from a physical, emotional, psychosocial and vocational perspective.

i. Neurology – Medical services that specialize in the diagnosis and treatment of nervous system disorders.

j. Nursing – Medical nursing services performed as necessary in the context of the provision of other allowable outpatient rehabilitative services.

k. Psychiatry or Neuropsychiatry – Medical services that specialize in the diagnosis and treatment of behavioral abnormalities and mental diseases.

l. Speech/Language Therapy - Services that evaluate and treat problems of expression and understanding sounds and language, and issues relating to swallowing. Speech, swallowing, attention, writing, reading, and expression skills are all addressed through speech/language therapy. Instruction and exercise to improve comprehension and overall communication skills are also provided through speech/language therapy.

m. Therapeutic Recreation - Services that combine the client's interests and hobbies with basic therapy goals. Therapeutic recreation programs are designed that give the client an opportunity to enjoy activities of choice. The

goal of these programs may be improving specific physical or cognitive therapy goals and social skills, acquiring knowledge about how to use leisure resources, and encouraging the planning and organization of leisure activities.

n. Supportive Counseling - Services to assist the client in achieving more effective personal, emotional, social, educational, and vocational development and adjustment.

o. Work Skills Training - Services that are aimed at preparing an individual for paid or unpaid employment, but is not job-task oriented. Training includes teaching such concepts as compliance, attendance, task completion, problem solving and safety. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying goals directed at assisting the client toward greater independence, such as improving attention span and motor skills.

p. Substance Abuse Education and Prevention - Services aimed at individuals who are identified as not needing drug and alcohol treatment and designed to deter use of alcohol and other drugs. Services include increasing awareness and knowledge on the nature and extent of alcohol and drug use, abuse and addiction and the affects on individuals, families and communities, and developing refusal skills.

q. Respite - Services are provided to support individuals on a short-term basis due to the absence or need for relief of those persons continuously providing care. Respite services are provided to individuals in their own home, the home of a relative, the home of a family member, or in a day treatment program. Respite services must be provided through contracted Head Injury Program Provider and in half hour units. Respite services are available to HIP clients receiving Outpatient or Home and Community based services. Therapeutic Services cannot be provided in conjunction with Respite.

7. Rehabilitation Period / Inpatient Services Billable - Inpatient programs as defined below may be provided by the Contractor and billed according to the Rehabilitation Period / Inpatient Fee Schedule for clients whose rehabilitation service plan has been approved in writing by the Department. The daily rate for these programs includes room and board, personal care services as necessary, and, as indicated by the rehabilitation service plan, any of the outpatient services listed in Section 3, above. Routine Case Management Services (Section #8, below) and Transportation (Section #9, below) may also be charged by the Contractor during the Rehabilitation Period.

a. Community Re-Entry Residential Program – Services designed for individuals who have the potential to live in a more independent setting. These individuals may still benefit from therapy and structured support and may require up to 24-hour supervision. The person is ambulatory without supervision or is independent with respect to the use of an assistive device; able to perform basic self-care tasks; and follows safety guidelines.

b. Intensive Rehabilitation Level One - Services designed for individuals who require an intensive therapeutic environment and 24-hour supervision and assistance due to neurocognitive barriers. Therapy assessments and evaluations

serve to develop the structure and supports necessary for more independent functioning and improved communication and life skills. The person is ambulatory without supervision or is independent with respect to the use of an assistive device; may need minimal assistance for basic self care tasks; and responds to cues to follow safety guidelines.

c. Intensive Rehabilitation Level Two - Services designed for individuals who require an intensive therapeutic environment, requiring 24-hour supervision and assistance due to physical and medical issues (for example – swallowing, transfers, ADL needs) as well as significant neurocognitive barriers. Therapy assessments and evaluations serve to develop structure and supports necessary for more independent functioning and improved communication. The person requires moderate to maximum assistance to complete self-care tasks. Person requires moderate to maximum assistance for all functional mobility.

d. Intensive Neurobehavioral Residential Program - Services designed for individuals who exhibit behavioral problems including agitation or verbal/or physical aggression, or who are severely disoriented. These individuals require intensive structured environment with 24-hour supervision an intensive staff to client ratio. The person demonstrates little to no awareness of the brain injury barriers and need for structure/strategies. As a result, the person requires therapy assessments and ongoing interventions to develop replacement behaviors; skills and strategies to support improved functioning. The person demonstrates mood instability or behavioral difficulties or both of limited intensity, frequency, and duration.

8. The Contractor shall provide routine case management services during the Assessment Period and Rehabilitation Period. Reimbursement for routine case management services will be limited to the following activities as specified in the Fee Schedule: development and modification of rehabilitation service plans; monitoring the client's progress; accessing technological assistive devices; setting up resources; scheduling medical appointments; and discharge planning. Discharge planning shall be part of the client's rehabilitation service plan and shall outline the plan for services during the client's six-month transition following rehabilitation services. The Contractor may employ or contract with a case manager to provide these services.

9. During the Assessment Period and Rehabilitation Period, the Department will reimburse Contractors for mileage according to the Commonwealth established rate for Transportation. This mileage may be incurred in the course of traveling to/from a meeting with a client who may not be able to travel to the provider, or in transporting a client to HIP-reimbursable rehabilitation services approved via the rehabilitation service plan.

10. Transition Period - The Contractor shall provide transitional case management services following the client's completion of rehabilitation during the Transition Period. Transitional case management services shall be billed according to the Transition Period Fee Schedule for clients who have completed the Rehabilitation Period, and shall consist of the following:

    a. Assisting the client in gaining access to services from which the client may benefit and for which the client may be eligible.

b. Monitoring and evaluating the client's progress in completion of the discharge plan.

c. Determining that the client has fully transitioned in accordance with the established discharge plan.

II. STAFFING

The facility shall maintain staffing according to the accreditation standards under which the contractor has been approved to provide service.

III. REQUIREMENTS FOR PROVISION OF SERVICES

1. The Department, in its sole discretion, determines which applicants are eligible for an assessment and services under this Agreement. The Contractor under this Agreement must have a separate letter of authorization from the Department, or the Department's specifically authorized agent, prior to the provision of an assessment or any other services to applicants to the Head Injury Program. Individuals eligible for an assessment will be referred in writing to the Contractor for a pre-admission assessment and development of a rehabilitation service plan. The pre-admission assessment must be performed by a qualified clinician or team of clinicians with experience in cognitive, vocational, and behavioral rehabilitation. Documentation of the pre-admission assessment must be maintained in the client's file.

2. The Department will notify applicants in writing of their eligibility for enrollment after receiving the completed assessment or rehabilitation plan or both from the provider. The Department will send a letter notifying the Contractor of the enrollment of the applicant as a client of the Head Injury Program and authorizing the client's rehabilitation services as submitted in the approved rehabilitation service plan.

3. The Contractor must submit any requests for modifications to the rehabilitation service plan in writing in advance to the Head Injury Program in order to obtain written approval prior to implementation of any such modification. The Head Injury Program will review the request for modification and advise the Contractor in writing of the approval or disapproval of the request.

IV. PROVIDER STANDARDS

1. All services rendered by the Contractor shall be consistent with customary standards of professional practice in amount, duration, scope, and quality.

2. The Contractor, and its employees and agents who are providing services under this Agreement, shall be qualified, licensed or certified or both in their respective disciplines as required by the Commonwealth of Pennsylvania and meet staffing standards as required by the Commonwealth of Pennsylvania and their respective accrediting body or waiver agreement.

V. MINIMUM QUALIFICATIONS OF REHABILITATION CONTRACTORS

1. A Contractor shall be accredited by an accrediting body recognized and approved by the Department. The names of the specific accrediting bodies are available upon request from the Department. To make such a request the Contractor should write or

call the Head Injury Program, Department of Health, 7th Floor East Wing, 625 Forster Street, Harrisburg, PA 17120. The telephone number is (717) 772-2762. The Contractor shall submit documentation of its accreditation to the Head Injury Program prior to receipt of a fully executed and approved contract. The Contractor shall maintain such accreditation throughout the term of the contract.

2. The Contractor and all subcontractors shall be licensed by the appropriate Pennsylvania agency according to the laws of the Commonwealth of Pennsylvania. The Contractor shall submit documentation of its licensure to the Head Injury Program prior to receipt of a fully executed and approved contract.

3. The Contractor shall notify the Department immediately of any changes in its accreditation or licensure status.

4. When possible, the Contractor shall participate in other state programs that fund head injury rehabilitation services unless granted an exception in writing by the Head Injury Program. Those other state programs include but are not limited to the Department of Human Services, Office of Social Programs, Community Services Program for Persons with Physical Disabilities (CSPPPD) and COMMCARE Waiver Programs; and the Department of Labor and Industry, Office of Vocational Rehabilitation Program (OVR). The Contractor, if licensed as an outpatient clinic, or if eligible otherwise, shall participate in the Department of Human Services, Office of Medical Assistance Program. The Contractor shall maintain this participation throughout the contract term. The Contractor shall notify the Department immediately of any change in participation.

5. The Contractor must provide staff training about available community resources and head injury rehabilitation programs and services throughout the Commonwealth of Pennsylvania.

VI. CLIENT TRANSFER

1. The Contractor must maintain a written agreement with at least one other facility that is geographically proximate and operating a similar head injury rehabilitation program to ensure continuing care in the event of an emergency, closure or Federal or state or both suspension of operation of the facility.

2. Except for an emergency, as defined in paragraph 3 below, the Contractor shall not transfer clients to another medical care facility or head injury rehabilitation facility unless prior arrangements for admission have been made and the client or legal guardian has agreed to the transfer.

3. The Contractor shall notify the Head Injury Program in writing in advance of a client transfer, unless the transfer results from an emergency due to natural disaster, immediate Federal or state closure of the facility, or the client requires hospitalization for emergency medical reasons. The Head Injury Program must approve transfers, except for emergency transfers, in writing before the transfer occurs.

VII. REPORTING REQUIREMENTS

1. The Contractor shall submit pre-admission assessment, and rehabilitation service plan forms as appropriate for each individual referred from the Head Injury Program. The Department may prospectively amend or revise the pre-admission assessment and

rehabilitation service forms, in writing, by notifying the Contractor at least 30 days in advance by first class U.S. mail of changes. Such changes are incorporated herein by reference as of their effective date(s), as indicated in the notice.

2. All modifications to the rehabilitation service plan must be submitted in writing to the Head Injury Program in advance for prior approval. The Head Injury Program will respond in writing to the request for modification. The Head Injury Program, as stated in Section VI, Client Transfer, must approve non-emergency client transfers, in advance. In addition, any unexpected changes in the client's status, such as death or voluntary discharge from treatment, must be reported within seven days to the Head Injury Program.

3. The Contractor shall prepare a progress report for each client, at a minimum of each 90-day period and submit the report to the Department. This report should include a status update on the client's progress toward achieving the goals and objectives stated in the most current service plan.

4. The Contractor must provide notification to the Department within seven days of each client's admission and discharge.

5. A discharge plan must be submitted at time of admission. A discharge summary must be submitted to the Head Injury Program within four weeks of discharge.

VIII. FEE SCHEDULE

1. The Department's approved Fee Schedule (Appendix C), which is attached, delineates the maximum allowable fee at which the Department will reimburse the Contractor.

2. The Department may prospectively amend or revise the Fee Schedule, in writing, by notifying the Contractor at least 30 days in advance by first class U.S. mail of changes. Such changes are incorporated herein by reference as of their effective date(s), as indicated in the notice.

IX. PREVIOUS AGREEMENTS

As of the effective date of this Agreement, any other agreement between the Contractor and the Department, whether written or oral, for services covered herein is terminated.

X. SUSPENSION OF CONTRACT SERVICES DUE TO UNAVAILABILITY OF FUNDS

1. The Department may, upon its determination that funds have or will become unavailable for any or all services provided under this Agreement, prospectively suspend provision of any or all of those services upon prior written notice to the Contractor by first class U.S. mail. This notification will instruct the Contractor that the services enumerated in the notice are to be suspended by the date set out in the notification. The Department will notify the Provider of the suspension of services as soon as practicable.

2. Department will not reimburse Contractor for suspended services under this Agreement unless and until the Department notifies the Provider in writing that the Department will do so.

3. All notifications sent out pursuant to this Section (X) become part of this Agreement and are incorporated herein by reference.

XI. MONITORING OF CONTRACTOR

1. The Contractor shall be subject to periodic on-site review by the Department or its designees, Commonwealth Auditor General, or the Inspector General.

2. Upon request, the Contractor shall submit to the Department such reports and records, including but not limited to, client utilization, medical incident reports and client needs assessments.

XII. EXAMINATION OF RECORDS

1. The Contractor agrees to maintain all records, including but not limited to, medical and financial records, pertaining to the services provided under this Agreement, and for which reimbursement is claimed, for a period of four years from the date of the final payment under this Agreement.

2. The Contractor agrees to make available at the office of the Contractor at reasonable times during the term of this Agreement, and four years thereafter, any of these records for inspection, audit or reproduction by any authorized representative of the Secretary of Health, the Auditor General, or the Inspector General.

3. The Contractor shall, upon request, furnish the Department with the itemized bills for all expenditures incurred in the performance of this Agreement and billed in a particular billing period (month). All expenditures must be documented. Documentation of expenditures shall include, but not be limited to, copies of vouchers, requisitions, invoices and receipts.

4. This Section supplements, but does not replace, Paragraphs 11 and 12 of the Standard General Terms and Conditions (Rev. 3/15), which are incorporated herein by reference.

XIII. TERMINATION PROVISIONS

1. Grounds for action. The Department may terminate a Provider's Agreement and seek reimbursement from that Provider if the Department determines that the Provider, owner of the Provider, or agent of the Provider has done any of the following:

    a. Submitted false or fraudulent claims to the HIP.

    b. Failed to comply with any term of this Agreement.

    c. Been precluded or excluded, either voluntarily or involuntarily, as a Medical Assistance provider.

    d. Been convicted of a Medicaid or Medicare related criminal offense.

    e. Been convicted of a criminal offense under state or Federal laws relating to the services covered by this Agreement.

f. Been subject to license suspension or revocation following disciplinary action entered against the Provider or its health care providers providing services under this Agreement by a licensing or certifying authority.

g. Had a controlled drug license withdrawn or failed to report to the Department changes in the Provider's Drug Enforcement Agency Number.

h. Knowingly submitted a fraudulent or erroneous patient application or assisted a patient to do so.

i. Refusal to permit authorized state or federal officials or their agents to examine the Provider's medical, fiscal or other records as necessary to verify claims made to the Department under this Agreement.

This section supplements but does not replace paragraph 27 of the Standard General Terms and Conditions, (Rev. 3/15), which are incorporated herein by reference.

2. The above is a non-exhaustive list which does not limit the Department's remedies for breach otherwise under this Agreement. Nor does this section prevent the Department from exercising any other right of termination the Department has under this Agreement or by law.

PENNSYLVANIA DEPARTMENT OF HEALTH
Head Injury Program
Pre-admission Assessment Form

Applicant: _____

Date of Birth: _____ Date of Injury: _____

Assessment By: _____ Date of Assessment: _____

Reason for Referral:

_____

_____

Previous Treatment:

_____

_____

Observations:

_____

_____

Psychosocial History:

_____

_____

Current Findings:

Health/Medical (Including Mobility):

_____

_____

Daily Living Skills:

_____

_____

Communication/Speech/Language:

_____

_____

Cognition:

_____

_____

Interpersonal Skills and Behavior (Mood):

_____

_____

Recreation:

_____

_____

Vocational:

_____

_____

Client and Family Goals:

_____

_____

Supports Available:

_____

_____

Expectations and Anticipated Outcomes:

_____

_____

Overall Goal (from Rehabilitation Service Plan):

_____

_____

Funding Limit and Time Needed to Achieve Goal:

_____

_____

Clinical Teams to complete and submit an attached Mayo Portland Adaptability Inventory (MPAI) to the Head Injury Program at pre-admission and prior to discharge.

Please return form to:

Head Injury Program
Pennsylvania Department of Health
Health and Welfare Building
7Th Floor East Wing
625 Forster Street
Harrisburg, Pennsylvania 17120

Muriel D. Lezak, PhD, ABPP & James F. Malec, PhD, ABPP

Name: _____ Clinic # _____ Date _____

Person reporting (circle one): Single Professional Professional Consensus Person with brain injury Significant other: _____

Below each item, circle the number that best describes the level at which the person being evaluated experiences problems. Mark the greatest level of problem that is appropriate. Problems that interfere rarely with daily or valued activities, that is, less than 5% of the time, should be considered not to interfere. Write comments about specific items at the end of the rating scale.

For Items 1-20, please use the rating scale below.

0	None	**1**	Mild problem but does not interfere with activities; may use assistive device or medication	**2**	Mild problem; interferes with activities 5-24% of the time	**3**	Moderate problem; interferes with activities 25-75% of the time	**4**	Severe problem; interferes with activities more than 75% of the time

Part A. Abilities

1. Mobility: Problems walking or moving; balance problems that interfere with moving about
0 1 2 3 4

2. Use of hands: Impaired strength or coordination in one or both hands
0 1 2 3 4

3. Vision: Problems seeing; double vision; eye, brain, or nerve injuries that interfere with seeing
0 1 2 3 4

4. *Audition: Problems hearing; ringing in the ears
0 1 2 3 4

5. Dizziness: Feeling unsteady, dizzy, light-headed
0 1 2 3 4

6. Motor speech: Abnormal clearness or rate of speech; stuttering
0 1 2 3 4

7A. Verbal communication: Problems expressing or understanding language
0 1 2 3 4

7B. Nonverbal communication: Restricted or unusual gestures or facial expressions; talking too much or not enough; missing nonverbal cues from others
0 1 2 3 4

8. Attention/Concentration: Problems ignoring distractions, shifting attention, keeping more than one thing in mind at a time
0 1 2 3 4

9. Memory: Problems learning and recalling new information
0 1 2 3 4

10. Fund of Information: Problems remembering information learned in school or on the job; difficulty remembering information about self and family from years ago
0 1 2 3 4

11. Novel problem-solving: Problems thinking up solutions or picking the best solution to new problems
0 1 2 3 4

12. Visuospatial abilities: Problems drawing, assembling things, route-finding, being visually aware on both the left and right sides
0 1 2 3 4

Part B. Adjustment

13. Anxiety: Tense, nervous, fearful, phobias, nightmares, flashbacks of stressful events
0 1 2 3 4

14. Depression: Sad, blue, hopeless, poor appetite, poor sleep, worry, self-criticism
0 1 2 3 4

15. Irritability, anger, aggression: Verbal or physical expressions of anger
0 1 2 3 4

16. *Pain and headache: Verbal and nonverbal expressions of pain; activities limited by pain
0 1 2 3 4

17. Fatigue: Feeling tired; lack of energy; tiring easily
0 1 2 3 4

18. Sensitivity to mild symptoms: Focusing on thinking, physical or emotional problems attributed to brain injury; rate only how concern or worry about these symptoms affects current functioning over and above the effects of the symptoms themselves
0 1 2 3 4

19. Inappropriate social interaction: Acting childish, silly, rude, behavior not fitting for time and place
0 1 2 3 4

20. Impaired self-awareness: Lack of recognition of personal limitations and disabilities and how they interfere with everyday activities and work or school
0 1 2 3 4

Use scale at the bottom of the page to rate item #21

21. Family/significant relationships: Interactions with close others; describe stress within the family or those closest to the person with brain injury; "family functioning" means cooperating to accomplish those tasks that need to be done to keep the household running

0	Normal stress within family or other close network of relationships	**1**	Mild stress that does not interfere with family functioning	**2**	Mild stress that interferes with family functioning 5-24% of the time	**3**	Moderate stress that interferes with family functioning 25-75% of the time	**4**	Severe stress that interferes with family functioning more than 75% of the time

Part C. Participation

22. Initiation: Problems getting started on activities without prompting

0 None	**1** Mild problem but does not interfere with activities; may use assistive device or medication	**2** Mild problem; interferes with activities 5-24% of the time	**3** Moderate problem; interferes with activities 25-75% of the time	**4** Severe problem; interferes with activities more than 75% of the time

23. Social contact with friends, work associates, and other people who are not family, significant others, or professionals

0 Normal involvement with others	**1** Mild difficulty in social situations but maintains normal involvement with others	**2** Mildly limited involvement with others (75-95% of normal interaction for age)	**3** Moderately limited involvement with others (25-74% of normal interaction for age)	**4** No or rare involvement with others (less than 25% of normal interaction for age)

24. Leisure and recreational activities

0 Normal participation in leisure activities for age	**1** Mild difficulty in these activities but maintains normal participation	**2** Mildly limited participation (75-95% of normal participation for age)	**3** Moderately limited participation (25-74% of normal participation for age)	**4** No or rare participation (less than 25% of normal participation for age)

25. Self-care: Eating, dressing, bathing, hygiene

0 Independent completion of self-care activities	**1** Mild difficulty, occasional omissions or mildly slowed completion of self-care; may use assistive device or require occasional prompting	**2** Requires a little assistance or supervision from others (5-24% of the time) including frequent prompting	**3** Requires moderate assistance or supervision from others (25-75% of the time)	**4** Requires extensive assistance or supervision from others (more than 75% of the time)

26. Residence: Responsibilities of independent living and homemaking (such as, meal preparation, home repairs and maintenance, personal health maintenance beyond basic hygiene including medication management) but not including managing money (see #29)

0 Independent; living without supervision or concern from others	**1** Living without supervision but others have concerns about safety or managing responsibilities	**2** Requires a little assistance or supervision from others (5-24% of the time)	**3** Requires moderate assistance or supervision from others (25-75% of the time)	**4** Requires extensive assistance or supervision from others (more than 75% of the time)

27. *Transportation

0 Independent in all modes of transportation including independent ability to operate a personal motor vehicle	**1** Independent in all modes of transportation, but others have concerns about safety	**2** Requires a little assistance or supervision from others (5-24% of the time); cannot drive	**3** Requires moderate assistance or supervision from others (25-75% of the time); cannot drive	**4** Requires extensive assistance or supervision from others (more than 75% of the time); cannot drive

28A. *Paid Employment: Rate either item 28A or 28B to reflect the primary desired social role. Do not rate both. Rate 28A if the primary social role is paid employment. If another social role is primary, rate only 28B. For both 28A and 28B, "support" means special help from another person with responsibilities (such as, a job coach or shadow, tutor, helper) or reduced responsibilities. Modifications to the physical environment that facilitate employment are not considered as support.

0 Full-time (more than 30 hrs/wk) without support	**1** Part-time (3 to 30 hrs/ wk) without support	**2** Full-time or part-time with support	**3** Sheltered work	**4** Unemployed; employed less than 3 hours per week

28B. *Other employment: Involved in constructive, role-appropriate activity other than paid employment.

Check only one to indicate primary desired social role: □ Childrearing/care-giving □ Homemaker, no childrearing or care-giving □ Student □ Volunteer □ Retired (Check retired only if over age 60; if unemployed, retired as disabled and under age 60, indicate "Unemployed" for item 28A.

0 Full-time (more than 30 hrs/wk) without support; full-time course load for students	**1** Part-time (3 to 30 hrs/ wk) without support	**2** Full-time or part-time with support	**3** Activities in a supervised environment other than a sheltered workshop	**4** Inactive; involved in role-appropriate activities less than 3 hours per week

29. Managing money and finances: Shopping, keeping a check book or other bank account, managing personal income and investments; if independent with small purchases but not able to manage larger personal finances or investments, rate 3 or 4.

0 Independent, manages small purchases and personal finances without supervision or concern from others	**1** Manages money independently but others have concerns about larger financial decisions	**2** Requires a little help or supervision (5-24% of the time) with large finances; independent with small purchases	**3** Requires moderate help or supervision (25-75% of the time) with large finances; some help with small purchases	**4** Requires extensive help or supervision (more than 75% of the time) with large finances; frequent help with small purchases

Part D: Pre-existing and associated conditions. The items below do not contribute to the total score but are used to identify special needs and circumstances. For each rate, pre-injury and post-injury status.

30. Alcohol use: Use of alcoholic beverages.

Pre-injury _____ Post-injury _____

0	No or socially acceptable use	**1**	Occasionally exceeds socially acceptable use but does not interfere with everyday functioning; current problem under treatment or in remission	**2**	Frequent excessive use that occasionally interferes with everyday functioning; possible dependence	**3**	Use or dependence interferes with everyday functioning; additional treatment recommended	**4**	Inpatient or residential treatment required

31. Drug use: Use of illegal drugs or abuse of prescription drugs.

Pre-injury _____ Post-injury _____

0	No or occasional use	**1**	Occasional use does not interfere with everyday functioning; current problem under treatment or in remission	**2**	Frequent use that occasionally interferes with everyday functioning; possible dependence	**3**	Use or dependence interferes with everyday functioning; additional treatment recommended	**4**	Inpatient or residential treatment required

32. Psychotic Symptoms: Hallucinations, delusions, other persistent severely distorted perceptions of reality.

Pre-injury _____ Post-injury _____

0	None	**1**	Current problem under treatment or in remission; symptoms do not interfere with everyday functioning	**2**	Symptoms occasionally interfere with everyday functioning but no additional evaluation or treatment recommended	**3**	Symptoms interfere with everyday functioning; additional treatment recommended	**4**	Inpatient or residential treatment required

33. Law violations: History before and after injury.

Pre-injury _____ Post-injury _____

0	None or minor traffic violations only	**1**	Conviction on one or two misdemeanors other than minor traffic violations	**2**	History of more than two misdemeanors other than minor traffic violations	**3**	Single felony conviction	**4**	Repeat felony convictions

34. Other condition causing physical impairment: Physical disability due to medical conditions other than brain injury, such as, spinal cord injury, amputation. Use scale below #35.

Pre-injury _____ Post-injury _____

35. Other condition causing cognitive impairment: Cognitive disability due to nonpsychiatric medical conditions other than brain injury, such as, dementia, stroke, developmental disability.

Pre-injury _____ Post-injury _____

0	None	**1**	Mild problem but does <u>not</u> interfere with activities; may use assistive device or medication	**2**	Mild problem; interferes with activities 5-24% of the time	**3**	Moderate problem; interferes with activities 25-75% of the time	**4**	Severe problem; interferes with activities more than 75% of the time

Comments:

Item #

_____ _____

_____ _____

_____ _____

_____ _____

Scoring Worksheet

Items with an asterisk (4, 16, 27, 28/28A) require rescoring as specified below before Raw Scores are summed and referred to Reference Tables to obtain Standard Scores. Because items 22-24 contribute to both the Adjustment Subscale and the Participation Subscale, the Total Score will be less than the sum of the three subscales.

Abilities Subscale

Rescore item 4. Original score = _____
If original score = 0, new score = 0
If original score = 1, 2, or 3, new score = 1
If original score = 4, new score = 3

A. New score for item 4 = _____
B. Sum of scores for items 1-3 and 5-12 = _____
(use highest score for 7A or 7B)

Sum of A and B = Raw Score for Abilities subscale = _____ (place in Table below)

Adjustment Subscale

Rescore item 16. Original score = _____
If original score = 0, new score = 0
If original score = 1 or 2, new score = 1.
If original score = 3 or 4, new score = 2

C. New score for item 16 = _____
D. Sum of scores for items 13-15 and 17-24 _____

Sum of C and D = Raw Score for Adjustment Subscale _____ (place in Table below)

Participation Subscale

Rescore item 27. Original score = _____
If original score = 0 or 1, new score = 0
If original score = 2 or 3, new score = 1
If original score = 4, new score = 3

Rescore item 28A or 28B. Original score = _____
If original score = 0, new score = 0
If original score = 1 or 2, new score = 1
If original score = 3 or 4, new score = 3

E. New score for item 27 = _____
F. New score for item 28Aor 28B = _____
G. Sum of scores for items 22-24 = _____ (place in Table below)
H. Sum of scores for items 25, 26, 29 = _____

Sum of E through H = Raw Score for Participation Subscale = _____ (place in Table below)

Use Reference Tables to Convert Raw Scores to Standard Scores

	Raw Scores (from worksheet above)	**Standard** (Obtain from appropriate reference Table)
I. Ability Subscale (Items 1-12)	_____	_____
II. Adjustment Subscale (Items 13-24)	_____	_____
III. Participation Subscale (Items 22-29)	_____	_____
IV. Subtotal of Subscale Raw Scores (I-III)	_____	
V. Sum of scores for items 22-24	_____	
VI. Subtract from V. from IV = Total Score	_____	_____

Head Injury Program
Rehabilitation Service Plan

Applicant/Client Name: _____ **Date of Birth**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____ **Date of Injury**: _____

Provider/Facility: _____ **Date of Admission**: _____

Name of Person Completing Form: _____ **Title**: _____

Signature: _____ **Date of Rehabilitation Service Plan**: _____

Initial Recommendations and Anticipated Outcomes: _____

For each of the Goal below include target date for achievement of the goal and outcome for the entire enrollment period, and include the services needed to obtain the goal.

Goal 1:

Services Required:

Target Date: Begin End

Goal 2:

Services Required:

Target Date: Begin End

Goal 3:

Services Required:

Target Date: Begin End

Goal 4:

Services Required:

Target Date: Begin End

Goal 5:

Services Required:

Target Date: Begin End

I have been given the opportunity to participate in the development of the above Rehabilitation Service Plan.

Applicant/Client's ***Printed*** Name Date

Authorized Representative's ***Printed*** Name Date

Applicant/Client's ***Signature*** or Authorized Representative's Signature

The above Rehabilitation Service Plan was developed with input from professionals with experience in cognitive, vocational and behavioral rehabilitation.

Printed Name, Program Director, Rehabilitation Provider

Signature, Program Director, Rehabilitation Provider Date

This form is to be maintained in the client's file and available for inspection upon the Department's request.

Head Injury Program Monthly Charge Estimate
Check the Appropriate Program Setting:

Fee For Service: ☐ Residential Rehabilitation ☐ Outpatient Services ☐ Home & Community Based Services
Per Diem: ☐ Community Re-Entry ☐ Intensive – Level One ☐ Intensive –Level Two ☐ Neurobehavioral
☐ Neurobehavioral/ Neurocognitive

Name of Provider: _____ Client Name: _____
Begin Date: _____ End Date: _____

	Begin Date	End Date	Rec. # of Days/Hrs/ miles/Month	Dollar Amount
☐ HR001 – Residential Services (Personal Care Daily Rate)				
☐ HR002 – Assisted Neurobehavioral Therapy				
☐ HR003 – Assistive Community Integration (Life Skills Training)				
☐ HR004 – Supportive Counseling				
☐ HR005 – Substance Abuse Education				
☐ HR006 – Therapeutic Recreation				
☐ HR007 – Work Skills Services Training)				
☐ HR008 – Routine Case Management Services				
☐ HR009 – Cognitive Therapy (Retraining) - Individual Session				
☐ HR010 – Occupational Therapy- Individual Session				
☐ HR011 – Physical Therapy - Individual Session				
☐ HR012 – Psychological Services – Individual Session				
☐ HR013 – Speech Therapy (and Language Therapy) -				
☐ HR014 – Cognitive Therapy (Retraining) - Group Session				
☐ HR015 – Occupational Therapy - Group Session				
☐ HR016 – Physical Therapy - Group Session				
☐ HR017 – Psychological Services - Group Session				
☐ HR018 – Speech Therapy (and Language Therapy) -				
☐ HR019 - Psychiatry or Neuropsychiatry				
☐ HR020 - Physiatry				
☐ HR021 - Neurology				
☐ HR022 - Nursing				
☐ HR023 - Community Re-Entry Residential				
☐ HR024 - Intensive Rehabilitation –Level One				
☐ HR025 - Intensive Rehabilitation –Level Two				
☐ HR026 - Intensive Neurobehavioral				
☐ HR027 - Transportation, in miles-				
☐ HR028 – Intensive Neurobehavioral/Neurocognitive Evaluation – not more than 90 days				
☐ HR029 – Respite				

Head Injury Program – Client-Provider Agreement

Client:

Terms and Conditions for HIP Service Delivery: The applicant/client agrees to comply with the above rehabilitation service plan and with all terms and conditions for participation in the Head Injury Program as specified in the Head Injury Program application.

Specific Responsibilities of the Applicant Relative to Implementation of Each HIP Service: The applicant agrees to participate in the above services, as described in this Rehabilitation Service Plan, for the period of time recommended by the rehabilitation service provider. The applicant agrees to comply with the requirements for participation established by the rehabilitation service provider.

Financial Responsibility of the Applicant: The applicant/client has already certified in their Application for Services that the income, financial and all other information they have provided to the Department of Health is true, correct and complete to the best of their knowledge. The applicant/client agrees to pay the rehabilitation service provider, based upon their annual share of cost determined by the Department of Health.

Discharge Planning: Upon discharge from the rehabilitation provider, the applicant/client will be discharged to an appropriate provider should continued services be necessary and if funding is available or to the care or supervision of their family when funding is not available or a suitable provider cannot be located.

I agree to the above terms and to participate in the Rehabilitation Service Plan as outlined above.

Applicant/Client's ***Printed*** Name _____ Date _____

Authorized Representative's ***Printed*** Name _____ Date _____

Applicant/Client's ***Signature*** or Authorized Representative's Signature _____

HIP Service Provider

Terms and Conditions for HIP Service Delivery: The rehabilitation service provider agrees to comply with all terms and conditions specified in their Participating Provider Agreement related to the delivery of services in this rehabilitation service plan.

Specific Responsibilities of the Rehabilitation Service Provider Relative to Implementation of Each HIP Service: The rehabilitation service provider agrees to provide the services identified above in the Rehabilitation Service Plan to the applicant/client as proposed. The rehabilitation service provider will perform, at a minimum, quarterly progress reviews to determine the client's progress in meeting the goals and objectives identified in the rehabilitation service plan. The results of the progress reviews will be conveyed to the client and his or her authorized representative.

Financial Responsibility of the Applicant, HIP and any Third Party: The Provider shall not bill enrolled patients, in part or in full, for any services listed on the Fee Schedule except where the Provider is so instructed, in writing, by the Department. Invoices submitted to the Department for enrolled patients who are expected to share in the cost of services will be rejected by the Department, in whole or in part, and the provider will be instructed, in writing, by the Department to bill the patient in whole or in part.

The Head Injury Program will reimburse the rehabilitation service provider, according to the approved fee schedule in the Participating Provider Agreement, after the provider bills the client when instructed by the Head Injury Program, the client's third party insurance and all other state programs. The Head Injury Program is a payer of last resort according to the Participating Provider Agreement.

I agree to the above terms, to provide services as described above, to conduct progress reviews and to promote the applicant/client's achievement of his or her rehabilitation goals.

Printed Name, Program Director, Rehabilitation Provider _____

Signature, Program Director, Rehabilitation Provider _____ Date _____

This form is to be maintained in the client's file and available for inspection upon the Department's request.

DEPARTMENT OF HEALTH

CONTRACT PAYMENT PROVISIONS

The Department agrees to pay the Contractor for services rendered pursuant to this Agreement as follows:

A. Subject to the availability of State funds and the other terms and conditions of this Agreement, the Department will reimburse Contractor in accordance with the fee schedule, APPENDIX C.

B. Payment to the Contractor made in accordance with the fee schedule set forth in APPENDIX C as follows:

1. Payments will be made monthly upon submission of an itemized invoice for services rendered pursuant to this Agreement using the invoice format in Attachment 1 to this Appendix. The Department shall have the right to disapprove any expenditure made by the Contractor that is not in accordance with the terms of this Agreement and adjust any payment to the Contractor accordingly. The Department will reimburse only for those services which are listed on the Fee Schedule (Appendix C), and which are delivered by Contractors who have an Agreement with the Department for the provision of post-acute traumatic head injury rehabilitation services. The Contractor may sub-contract with another entity for the provision of services if prior written authorization is granted by the Department as stated in the Standard General Terms and Conditions (Rev. 3/15), which are incorporated herein by reference.

2. The Contractor shall bill the Department at the current approved rate as indicated on the Fee Schedule, less any third party payment and the client's share. Reimbursement shall not exceed the amount indicated on the Fee Schedule, less third party payments and payments from the client for his/her share.

3. An original invoice (Attachment 1) and a detailed accounting (Attachment 2-4) itemized in accordance with the fee schedule shall be sent by the Contractor directly to Department of Health, Head Injury Program, 7th Floor East Wing, 625 Forster Street, Harrisburg, PA 17120. Invoices shall show SAP Vendor number, date when submitted, invoice number, name and address of the payee, billing period, total invoice amount, signature of person preparing the invoice, and date of signature.

4. Unless otherwise specified elsewhere in this Agreement, the following shall apply: Contractor shall submit monthly invoices within 30 days from the last day of the month within which the work is performed. The final invoice shall be submitted within 30 days of this Agreement's termination date. The Department will neither honor nor be liable for invoices not submitted in compliance with the time requirements in this paragraph unless the Department agrees to an extension of these requirements in writing. Contractor shall be reimbursed only for services acceptable to the Department.

5. The Department, at its option, may withhold the last 20% of reimbursement due under this Agreement, until the Project Officer has determined that all work and services required under this Agreement have been performed or delivered in a manner acceptable to the Department.

6. The Department is the payer of last resort under this Agreement. The Contractor shall seek reimbursement from all other federal and state programs for which the client may be eligible and, all third party payers including, but not limited to, private insurers, before billing the Department. If the payment provided by another payer is, by law or agreement, accepted by the Contractor as payment in full (e.g., Medicaid or Medicare or any other payer with whom the Contractor has such an agreement), the Contractor shall not bill the Department or client for services provided to the client.

7. The Contractor shall not bill eligible clients, in part or in full, for any services listed on the Fee Schedule except when the Contractor is so instructed in writing by the Department. If the Contractor submits invoices to the Department for clients who are expected to share in the cost of services, the Department will reject those invoices in whole or in part, and the Contractor will then be instructed in writing by the Department to bill the client in whole or in part accordingly.

8. The Department will reimburse Contractors for mileage according to the Commonwealth established rate for Transportation in accordance with the Commonwealth Travel and Subsistence Rates (Rev. 4/15), which are incorporated herein by reference. This mileage may be incurred in the course of traveling to/from a meeting with a client who may not be able to travel to the provider or in transporting a client to HIP-reimbursable rehabilitation services approved via the rehabilitation service plan.

9. The Department will not reimburse Contractors for lodging, parking, tolls, telephone calls, subsistence, copying, faxing, postage, or invoice preparation. Other non-reimbursable services include:

   Intra-agency meetings (meetings that take place among staff of the same agency) such as staff meetings, case conference, internal progress/planning meetings.

   Intake and clerical functions such as eligibility determination or routine, ongoing scheduling of appointments for other intra-agency staff.

   Assigning or supervising direct service staff.

   Missed appointments with the family/caretaker and client or the service provider(s).

   Record keeping or medical documentation activities.

10. In the event a payment is received from another payer for a service that has been paid by the Department, a reimbursement check for the whole or part of the amount of the Department's payment, as appropriate, shall be made payable to the "Commonwealth of Pennsylvania – Head Injury Program" and mailed to the address to which invoices are to be sent, above. The name of the client, social security number, date of service, description of service, PPA number, and amount paid by the Department shall accompany each reimbursement check. Refunds to the Department as a result of overpayment or collection from another source of payment shall be refunded to the Department by the Contractor within 30 days of the Contractor's receipt of excess payment.

11. The Department may prospectively amend or revise the head injury rehabilitation services invoice and the requirements stated herein, in writing, by notifying the Contractor at least 30 days in advance by first class U.S. mail of such changes. Such changes are incorporated herein by reference as of their effective dates.

(Revised 4/17)

INVOICE

Payee Name and Address:

Date:

Current Billing Period:

Invoice Number:
SAP Vendor Number:

Location Code:
Department of Health - Division of Child & Adult Health
67CHLDADLT
P.O.Box 69183
Harrisburg, PA 17106

	Category	Invoice Amount
I.	Personnel Services	
	Staff Personnel	
	Fringe	
II.	Consultant Services	
III.	Subcontract Services	
IV.	Patient Services	
V.	Equipment	
VI.	Supplies	
VII.	Travel	
VIII.	Other Costs	
		$ -

CERTIFIED BY:

Contractor's Authorized Signature Date

Department of Health's Authorized Signature Date

FUND - 10 digits	COST CENTER - 10 digits	INTERNAL ORDER - 12 digits

HEAD INJURY PROGRAM INVOICE Fee for Service

Payee: _____ Date:_____

Billing Period: _____ (current billing period only)

Client's Name_____

Check the client's service setting for this month based upon the approved Rehabilitation Service Plan:

☐Residential Rehabilitation ☐Outpatient Services ☐Home and Community –Based Services

Service Code	Service Date From	Service Date To	#Units or miles	Fee Schedule Amount	Total Cost to DOH
HR001				$55.00	
HR002				$50.00	
HR003				$50.00	
HR004				$19.25	
HR005				$19.25	
HR006				$50.00	
HR007				$50.00	
HR008				$26.25	
HR009				$54.75	
HR010				$54.75	
HR011				$50.25	
HR012				$50.75	
HR013				$36.00	
HR014				$30.00	
HR015				$30.00	
HR016				$30.00	
HR017				$30.00	
HR018				$30.00	
HR019				$87.50	
HR020				$87.50	
HR021				$87.50	
HR022				$25.00	
HR027				Commonwealth rate	
HR029				$25.00	
HT001				$ 7.50	
Total					

4/17

HEAD INJURY PROGRAM INVOICE PER DIEM

Payee: _____ Date: _____

Billing Period: _____ (current billing period only)

Client's Name_____

Check the client's service setting for this month based upon the approved Rehabilitation Service Plan:

☐ Community Re-Entry ☐ Intensive – Level One ☐ Intensive – Level Two ☐ Neurobehavioral

Service Code	Service Date From	Service Date To	#of Units (DAYS, miles or units)	Fee Schedule Amount	Total Cost to DOH
HR023				$400.00	
HR024				$450.00	
HR025				$600.00	
HR026				$650.00	
HR027				Commonwealth rate	
HR028				$850.00	
HR008				$ 26.25	
Total					

4/17

HEAD INJURY PROGRAM INVOICE PREADMISSION ASSESSMENT

Payee: _____ Date: _____

Billing Period: _____ (current billing period only)

Client's Name_____

Service Code	Service Date From	Service Date To	#of Units or miles	Fee Schedule Amount	Total Cost to DOH
HA001				$350.00	
HA003				$1,500.00	
HA004				$105.00	
HR008				$26.25	
HR027				Commonwealth rate	
Total					

4/17

HEAD INJURY REHABILITATION FEE SCHEDULE Effective July 1, 2017 Appendix C

	Description	Fee	Effective Date	Limit Description
Assessment Period				
HA001	Pre-Admission Assessment and Other Assessment	$350.00	11/01/2001	For 1 Day Assessment Maximum Fee
HA003	Comprehensive Neuropsychological Evaluation	$1,500.00	10/01/2008	Per Evaluation (Limit 1 Evaluation)
HA004	Brief Neuropsychological Evaluation	$105.00	10/01/2008	Per Hour Maximum, 5 Hours Service Maximum
HR008	Routine Case Management Services	$26.25	07/01/2013	Per ½ hour limited to as specified in Agreement
HR027	Transportation	Common-wealth rate	04/01/2005	Mileage rate per Commonwealth policy
Rehabilitation Period / Outpatient Services Billable All services must be documented in the Department of Health approved rehabilitation service plan for reimbursement.				
HR001	Residential Services (Personal Care Daily Rate)	$55.00	11/01/2001	Per day (includes room and board, personal care and supervision)
HR002	Assisted Neurobehavioral Therapy (Behavioral Management Therapy)	$50.00	10/01/2008	Per ½ hour Group or Individual Session
HR003	Assistive Community Integration (Life Skills Training)	$50.00	10/01/2008	Per ½ hour Group or Individual Session
HR004	Supportive Counseling	$19.25	10/01/2008	Per ½ hour Group or Individual Session
HR005	Substance Abuse Education and Prevention	$19.25	10/01/2008	Per ½ hour Group or Individual Session
HR006	Therapeutic Recreation	$50.00	10/01/2008	Per ½ hour Group or Individual Session
HR007	Work Skills Services (Training)	$50.00	10/01/2008	Per ½ hour Group or Individual Session
HR008	Routine Case Management Services	$26.25	07/01/2013	Per ½ hour limited to as specified in Agreement
HR009	Cognitive Therapy (Retraining)	$54.75	10/01/2008	Per ½ hour Individual Session
HR010	Occupational Therapy	$54.75	10/01/2008	Per ½ hour Individual Session
HR011	Physical Therapy	$50.25	10/01/2008	Per ½ hour Individual Session
HR012	Psychological Services	$50.75	10/01/2008	Per ½ hour Individual Session
HR013	Speech Therapy (Speech and Language Therapy)	$36.00	11/01/2001	Per ½ hour Individual Session
HR014	Cognitive Therapy (Retraining)	$30.00	11/01/2001	Per ½ hour Group Session
HR015	Occupational Therapy	$30.00	11/01/2001	Per ½ hour Group Session
HR016	Physical Therapy	$30.00	11/01/2001	Per ½ hour Group Session
HR017	Psychological Services	$30.00	11/01/2001	Per ½ hour Group Session
HR018	Speech Therapy (Speech and Language Therapy)	$30.00	11/01/2001	Per ½ hour Group Session
HR019	Psychiatry or Neuropsychiatry	$87.50	04/01/2005	Per ½ hour Individual Session

HR020	Physiatry	$87.50	04/01/2005	Per ½ hour Individual Session
HR021	Neurology	$87.50	04/01/2005	Per ½ hour Individual Session
HR022	Nursing	$25.00	04/01/2005	Per ½ hour Group or Individual Session
HR027	Transportation	Common-wealth rate	04/01/2005	Mileage rate per Commonwealth policy
HR029	Respite	$25.00	07/01/2017	Per ½ hour (maximum of 24 hours)

Rehabilitation Period / Inpatient Services Billable

All services must be documented in the Department of Health approved rehabilitation service plan for reimbursement.

HR023	Community Re-Entry Residential	$400.00	04/01/2005	Per day
HR024	Intensive Rehabilitation –Level One	$450.00	04/01/2005	Per day
HR025	Intensive Rehabilitation –Level Two	$600.00	04/01/2005	Per day
HR026	Intensive Neurobehavioral	$650.00	04/01/2005	Per day
HR027	Transportation	Common-wealth rate	04/01/2005	Mileage rate per Commonwealth policy
HR028	Intensive Neurobehavioral Evaluation	$850.00	02/01/2007	Per day (maximum of 90 days)
HR008	Routine Case Management Services	$26.25	07/01/2013	Per ½ hour limited to as specified in Agreement

Transition – Maximum reimbursement $1,000 for 6 consecutive months.

HT001	Transitional Case Management Services	$7.50	11/01/2001	Per quarter hour (Limit $1,000 per client or 33.34 hours for six month period)

Assisting the client in gaining access to services from which the client may benefit and for which the client may be eligible. Monitoring and evaluating the client's progress in transitioning to living in their home or community setting with any necessary supports or to placement in a long-term care facility. Determining that the client has fully transitioned to their home or community or is referred to the appropriate long-term service provider.