

**Commonwealth of Pennsylvania
Department of Human Services
Office of Developmental Programs**

**Individual Support Plan (ISP)
Manual for Individuals Receiving Targeted
Services Management, Base Funded Services,
Consolidated Waiver Services, P/FDS Services
or Who Reside in an ICF/ID**

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Section 1: ISP Process

The Supports Coordinator (SC) should assist the individual¹ and his or her family to understand the Individual Support Plan (ISP) process and who participates in it. This includes understanding the concepts of Positive Approaches, Everyday Lives, and person-centered planning, the options for services and service delivery and supporting the individual in gaining the tools needed to be effective in leading and meaningfully participating in the development of his or her ISP.

To aid understanding of the ISP process, the SC can provide the annotated ISP, which provides a reference for the individual regarding each section of the ISP, as well as resources available through Support Coordination Organizations (SCOs), Administrative Entities (AEs), the Department of Human Services (DHS) website and the Home and Community Services Information System (HCSIS) that describe the service planning and delivery process, available services and providers, and rights and safeguards.

Developing an ISP is based on the philosophies and concepts of Positive Approaches, Everyday Lives, and person-centered planning that captures the true meaning of working together to empower the individual to dream, plan, and create a shared commitment for his or her future. The purpose of Positive Approaches is to enable individuals to lead their lives as they desire by providing supports for them to grow and develop, make their own decisions, achieve their personal goals, develop relationships, face challenges, and enjoy life as full participating members of their communities. The core values of Everyday Lives are choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, and success, contributing to the community, collaboration, and mentoring. Person Centered Planning discovers and organizes information that focuses on an individual's strengths, choices, and preferences. It involves bringing together people the individual would like to have involved in the planning process, listening to the individual, describing the individual as fully as possible with a true focus on understanding who he or she is, and dreaming and imagining with the individual of possible ways things could be different, both today and tomorrow. To assist in person-centered planning, the SC is responsible for ensuring that the individual has all necessary information and support to ensure that he or she directs the process to the maximum extent possible. Integrating the values of Positive Approaches, Everyday Lives, and person-centered planning into the ISP maximizes an individual's opportunities to incorporate their personal values, standards, and dreams into their everyday lives and services and supports.

¹ Future use of the term individual in this manual means both a waiver participant and an individual supported by base funding as well as the individual's family and surrogate, when applicable.

Section 2: ISP Preparation

In addition to providing the necessary supports and accommodations to ensure that the individual can participate, the SC supports the individual in determining who should be present and involved in the development of the ISP. It is important to include people who know the individual best and who will offer detailed information about the individual and his or her preferences, strengths, and needs.

The ISP team may consist of:

- The individual.
- The individual's family, guardian, surrogate or advocate.
- The SC.
- Providers of service.
- The common law employer or managing employer if the individual has chosen to self-direct.
- Other people who are important in the individual's life and who the individual chooses to include.

ISP team requirements according to 55 Pa. Code Chapters 2380, 2390, 6400, 6500:

- The plan team that shall participate in the development of the ISP includes the individual, the program specialist or family living specialist, the direct service worker for the licensed provider and other people the individual chooses to invite. 55 Pa. Code §§ 2380.184(a), 2390.154(a), 6400.184(a), 6500.154(a).
- At least three plan team members must be present for the ISP meeting. 55 Pa. Code §§ 2380.184(b), 2390.154(b), 6400.184(b), 6500.154(b).
- Per 55 Pa. Code §§ 2380.33(b)(4), 2390.33(b)(4), 6400.44(b)(4), 6500.43(d)(4), the program specialist is the only plan team member that is required at the plan team meeting. ODP will cite the facility or program for a violation if the program specialist or an assigned proxy does not attend the team meeting.
- The individual receiving services has the choice to attend the meeting. 55 Pa. Code §§ 2380.184(b), 2390.154(b), 6400.184(b), 6500.154(b).

The SC is responsible for reaching out to the individual to determine if he or she has preferences about the date and location of the ISP meeting. The SC should make at least three attempts to contact the individual to discuss this information. After the discussion takes place, the SC is responsible for accommodating the individual's preferences to the extent possible.

Some things the SC should discuss with the individual regarding the meeting location include:

- It should be a place where the individual feels comfortable.
- It should be accessible to all ISP team members.
- It should have enough space to accommodate all ISP team members .
- It should be as free from distractions as possible so the ISP team members can focus on what everyone has to say during this very important meeting.

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If by the third attempt, the individual refuses to provide input on their preference in scheduling the meeting, the SC must proceed in scheduling the meeting in accordance with the timelines set forth in the waiver, 55 Pa. Code §51.28 (c) and Section 3.10 of this manual.

Section 2.1: ISP Invitation Letter

Once the ISP meeting details are confirmed, the SC develops the ISP meeting invitation letter and is responsible to send it to all ISP team members at least 30 calendar days prior to the annual ISP meeting. Please note, the SC can develop an ISP invitation letter that identifies all team members who are invited to participate in the ISP meeting, or send a separate invitation letter for each invited team member.

✍ SC documentation requirements for ISP invitation letters:

- A copy of the invitation letter(s) that were sent to each ISP team member must be maintained in the individual's file at the SCO.

Section 2.2: Information Gathering

Preparing for the ISP meeting involves information gathering that should begin at least 90 calendar days prior to the end date of the plan.

Information gathering includes:

- Involvement of people who know the individual best and can offer rich and detailed information about the individual and his or her needs.
- Identification, coordination and collection of new and/or updated information from team members and/or other professionals in the following areas:
 - Formal and informal assessments, including ODP's statewide needs assessment.
 - Communication.
 - Educational background.
 - Learning styles.
 - Employment preference/experiences.
 - Living situation.
 - Interest in Life sharing (if the individual has expressed interest in a different living situation).
 - Personal preferences (interests and hobbies).
 - Incident reports.
 - Evaluation of risk (incident histories).
 - Personality traits.
 - Interactions with others.
 - Relationships that impact the individual's quality of life.
 - .
 - Progress toward Outcomes and Social/emotional information.
 - Environmental influences.

- SC monitoring findings
- IM4Q considerations and other external monitoring, if relevant.
- Financial information.
- Medical information including current health status.
- Physical development.
- Lifetime Medical History.

Section 2.3: Assessment Process

The ISP identifies information about the individual and summarizes all assessment results. ODP utilizes a multifaceted assessment process to drive initial and ongoing ISP development in order to gain and capture person-centered information to determine the individual's needs and risk factors. ODP recognizes that there are many assessment instruments, both formal and informal, that are being utilized statewide. Both types are considered to be valuable tools.

Formal assessment types include, but are not limited to: the Vineland, Adaptive Behavior Scale (ABS), Alpern-Boll Developmental Profile (LPRN BOAL), therapy and medical evaluations, Office of Vocational Rehabilitation (OVR) assessments, and Individual Educational Plans (IEPs). Informal assessments include, but are not limited to: a provider's annual assessment, other school-aged assessments, family and friends' observations, observations by direct care professionals, and understanding of the individual and his or her needs.

An individual age 16-72 must have a standardized needs assessment prior to being enrolled in the waiver. The purpose of the assessment is to ensure that services provided through the waiver will meet the needs of the individual. Once an individual is entered into the queue in HCSIS, Statewide Needs Assessment scheduling occurs. After enrollment in either the Person/Family Directed Support (P/FDS) or Consolidated Waiver, all individuals must then have a statewide standardized needs assessment completed once every three years. An individual requires a new standardized needs assessment be completed when he or she experiences a major change that has a lasting impact on his or her support needs that is anticipated to last more than six months, and makes his or her standardized assessment inaccurate and no longer current.

Standardized Needs Assessments

The Supports Intensity Scale® (SIS®) and PA Plus are the primary statewide standardized needs assessments used by ODP. The SIS is administered by an independent contractor and the results are available to team members in the form of the PA Universal Summary Report in HCSIS. The SC is responsible for distributing the PA Universal Assessment Summary Report to the individual, people who participated in the completion of the SIS assessment, and ISP team members.

For more information about utilizing the information from the SIS assessment in the ISP, please visit the ODP Consulting website, listed at the end of this document, for a SIS/ISP Crosswalk. For more information regarding the purpose of the SIS and SIS requirements, please review ODP Bulletins 00-07-02, *Overview of the Supports Intensity Scale© (SIS©) and the PA Plus* and 00-08-11, *Supports Intensity Scale™ (SIS™) and PA Plus Users Manual*. These bulletins are available at <http://www.dhs.pa.gov/publications/bulletinsearch/index.htm#>.

SC documentation requirements for SIS assessments:

- SCs must document the date the SIS and PA Plus were administered in the Non-Medical Evaluation section of the ISP.
- SCs must use the ISP Signature Page Form to indicate whether the SIS and PA Plus were reviewed during the individual's ISP meeting.
- Assessment results are documented in the information gathering sections relevant to the questions within the ISP and can make some of the information provided by the SIS available to the ISP team. Although some of this information may already be known, there may be new items of interest that can be useful in the ISP planning process. Though not an exhaustive list, information from the following SIS domains could be used in the sections of the ISP listed under the domains:
 - Home Living
 - Individual Preferences
 - Functional Information
 - Health and Safety
 - Community Living
 - Individual Preferences
 - Health and Safety
 - Lifelong Learning
 - Individual Preferences
 - Functional Information
 - Employment
 - Individual Preferences
 - Functional Information
 - Health and Safety
 - Health and Safety
 - Health and Safety
 - Individual Preferences
 - Medical Information
 - Functional Information
 - Social Activity
 - Individual Preferences
 - Functional Information
 - Health and Safety
 - Protection and Advocacy
 - Individual Preferences
 - Functional Information
 - Medical Supports
 - Medical Information
 - Health and Safety
 - Functional Information
 - Behavioral Supports
 - Health and Safety
 - Medical Information

Assessments

An assessment is also required for other individuals for whom the SIS is not designed and utilized (individuals under 16 years of age and over 72 years of age) . For these individuals, other information should be considered such as possible changes in an individual's living situation or health status, any incidents reported, and possible monitoring findings. Part of the assessment process also reflects input from an individual's network of family and friends.

ODP ensures that all individuals who are deaf and enrolled in the Consolidated Waiver have a Communication Assessment. The Communication Assessment will evaluate expressive and receptive language skills including:

- Ability to sign, speak, read, write, speech read, use technology, gesture;
- Ability to learn the above;
- Current preferred method of communication; and
- Most promising method to learn.

The Communication Assessment will also include recommendations concerning:

- Staff skills (level of American Sign Language fluency, visual/gestural training or other) needed for effective communication now;
- Staff skills needed to improve the individual's ability to communicate;
- Specialized services or equipment needed to improve communication ability;
- Whether a fully signing environment would be appropriate for effective communication and/or improving communication. (The assessor is not to determine whether it is desired by the individual);
- Needed communication assistance at meetings/appointments;
- Timing of reassessment;
- Whether a separate assistive technology evaluation is necessary; and
- Any other matter the assessor deems relevant.

Communication Assessment results are sent to the individuals and to SCs.

SC documentation requirements for Deaf Services Assessment:

- The last section of the Communication Assessment includes information to be added to the "Know and Do" and "Communications" sections of the ISP. This section is designed to be pasted verbatim in the ISP.
- A copy of the entire Communication Assessment should be retained in the individual's file and accessible during ISP team meetings.

Please note that the U1 modifier should be utilized for an individual enrolled in the Consolidated Waiver who has been assessed as needing a waiver service by a staff person who is proficient in sign language and the provider has been qualified for the enhanced communication rate. The term sign language includes American Sign Language, sign language from other countries, such as Spanish Sign Language; Signed Exact English; and a mixture of ASL and signed English; tactile sign; and visual-gestural communication.

 SC documentation requirements for other assessments:

- This information should be listed in the relevant assessments linked to outcomes and described in the appropriate section(s) of the ISP.

Assessment information about items where consensus could not be reached can also be brought to the planning meeting as key items for discussion and follow up.

Assessments also describe potential risks for the individual. Through the ISP development process, the team develops strategies to identify, reduce, and address identified risks. The strategies identified to both mitigate and deal with risks reflect the underlying person centered principles of the process and are structured in a manner that reflects and supports individual preferences and goals. Each ISP contains detailed information on supports and strategies designed to mitigate risk to the individual, including a back-up plan specific to the individual. The provider develops a back-up plan that outlines how the provider will provide the authorized service(s). The back-up plan must then be shared with the SC, the individual and the team. These back-up plans are developed with the unique needs and risk factors of the individual in mind and are incorporated into the ISP by the SC to ensure that the entire team is aware of the strategies necessary to reduce and, when needed, address risks. For more information please go to Section 3.8 regarding Provider Back-up Plans.

Section 3: Development of the ISP

Anyone who has been found eligible for intellectual disability services must have an ISP completed and entered into HCSIS.

- Abbreviated ISPs may only be completed for an individual who is not eligible for Medical Assistance and receives non-waiver services that cost less than \$2,000 in a Fiscal Year (FY). When completing an abbreviated ISP, the following minimum screens must be completed:
 - Demographics
 - Individual Preferences.
 - Outcome Summary.
 - Outcome Actions.
 - Services and Supports Directory (Provider, Vendor, and/or ISO).
 - Service Details (only for individuals who have a funded service).
- Although the cost of base-funded case management services will not be included in the \$2,000 limit listed in the previous bullet, ODP recommends that individuals, SCs and teams include in the ISP the specific actions the SC will perform in support of the individual's outcomes and priorities.

The ISP is developed by the individual and his or her ISP team and is facilitated by the SC in accordance with the ISP Bulletin. If the individual uses an alternate means of communication or his or her primary communication and language preference is not English, the ISP process should be completed using his or her primary means of communication, an interpreter, or someone who has a close enough relationship with the individual to accurately speak on his or her behalf. All ISP team members play vital roles in the ISP meeting by fully participating to share knowledge, perspective, and insight as the SC develops the ISP based on that information. Each ISP team member ensures that information provided is current and is presented professionally and with sensitivity. The information collected presents a complete and comprehensive picture of the individual. Specific examination of information will be part of the ISP process, including possible changes in the individual's living situation or health status, incident reports documented in HCSIS, monitoring findings or other changes that will impact the individual's health and welfare, services and supports or ability to have an everyday life. Service options must be promoted and fully explored with every individual.

Once an assessed need is identified, the ISP team should discuss whether the need can be met through natural supports (i.e. family, friends, neighbors, etc.) or if the need requires the support of a paid service. Paid services are appropriate when naturally occurring supports are not available or when a person or entity with special skills or training is necessary to support the assessed need. While all needs must be reviewed, not all needs require a paid service.

If the individual and the ISP team determine that an additional paid service is necessary to address an assessed need, they must identify the specific skill the individual wants to work on and develop a measurable Outcome Action to support the skill development. The ISP also identifies who will provide services, with what frequency, and specifies who holds responsibility for different aspects of ISP implementation. Any changes to the individual's demographic information should be addressed and updated in HCSIS as they occur.

Section 3.1: Annotated ISP (Attachment #4)

Attached to this bulletin, and located in the Learning Management System (LMS), is the annotated ISP which is a valuable tool for SCs to use when creating, updating, and/or revising ISPs. It provides clear and concise description summaries for each section of the ISP that will help all team members assist in the development of a quality ISP.

Section 3.2: Questions to Help Facilitate the Development of the ISP (Attachment #5)

In addition to the information in the annotated ISP, the attachment “questions to help facilitate the development of the ISP” may help to generate information that ensures the individual and team have considered significant aspects of the individual’s everyday life. It should be noted that not all areas are applicable to every individual and therefore not all areas need to be discussed during the ISP meeting. If there is an area of an individual’s life that clearly stands out as an area in which the individual needs a change, this area should be included in the information gathering process, as well as, developed into an outcome.

Section 3.3: Outcome Development

Outcomes signify a shared commitment to take action. Within ISP Outcomes, the things that are important to maintain or change (Outcome Statements) are joined with the method to attain them (Outcome Actions). Outcome Actions specify what will occur to achieve the Outcome Statement, including paid services (when they are necessary), to meet assessed needs and maintain health and welfare.

The ISP team develops measurable Outcome Actions based upon the individual’s ability to acquire, maintain or improve skills, including those that increase his or her safety and well-being.

Outcome Statements represent what is important to the individual, what the individual needs, what the individual wants to maintain or change in his or her life. Outcome development builds on information gathered during the ISP process and signifies a shared commitment to take action that could make a difference in the individual’s life in meeting his or her assessed needs. It is crucial to address barriers and obstacles that may affect the individual’s success in achieving the Outcome Statement, especially if these obstacles can impact his or her health and welfare.

Outcome development criteria:

- There should be a clear connection between the individual’s preferences and choices and the actions the ISP team determines are necessary to meet needs associated with the individual’s preferences and choices.
- The individual and ISP team should work together to find acceptable Outcome Statements that enable the individual to exercise his or her choices, while at the same time Outcome Actions that meet the individual’s needs, minimize risk, and achieve or maintain good health.

- Although every funded service must be linked to an Outcome, not every Outcome requires a funded service. There may be Outcome Statements that are important to the individual but do not relate to, or are not supported by, a funded service.
- Any barriers or concerns that prevent the Outcomes from being tangible and reachable must be addressed during the ISP process.

An Outcome Statement supported by a funded service should relate back to the service definition and the assessed need for the service. For example, an Outcome Action supported by Home & Community Habilitation should show how the individual will acquire, maintain or improve a skill.

Section 3.4: Outcome Actions

A completed ISP should provide a means of achieving Outcomes important to the individual. Outcome Actions help the ISP team determine what actions, services and supports are needed to achieve the Outcome. When developing actions to support Outcome Statements, the ISP team begins by considering the natural and non-paid services available. When identifying services and supports, the team considers all available resources, which includes natural supports such as friends, family, spiritual activities, neighbors, local businesses, schools, civic organizations and employers.

Enlisting natural and non-paid supports in supporting Outcome Actions encourages teams to find ways for individuals to foster choice, develop meaningful personal relationships, and exercise control in their lives and experience rewarding inclusion in their communities.

Teams may determine it is necessary to include paid services in Outcome Actions to meet assessed needs and ensure health and welfare while the Outcome is being pursued. When Outcome Statements require services, they include clear statements regarding the expected result, given the service the individual is receiving, by answering the following questions:

1. What difference will the service make in the individual's life?
2. What is the current value of the service and is it helpful?
3. What assessed needs, and/or health and welfare concerns, is the service intended to address?
4. What does the person hope to learn or accomplish?

An important part of connecting services to Outcomes is having open discussions during ISP meetings. By keeping the lines of communication open, the team can identify new and creative ways to help identify Outcomes and address needs and preferences.

Finally, team members should work in partnership to ensure that the individual is making progress and Outcome Actions are being achieved or remain relevant. The ISP must be a living document, responsive to the individual and his or her needs. In order for the ISP to be responsive, it should be updated throughout the year to reflect needed changes to the services and Outcomes.

Section 3.5: Identification of Services and Supports

A completed ISP should provide a means of achieving Outcome Statements important to the individual by integrating natural supports and funded supports. The ISP must address all assessed needs that affect the individual's health and welfare.

- Natural supports and other funding sources should be considered prior to ODP funding.
- The team uses the Outcome Actions to ensure that services reflect the action steps needed to promote the achievement of the Outcome Statement.
- Each funded service must be linked to an assessed need and an Outcome.
- The team should identify the type, duration, frequency and amount of each service needed to achieve the Outcome Actions identified in the ISP.
 - Type of service is documented through the service name on the *Service Details* screen in HCSIS.
 - Duration of services is documented through the start and end dates of the service on the *Service Details* screen in HCSIS. Duration is also documented under the *Outcome Actions* section in the *Frequency and Duration of actions needed* field. Duration means length of time.
 - Frequency of services is documented on the *Outcome Actions* screen in the *Frequency and Duration of the actions needed* field. The frequency of a service is the number of times that the service is rendered (i.e. daily, weekly, monthly or annually depending on the service) based on the needs of the individual.
 - Amount of services is documented through the number of units included on the ISP in the *Service Details* screen in HCSIS.
 - Training to meet the needs of the individual which includes, but is not limited to (communication, mobility and behavioral).

SC documentation requirements for identification of services and supports:

- The type, duration, frequency, and amount of each service are documented in the service and supports section of the ISP.
- If natural supports are not available at the time the ISP meeting is held, the SC should document the efforts he or she has made to explore natural supports within the Outcomes Section of the ISP.
- Other non-ODP funding sources, including but not limited to the Pennsylvania Medical Assistance (MA) State plan, Behavioral health, OVR and the Department of Education should also be documented in the Outcomes Section of the ISP.

Section 3.6: Participant-Directed Services (PDS)

At intake, ISP meetings, and upon request, the SC, AE, and County Program are responsible to provide individuals with information on PDS and the various choices of service management in accordance with the approved waivers, ODP policies, and the *Pennsylvania Guide to Participant Directed Services*. Documentation of choice of these options is documented on the Individual Support Plan Signature form (DP 1032). Financial Management Service (FMS) organizations are responsible to explain the delivery of the administrative services the FMS offers and how to complete any applicable paperwork related to the use of the financial management option the FMS provides.

Who can use Participant-Directed Services?

- To be eligible for PDS, the individual **must live** in a private home. Individuals living in agency owned, rented, leased or operated homes **may not** participate in PDS, but must be given choice in their lives. However, there is an exception for the Supports Broker service which may be provided for individuals who reside in a waiver residential habilitation setting in the following circumstances:
 - The individual has a plan to transition from a residential setting to a private residence, and
 - The individual has a plan to self-direct his or her services through an Agency with Choice (AWC) or Vendor Fiscal/Employer Agent (VF/EA) FMS once they are in a private residence.

How is this different from choosing a provider agency to manage all of the individual services?

- The individual is the common-law employer or managing employer.
- The individual has more control over his or her services and is given the ability to manage them and the qualified support service workers (SSWs) who provide them.

What are the types of Financial Management Services (FMS) the individual can choose from?

There are two FMS models to choose from that offer employer authority:

- VF/EA FMS option: The individual becomes the “**Common Law Employer**” or the legal employer. There is one statewide organization that provides this administrative service.
- AWC FMS option: The individual becomes the “**Managing Employer**,” however the AWC FMS is the legal employer. Each county is required to have one AWC FMS available to provide this administrative service.

The VF/EA or AWC FMS that are available to an individual are “**administrative services**” provided under contracts. For individuals receiving waiver services, when something is an “administrative service” it is not like other waiver services. The individual does not have a choice of organizations that provide the administrative service. However, the individual may select the type of FMS model he/she wants to use. The fee associated with FMS is not included in the ISP “services” budget.

What services can an individual self-direct?

- Home and Community Habilitation (Unlicensed)
- Supported Employment
- Homemaker/Chore
- Respite in an unlicensed setting
- Specialized Supplies
- Supports Broker
- Companion
- Home Accessibility Adaptations
- Vehicle Accessibility Adaptations
- Assistive Technology
- Transportation (Mile) and Public Transportation
- Education Support

- Respite Camp

✎ SC documentation requirements for participant-directed services:

- Individuals who choose to self-direct must select one of the two FMS options to assist with PDS.
- The individual's ISP must have at least one participant-directed service. This includes participant-directed services with an hourly wage and/or participant-directed vendor services.
- The individual's ISP must include the designated procedure code for the FMS organization's monthly administrative service per ODP instructions.

Section 3.7: Choosing Qualified Providers for Funded Services

The SC is responsible to provide information regarding potential qualified providers for needed services during the initial plan meeting and at least annually thereafter. Providers that are qualified to provide a service necessary to support the individual's assessed needs and support achievement of the individual's Outcome Statements are reviewed with the individual. The individual shall exercise choice in the selection of qualified providers, including SCO. Providers of waiver services are qualified according to the provider qualification standards established in Appendix C of the approved waivers. Providers who are providing non-waiver funded services are qualified according to the standards established by the County Program. Providers are responsible for making decisions about their willingness to provide services based on their ability to meet the individual's needs.

The SC is responsible to make referrals to chosen providers promptly based on the individual's selections so needed services and supports are secured.

✎ SC documentation requirements for choice of qualified providers:

- The choice of qualified providers, including SCO, should be documented on the ISP signature form.

Section 3.8: Provider Back-up Plans

Providers are obligated to render services in accordance with the approved and authorized ISP. A back-up plan is the written strategy developed by a provider to ensure the services the provider is authorized to provide are delivered in the amount, frequency, and duration as referenced in the individual's ISP. These back-up plans are discussed with the individual and developed to address the individual's needs and risk factors. discussed and shared with the individual and team. A provider shall develop and provide detailed information on the back-up plan in accordance with 55 Pa. Code §51.32 when individuals are supported in their own private residence or other settings where staff might not be continuously available. The ISP should include a backup plan to address contingencies, including the failure of a support worker to appear when scheduled to provide necessary services when the absence of the service presents a risk to the individual's health and welfare. Back-up plans are discussed and updated when necessary, throughout the year or during the next ISP meeting. SCs should monitor that

the individual is receiving the appropriate type, amount, duration, and frequency of services to address the individual's assessed needs and that support desired Outcome Statements as documented in the approved and authorized ISP. If services are not rendered per the ISP due to the individual not being available because they are in hospital/rehabilitation care for an extended period, the provider should notify the SC and AE immediately. Individuals who self-direct their services already complete an emergency back-up designation form. The following represents ODP criteria for all other back-up plans:

- The name and phone number of the provider to be called if the worker does not show up.
- The name and phone number of the primary caregiver and two natural support persons who may be called in the absence of a primary caregiver if the individual cannot get in touch with the provider.
- A description of what things need to occur if no one is available to assist the individual (the individual's urgent needs and any actions that need to take place).

 SC documentation requirements for back-up plans:

- The SC will document within the crisis support section of the ISP that all back-up plans for providers rendering services to the individual were reviewed to ensure that the plan meets ODP criteria, a copy of the plan was given to the individual and shared with the SC for inclusion in the ISP, and where the original plan can be located (ie: individual file located at Provider agency).

Section 3.9 Qualified Provider ISP Roles and Responsibilities

For licensed services, the ISP will be the first source of review to determine compliance with planning and assessment standards. Qualified providers of service must participate in the assessment and planning process, including ISP team meetings, and provide necessary information to the SC for incorporation into the ISP. Qualified providers should maintain documentation of the submission of ISP information to the SC. Qualified providers are not required to develop their own separate ISP if the individual has a SC. Individuals who receive funding for service from another state may not have a SC.

Qualified providers are responsible for completing assessments and evaluations related to the individual as well as progress notes that ensure service delivery is occurring at the quality, type, frequency, and duration stated in the ISP Outcome Actions, per service authorizations and applicable regulations and policies.

Section 3.10: SC Responsibilities Regarding The Timeline For ISPs

The ISP timeline assists all team members with identifying ISP roles and the activities associated with the ISP process. The SC is responsible for developing ISPs by performing the following activities in accordance with the ISP timelines established by ODP:

- Collaborating with the individual, family, provider, and other team members to coordinate a date, time, and location for the Annual Review ISP Meeting at least 90 calendar days prior to the end date of the ISP.

- Coordinating information gathering and assessment activity, which includes utilizing and incorporating statewide needs assessment information from the Annual Review ISP Meetings, at least 90 calendar days prior to the end date of the ISP.
- Distributing invitations to ISP team members at least 30 calendar days before the ISP meeting is held.
- Facilitating the ISP meeting with all team members invited at least 60 calendar days prior to the end date of the ISP.
- Submitting the Annual ISP to the AE or county for plan approval and service authorization at least 30 calendar days prior to the end date of the ISP.
- Distributing the ISP Signature Form to ISP team members.
- Resubmitting the ISP for approval and authorization within seven calendar days of the date it was returned to the SCO for revision.
- Distributing approved and authorized ISPs to the individual, family, and other ISP team members (identified on pages 4-5) who do not have HCSIS access within 14 calendar days prior to the end date of the ISP.

The ISP timeline is included as Attachment #2 to this bulletin. ODP will use the timeline as a basis for compliance to ensure that the ISP is completed timely.

Section 3.11: ISP Development Under 55 Pa. Code Chapters 2380, 2390, 6400 and 6500:

- In most cases, the individual will have an SC that creates the ISP in HCSIS before the individual receives the 2380, 2390, 6400 or 6500 service.
- An ISP must be completed, but not entered in HCSIS, for any individual who attends a facility licensed under 55 Pa. Code Chapters 2380, 2390, 6400, and 6500, who does not have an SC. If the individual does not have an SC, the plan lead will complete the annotated ISP in Microsoft Word.
- These specific ISPs will be monitored during ODP's licensing inspection. An ISP is not required for an individual who lives in an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID), but attends a facility licensed under 55 Pa. Code Chapters 2380 or 2390.
- The plan lead must develop the initial ISP within 90 calendar days after admission to the facility or program.

Section 4: ISP Signature Form (DP 1032) (Attachment #3)

The SC is responsible to review the information on the ISP signature form with the individual. This includes reading and thoroughly explaining each question to the individual prior to indicating the appropriate answer on the check box on page 2 of the ISP signature form.

At the conclusion of the ISP meeting, the ISP signature form must be completed. Each person in attendance at the ISP meeting should print their name; identify their relationship to the individual including title/provider agency, and then sign and date the form. If the individual or any other ISP team member was not present, the reason for his or her absence must be documented on the ISP signature form. If the individual was not able to be present, the SC will review the results of the meeting with the individual. The SC should document this review by having the individual sign the ISP signature form noting the date the review was held.

If the individual was in attendance, but chooses not to sign the ISP signature form, the SC must indicate this on the ISP signature form.

If the individual or any other ISP team member disagrees with the discussions held during the ISP meeting and/or the content of the ISP, they must print their name, identify their relationship or title/provider agency, and sign at the designated section of the ISP signature form.

Providers of 6400, 6500, 2380 and 2390 licensed services, should report content discrepancies according to the regulations set forth under those chapters to the SC (if the individual does not have an SC, then to the designated plan lead), and ISP team members as applicable.

The SC is responsible for ensuring that the signature form is completed correctly as per the instructions included on the signature form as well as sending copies of the signature form to all ISP team members once the ISP is submitted to the AE for approval.

Section 5: ISP Approval and Authorization

The Annual Review ISP must be completed, approved, and have services authorized by the Annual Review Update Date. The AE is responsible to review, approve and make authorization decisions about ISPs in HCSIS within 30 calendar days prior to the end date of the ISP. In addition, SCs must ensure that all Annual Review ISPs are distributed to required team members within 14 calendar days prior to the Annual Review Update Date. In order to assist the ISP team, HCSIS generates an alert for the SC based on the date entered into the Annual Review Update Date field. This alert is intended to inform the SC that an update to the current ISP is due within 45 days.

By definition in Section 18 of this manual, the Annual Review Update Date is the end date of the current ISP plan year.

The Annual Review Update Date does not change from year to year. Only the year changes, not the month or day. For example: if last year's Annual Review Update Date was 8/9/13, this year's Annual Review Update would be 8/9/14. The only exception is during a Leap Year.

SCs should enter the Annual Review Update Date as well as the Annual Review Meeting Date into HCSIS when completing Annual Review plans. Correct completion of these fields will ensure that reporting mechanisms in HCSIS related to the ISP data are accurate. If the team wishes for the Annual Review Update Date to be updated in order to align with other requirements, there should be a team agreement. The Annual Review Update Date can be changed if needed. The team should consider all timeframe impacts (i.e. provider quarterly meeting requirements per the ISP Regulations) prior to making this change.

The SC should enter the ISP into HCSIS in accordance with ODP policy and DHS standards and submit to the AE for approval and authorization at least 30 calendar days prior to the end date of the ISP. If the AE sends the ISP back to the SC for revision, the SC must make the necessary corrections and resubmit the ISP to the AE within seven days of the date it was returned.

Prior to authorizing a service in an ISP, the AE shall validate that:

1. Required prior authorization or ODP approval of an exception to service limits was completed. All Assessed Needs as identified through the Statewide Needs Assessment instrument, other assessments as appropriate.
2. The Outcome Statements listed in the ISP relate to what the individual and ISP team identified as important to the individual and Outcome Actions relate to identified needs.
3. Services are identified to support assessed needs related to Outcome Statements.
4. The ISP reflects the full range of a waiver individual's needs and therefore must include all Medicaid and non-Medicaid services, including informal, family and natural supports and supports paid by other service systems to address those needs.
5. The ISP includes the type of services to be provided; the amount, duration and frequency of each waiver-eligible service and the provider that furnishes each service.
6. Services are consistent with the approved waivers and current waiver service definitions.

The AE shall not authorize services to be funded through one of the waivers which are provided under the state plan, private insurances or other third party payers, unless evidence that all other payers have been exhausted and other funding types are not available.

Section 6: ISP Review Checklist, DP 1050

ODP uses the ISP Review Checklist as a source to assess and verify compliance with the regulatory requirements regarding the provision of waiver funded Residential Habilitation services as described in the provisions of 55 Pa. Code Chapter 51 (ODP's Home and Community Based Services regulations), § 51.28 and the approved Consolidated and Person/Family Directed Support (P/FDS) Waivers. The ISP Review Checklist serves as a tool in the review of the completed ISP that can be used by SCO management, AEs, and ODP reviewers. The DP 1050 can be accessed at

http://documents.odpconsulting.net/alfresco/d/d/workspace/SpacesStore/568a1b50-8958-4e48-a752-ba261f7d86ee/ISP_Review_Checklist_DP_1050_UF.pdf.

In September 2015, ODP released Informational Memo 085-15 which immediately eliminated the requirement to complete six month reviews for Residential Habilitation, Licensed 6400 One Person Homes, Prevocational services and the job finding component of Supported Employment. Completion of individual monitoring will satisfy the six month review requirements for these services. If the monitoring reveals that there is a change in need involving a service for which completion of the checklist was formerly required, a critical revision to the ISP must be completed. Bi-annual ISPs are no longer required for services that require a six-month review. All the remaining requirements for use of the ISP Review Checklist remain in effect.

Section 7: Implementation of Services

Authorized waiver services should begin within 45 calendar days after the effective date of the waiver enrollment date, unless otherwise indicated in the ISP (e.g. individual's choice of provider delays service start, individual's medical or personal situation impedes planned start date). Any delays in the initiation of a service after 45 calendar days must be discussed with the individual and agreed to by the individual.

Authorized services must also be implemented as written per the current approved ISP, including the type, amount, frequency, and duration listed in the Outcome Actions section of the ISP. Those responsible for service implementation are accountable for services as indicated in the ISP and are responsible for documentation to support the provision of services as per Department standards referenced in 55. Pa. Code, Chapter 51 "Office of Developmental Program's Home and Community Based Services" Regulations.

Section 8: Addressing Changes in Need throughout the Year

The following guidelines, in regard to the funding source, should be used when addressing changes in need:

- **Waiver Individuals:** Individuals enrolled in one of the waivers must have their assessed needs addressed within the scope and limitation of the applicable waiver, therefore the ISP services must be updated as necessary to address a change in need.
 - If the change in need impacts the currently authorized services and/or funding, the SC must create a critical revision. The critical revision must be created and submitted for authorization to the AE within seven calendar days of notification of the change.
 - If a change in need does not impact services or funding, the SC must create a general update. The general update must be created and finalized in HCSIS within seven calendar days of verification of the change in need.
 - If the new service(s) or funding is denied by the AE, the AE must provide the individual their due process rights.
 - When an individual's service needs change which will cause the P/FDS cap to be exceeded, the individual should be considered for enrollment in the Consolidated Waiver. If capacity is not available, a PUNS should be initiated to assess these needs. In the interim, base funds if available may be used to augment the services required by the individual in the P/FDS Waiver.
 - If an individual must request an exception to exceed the established limits or service conditions as detailed in the approved waiver service definitions, a "*Request for Exception to established limits or maximum number of service units*" DP # 1023 must be completed by the SCO and forwarded to the appropriate AE, who will review it and forward it to the appropriate ODP Regional Program Manager.
 - The AE must approve and authorize or deny the revised ISP, including the attached funding, within 14 calendar days of receiving the revised ISP.

SC documentation for changes in need throughout the year:

- If an individual experiences a change in need throughout the year, this change must be reflected in the individual's ISP.
- Upon verification of a change in need, the SC must document the change in a Service Note in HCSIS, update the individual's PUNS if applicable and initiate a critical revision to the ISP.

Section 9: Updating ISPs

ISP teams should review services at least annually and as needs change throughout the year. ISP decisions made by teams, Bureau of Hearings and Appeals (BHA) or the Secretary of Human Services, are specific to the circumstances or needs of the individual at the time the decision was made and, in most cases, are not considered permanent or lifetime decisions. It is expected that these types of ISP decisions are revisited at least annually at the Annual Review ISP Meeting. If, at any time, the ISP team or AE determines the services that were included in the ISP as a result of previously made decisions are not needed, the ISP should be revised to reflect the current needs of the individual.

There are seven ISP formats in HCSIS that are used in creating and updating ISPs. It is recommended that if any of the following ISP formats are utilized, all information and/or changes known at the time (such as demographic changes) be included in the ISP:

- **Plan Creation** – A plan creation is used when creating an ISP for the first time in HCSIS (referred to as the initial ISP), when there is not a current ISP in HCSIS or when there is a time-span or gap between two ISPs. The team sets proposed ISP review dates within the 365 calendar day required timeline. The initial ISP is considered a “bridge plan”, with a start date that is generally 60 to 90 calendar days after the initial ISP meeting and an end date of the following June 30, the last day of the FY. The initial ISP does not encompass an entire FY due to the timing of the initial ISP meeting. The “bridge plan” is used to align the ISP end date with the FY end date.
- **Fiscal Year (FY) Renewal** – A fiscal year renewal is used to renew the ISP for the following FY. The start date of the HCSIS ISP coincides with the start of the FY, or July 1. The FY ISP “expires” at the end of the fiscal year, or June 30. ISPs are developed on a FY basis in order to create service authorizations that encompass the full FY. Authorization takes place by service and each service is assigned a start and end date. The FY ISP can include up to one year of service. The ISP created through a fiscal year renewal will pre-populate with information from the previous ISP. Therefore, care should be taken to ensure that services continue to be accurately reflected. This process of renewing plans on the FY promotes efficiency in provider billing, as well as, the ability to generate reports that accurately reflect all services and payments by FY. Additionally, as major changes to the waivers typically occur at the beginning of the FY, it allows for easier maintenance of any changes. If an annual review update and the FY renewal planning activities fall within the same month, it is recommended that the annual review update be completed first.
- **Critical Revision** – A revision to the ISP is used when an individual experiences a change in need which requires a change in current services, addition of services or a change in the amount of funding required to meet the needs of the individual. A critical revision to an ISP must be approved and authorized by the AE. The ISP team members should discuss and agree on changes made to the ISP before all critical revisions are finalized. If the individual, family member or any other team member disagrees with the content of the ISP, this should be documented on the ISP Signature Form (DP 1032).

- **Bi-Annual Review** – A bi-annual review is a requirement for Pennhurst Class Action members (see Section 6: ISP Review Checklist), regardless if there are any updates. A bi-annual review is used for editing or updating an existing ISP that requires a review of the ISP twice a year, or every 6 months. This option will not allow the SC role to modify the plan start and end dates.
- **Quarterly Review** – A quarterly review is required by 55 Pa. Code Chapters 2380, 2390, 6400 and 6500. This review is used to edit or update an existing ISP at least every three months when no changes to the existing services and supports are required. The 4th quarterly review date originates from the date of the annual review and therefore, is the annual review update meeting. This option will not allow the SC role to modify plan start and end dates.
- **General Update** – The category field in HCSIS used to update content in the ISP that does not impact services or funding.
- **Annual Review Update** – An annual review update is used to document the results of an annual review ISP meeting.

Section 10: Service Utilization

Service utilization is one of many important pieces of ISP development. Service utilization is a comparison of the amount and type of services authorized on an individual's ISP with what services have been provided. Service utilization is one of the ways to assist the ISP team in discussing the management of services. Services are based on the individual's assessed needs being met and the services promote the achievement of the Outcome Statements identified in the ISP. Service utilization data can assist the ISP team with discussions and future decisions on supports and services necessary to address assessed needs.

The SC's role in service utilization is to monitor and verify the type, duration, amount, and frequency of services and supports outlined in the ISP on a regular basis.

There are five guiding principles that should be addressed when looking at service utilization on an ISP:

1. Determine if the designated service has the desired effect to address the specified need, which promotes the achievement of an Outcome Statement.
2. Determine if there is an established limit associated with the service.
3. Determine that the units in the ISP are necessary based on the individual's current needs and are not above the established limit.
4. Review the previous year's utilization to inform discussions for future decisions.
5. Determine continued need and skill attainment.

It is important to understand why an individual over or underutilized services and supports. There are four types of utilization issues that may be identified through service utilization reviews that help inform discussions and decisions:

- Service Delivery – utilization issue is occurring due to problems with service delivery (i.e. provider staffing, individual not available for the service to be delivered [hospitalization, vacation, etc.]).
- Billing Issues – provider is not billing regularly or successfully, therefore, services rendered are not reflected when looking at utilized units.
- Temporary Change in Need – an issue is occurring due to a life event that is happening to an individual, or his or her family member, that would cause temporary change to a service need (i.e. short term hospitalization of caregiver, resulting in a temporary need for increased supports).
- Permanent Change in Need – an issue is occurring due to a life event that is happening to an individual, or their family member, that would cause a permanent change of service need.
- Provider not rendering service per the frequency and duration as outlined in the ISP.

SC documentation for service utilization:

- The SC should have conversations about service utilization with the individual, family and ISP team and document those conversations in the individual's service notes and monitoring tools in HCSIS. Documentation should include the reason(s) for any under or

overutilization that has occurred. This information should also be discussed and documented during the annual review ISP meeting.

Section 11: Monitoring of Services

The SC and ISP team gather information and review the Outcomes and authorized services on an ongoing basis to ensure that the ISP continues to reflect what is important to and for the individual and that it continues to address the individual's needs. The ISP is revised or updated as needed based on these reviews. All revisions and updates are discussed with the individual and his or her family, surrogate or advocate and ISP team.

ODP exercises oversight of the ISPs through its standard monitoring processes to ensure that ISPs are implemented as written, including implementation of services and Outcomes, as well as, to ensure that ISPs for individuals enrolled in a waiver are developed in accordance with the approved waivers.

SC monitoring verifies that the individual is receiving the appropriate type, scope, amount, duration, and frequency of services to address the individual's assessed needs and desired Outcome Statements as documented in the approved and authorized ISP.

Supports Coordination Monitoring Requirements:

Consolidated Waiver

For individuals enrolled in the Consolidated Waiver who receive a monthly service, the SC shall conduct a minimum of three face-to-face monitoring visits every three calendar months. Of these visits:

- At least one of the visits must take place at the waiver individual's residence;
- One visit must take place at the waiver individual's day service; and
- One visit may take place at any place agreeable to the waiver individual.

Deviations of the minimum monitoring frequency that involve monitoring at a frequency and location that differ from the above requirements are permitted for individuals living with family members under the following circumstances:

- The individual requests the deviation;
- The deviation is included in the individual's approved ISP; and
- There are alternative mechanisms in place to ensure the individual's health and welfare, and these mechanisms are included in the individual's approved ISP.

Deviations in monitoring frequency may not result in monitoring that takes place at a frequency less than four face to-face monitoring visits per calendar year. Deviations in monitoring location may only be approved if the deviation allows for monitoring of service delivery at authorized service locations. Deviations in monitoring frequency and location must be prior approved by ODP. The process to be followed is outlined in Informational Packet 048-11, *Instructions on Request for Deviation in Monitoring Frequency*.

If a monthly service is not provided as per the conditions outlined in Appendix B-6-a-ii of the Consolidated Waiver, deviations of monitoring frequency and location are not permitted. For these situations, ODP requires a face-to-face monitoring visit by SCs at least once every calendar month during the period of time when a monthly service is not provided.

P/FDS Waiver

For individuals enrolled in the P/FDS Waiver who are receiving a monthly service, the SC shall conduct monitoring at the following minimum frequency:

- For individuals living with a family member, the SC shall conduct a phone monitoring with the individual once every three calendar months at a minimum and shall conduct a face-to-face monitoring once every six calendar months at a minimum. At least one face-to-face monitoring per calendar year must take place in the individual's home.
- For individuals in any other living arrangement, including but not limited to their own home, Personal Care Homes, or Domiciliary Care Homes, the SC shall conduct a phone monitoring with the individual at least once every calendar month at a minimum and shall conduct a face-to-face monitoring once every three calendar months at a minimum. At least one of the face-to-face monitoring visits every six calendar months must take place in the individual's home.

Deviations of the minimum monitoring that involve monitoring at a frequency and location that differ from the above requirements are permitted for individuals living with a family member under the following circumstances:

- The individual and/or their representative requests the deviation;
- The deviation is included in the individual's approved ISP; and
- There are alternative mechanisms in place to ensure the individual's health and welfare, and these mechanisms are included in the individual's approved ISP.

Deviations in monitoring frequency may not result in monitoring that takes place at a frequency less than two contacts per calendar year and one face-to-face visit per calendar year. Deviations in monitoring location may only be approved if the deviation allows for monitoring of service delivery at authorized service locations. Deviations in monitoring frequency and location must be prior approved by ODP. The process to be followed is outlined in Informational Packet 048-11, *Instructions on Request for Deviation in Monitoring Frequency*.

For individuals enrolled in the P/FDS waiver who do NOT receive at least one Waiver service each calendar month, ODP requires the following monitoring frequency by the SC, regardless of the individual's living arrangement:

- Phone monitoring once every calendar month at a minimum; and
- A face-to-face monitoring contact once every three calendar months at a minimum. At least two of the face-to-face visits per calendar year must take place in the individual's home.

Deviations of monitoring frequency and location are not permitted for these circumstances.

Targeted Services Management and Base-Funded Case Management

For individuals not enrolled in the Consolidated or P/FDS waivers, case management monitoring must take place at least annually and on a separate day from the ISP meeting, or at a frequency necessary to ensure the health and welfare of the individual. Deviations of monitoring frequency are not permitted for these circumstances.

Section 12: Waiver and Base Administrative Services

VF/EA FMS (Self-directing)

The procedure code and service unit for VF/EA FMS for the Monthly Administrative Fee:

Provider Type **54** - Intermediate Services Organization

Specialty **541** - ISO - Fiscal/Employer Agent

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old;

Base Funding: 0 – 120 years old

Allowable Place of Service: 11-Office 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7318	Vendor Fiscal/Employer Agent Financial Management Services	An administrative service that assists individuals with intellectual disability and/or their surrogates in the direct employment and management of qualified SSWs and management of qualified small unlicensed providers and vendors.	Per month

AWC FMS (Self-directing)

The procedure code and service unit for AWC FMS Monthly Administrative Fee:

Provider Type **54** - Intermediate Services Organization

Specialty **540** - ISO-Agency with Choice

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3–120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7319	Agency with Choice Financial Management Services	An administrative service that assists individuals with intellectual disability and/or their surrogates in the employment and management of qualified SSWs and management of qualified small unlicensed providers and vendors.	Per month

VF/EA FMS Transition Service

During the transition of an individual from the existing statewide VF/EA FMS to the new statewide VF/EA FMS, a **one-time** per individual transition service is available for each individual that has decided to transition to the new statewide VF/EA FMS in order for the new statewide VF/EA FMS to complete all required transition activities.

The procedure code and service unit for VF/EA FMS One-Time Transition Services:

Provider Type **54** - Intermediate Services Organization
Specialty **541** - ISO - Fiscal/Employer Agent

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 11-Office 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W0190	VF/EA FMS Transition Service	A one-time per individual transition service related to the completion of all required transition activities in order for an individual to transition from the existing statewide VF/EA FMS to the new statewide VF/EA FMS.	Flat fee

VF/EA FMS Start-up Service

A **one-time** start-up service is available to be approved for each individual concurrent with service authorization. The start-up service is for required activities related to the individual's enrollment with the statewide VF/EA FMS. The start-up service is approved for each individual in the month prior to approval of W7318 (the ongoing monthly per individual administrative service). This start-up service **may not** be approved for individuals transitioning from the existing statewide VF/EA FMS to the new statewide VF/EA FMS and may only be approved for new individuals enrolling with the statewide VF/EA FMS after a date specified by ODP. The VF/EA FMS start-up service may not be approved for the same individual in the same month as any other VF/EA FMS administrative service approved for the new statewide VF/EA FMS.

The procedure code and service unit for VF/EA FMS One-Time Start-Up Services:

Provider Type **54** - Intermediate Services Organization
Specialty **541** - ISO - Fiscal/Employer Agent

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 11-Office 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W0191	VF/EA FMS Start-up Service	After a date specified by ODP, a one-time start-up service approved for each individual enrolling with the statewide VF/EA FMS. This start-up service may not be approved for individuals transitioning from the existing statewide VF/EA FMS to the new statewide VF/EA FMS and may only be approved for new individuals enrolling with the statewide VF/EA FMS after a date specified by ODP. The VF/EA FMS start-up service may not be approved for the same individual in the same month as any other VF/EA FMS administrative service approved for the new statewide VF/EA FMS.	Flat fee

Base-Funded AWC or VF/EA FMS One-Time Vendor Payment (Self-directing)

The procedure code and service unit for **Base-Funded AWC or VF/EA FMS one-time vendor payment** follows:

Local VF/EA FMS & AWC FMS Service

Provider Type **54** - Intermediate Services Organization

Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Provider Type **55** - Vendor

Specialties: **267** - Nonemergency; **543** - Environmental Accessibility Adaptations; **552** - Adaptive Appliances/Equipment; **431** - Homemaker/Chore Services; **430** - Homemaker Services; **533** - Educational Service; **553** - Habilitation Supplies; **519** - FSS/Consumer Payment

Age Limits & Funding:

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W0025	Agency With Choice and Local Vendor Fiscal/Employer Agent Financial Management Services— Base Funded individuals	An indirect service that assists individuals with intellectual disability who receive base-funded services and/or their surrogates in the employment and management of employee related services (that is, qualified SSWs) and the management of qualified small unlicensed providers and vendors services. The administrative service is billed as something other than a monthly fee.	Outcome Based

OHCDs One-Time Vendor Payments (Non Self-Directing)

Individuals who do not self-direct their services may have situations when vendor services are identified as a need. The needed vendor service can be managed through an OHCDs provider when the vendor does not enroll directly with HCSIS to provide the service nor enroll directly with PROMISe™ to submit a claim to be paid for the rendered service. The OHCDs provider can charge an administrative fee for one-time vendor services per the ODP billing requirements. This administration fee is \$25.00 or 15% per transaction, whichever is less.

The procedure codes, modifier, and service units for OHCDs providers One-Time Vendor Payment Services:

Provider Type **55** - Vendor
Specialty **267** - Non-Emergency

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W0026		OHCDs, Transportation Services	This is an administrative service to pay the administration fee that is charged when the OHCDs provides an administrative service directly related to the delivery of a Transportation vendor service (one time vendor) for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is \$25.00 or 15% per transaction, whichever is less.	Outcome Based

OHCDs One-Time Respite Camp Vendor Payments

Provider Type **55** - Vendor
Specialties: **554** - Respite-Overnight Camp; **555** - Respite-Day Camp

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W0026	U2	One-Time Vendor Payment for Respite Camp	This is an administrative service to pay the administration fee that is charged when the OHCDs provides an administrative service directly related to	Outcome Based

			the delivery of a Respite Camp vendor service (one time vendor) for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is \$25.00 or 15% per transaction, whichever is less.	
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OHCDs One-Time Other Vendor Payments

Provider Type **55** - Vendor

Specialties: **543** - Environmental Accessibility Adaptations; **552** - Adaptive

Appliances/Equipment; **431** - Homemaker/Chore Services; **430** - Homemaker Services; **533** - Educational Service; **553** - Habilitation Supplies

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W0027	OHCDs, Other Vendor Services	This is an administrative service to pay the administration fee that is charged when the OHCDs provides an administrative service directly related to the delivery of a vendor service (one time vendor) other than Transportation or Respite Camp for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is \$25.00 or 15% per transaction, whichever is less.	Outcome Based

Section 13: Waiver Services

This section contains information on each specific service reflected in Appendix C of the approved Consolidated and P/FDS Waivers. Services that are solely diversional (i.e. related to recreation and leisure or entertainment activities) are not eligible waiver services. Membership and entrance fees are not allowable waiver costs. Recreation services and fees may be provided under family support services with base funding or individuals can choose to use their personal funds.

In accordance with 55 Pa. Code §51.44 (c), payment for waiver services may only be made after the service has been rendered. It is not allowable for waiver funds to be utilized to provide a deposit for services that are to be performed at some point in the future.

The cost of P/FDS Waiver services provided to any individual enrolled in the P/FDS Waiver within a fiscal year, with the exception of Supports Coordination, Supports Broker services and administrative services may not exceed the funding cap established in the current approved P/FDS Waiver. There is no similar cap associated with the Consolidated Waiver.

Waiver-funded home and community-based services may be provided to residents of certain residential settings, such as Domiciliary Care Homes, when these homes have a licensed capacity of 10 or fewer unrelated persons and when the home is located in a local community in noncontiguous and non-campus settings.

Individuals residing in licensed Personal Care Homes (55 Pa. Code Chapter 2600) with 11 or more residents with a move-in date for the Personal Care Home of July 1, 2008 or after are excluded from enrollment in the P/FDS Waiver. The move-in date applies to the Personal Care Home where the person is residing and may not be transferred to a new home. Waiver-funded home and community-based services may not be used to fund the services that the PCH or Domiciliary Care Home is required to provide to the individual.

In accordance with 42 CFR §441.301(b)(1)(ii), waiver services may not be furnished to individuals who are inpatients of a hospital, nursing facility or ICF/ID. Waiver services *may* be available to individuals who are residing in residential treatment facilities, correctional facilities on a temporary basis², or drug and alcohol facilities while the individual is not in the care of the facility. The waivers may not pay for the cost of the facility, but can be used to meet the needs of the individual outside of the facility. In these instances, the primary purpose of the waiver services is reunification of the individual with his or her family, friends, and community, and to ensure the individual's health and welfare. In addition, an individual residing in one of these settings may receive waiver services to support them while visiting family during weekends or over holidays. Please note that all waiver enrollment policies apply to these individuals.

Each service definition identified in this section contains:

- A service description.
- Suggestions for determining need.
- Documentation requirements.
- Service limits.

² Individuals who are placed in a correctional facility temporarily pending full incarceration may access certain Waiver services to meet their needs.

The following questions should be answered and documented in the ISP for each particular service:

- What Outcomes(s) are to be achieved? How does the service support the outcome?
- What service would best support each assessed need of the individual?
- How will this service protect the individual's health and welfare?
- What formal statewide needs assessments or informal needs assessments were used to determine the assessed needs of the individual?
- What will the individual be learning or gaining by receiving this service?
- Is there any specific training (beyond general staff orientation) and/or any specific skills needed to provide this service?
- Have the necessary prior authorization or service limitations/exceptions been approved by ODP?
- What is the amount, frequency and duration of the service needed?
- How many units of service are required to attain the specific Outcome Action(s)?
- How will progress and/or success be measured and reached?
- If progress and success are not being demonstrated, what is the rationale for continuing the service?

SC documentation requirements:

- Document answers to these questions in the ISP. If any additional questions are necessary to determine the need for a specific service, a sub-section titled "Determining the Need for Services" will appear under that service heading in this manual. If there are no additional questions, the questions listed above are sufficient to assist in the identification of the most appropriate service.

The following represents services within the Consolidated and P/FDS Waivers. Note: Residential habilitation services (licensed and unlicensed) are only available in the Consolidated Waiver and referenced as such within the manual.

Section 13.1: Assistive Technology

An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve an individual's functioning. Assistive Technology services include direct support to an individual in the selection, acquisition, or use of an assistive technology device, limited to:

- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the individual;
- Selecting, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices. Repairs are only covered when they are more cost effective than purchasing a new device and are not covered by a warranty;
- Training for the individual, or where appropriate, the individual's family members, guardian, advocate, staff, or authorized representative on how to use and/or care for the assistive technology;
- Extended warranties; and
- Ancillary supplies, software, and equipment necessary for the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices.

Assistive Technology includes independent living technology or smart home technology devices that promote the independence of individuals and decrease their need for assistance from others such as; medication dispensers, electric stove sensors, water sensors, and panic pendants. This list is instructive and not intended to be an all-inclusive description of allowable items, devices or services. Documentation of the individual's informed consent must be obtained prior to authorization of these devices. The monthly monitoring fees for these devices are also covered under Assistive Technology.

Electronic devices are included under Assistive Technology when there is documentation that the device is a cost effective alternative to a service or piece of equipment. The device must be the least expensive and most effective device to meet the individual's need as documented by the evaluation. Assistive Technology also includes applications for electronic devices that assist individuals with a need identified through the evaluation described below.

Generators are covered for individuals residing in private homes.

All items shall meet the applicable standards of manufacture, design, and installation. Items reimbursed with waiver funds shall be in addition to any equipment or supplies provided under the MA State Plan. Excluded are those items that are not of direct medical or remedial benefit to the individual, or are primarily for a recreational or diversionary nature. Items designed for general use shall only be covered to the extent necessary to meet the individual's needs and be for the primary use of the individual. If the individual receives Behavioral Therapy or Behavioral Support Services, the assistive technology must be consistent with the individual's behavior support plan.

Assistive technology devices must be recommended by an independent evaluation of the individual's assistive technology needs. The organization or professional providing the evaluation shall be credentialed, licensed, or certified in an area related to the specific type of technology needed and may not have a fiduciary relationship with the assistive technology provider. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of

the elements listed) that would be most effective to meet the need(s) of the individual. The least expensive option from the list must be selected for inclusion on the ISP.

Additional Service Definition Clarification:

Electronic devices include tablets such as iPads and Samsung Galaxy tablets.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- How will the assistive technology service increase, maintain or improve the individual's functioning?
- Has the individual used an assistive technology device in the past to address a similar need?
 - If yes, what worked well with this device? What didn't work well with this device?
 - If the device being recommended is similar or the same as a device that didn't work well for the individual in the past, why do you think this device will be more successful?
- Was a recommendation obtained from an independent evaluation of the individual's assistive technology needs?
- Is the device cost effective?
 - For independent living technology, does the technology decrease the individual's need for assistance from others?
 - For electronic devices, is the device a cost effective alternative to a service or other piece of equipment?

Service limit:

- All items shall meet the applicable standards of manufacture, design, and installation.
- Items shall be specific to the individual's needs and not be a device or equipment that benefits the public at large, staff, significant others, or family members.
- If the individual receives Behavioral Therapy or Behavioral Support Services, the Assistive Technology must be consistent with the individual's behavior support plan.
- No more than one replacement electronic device is allowed every five years.
- The following list contains items excluded as Assistive Technology (please note this is not an exhaustive list of excluded items):
 - Durable medical equipment which is any equipment that provides therapeutic benefit to an individual in need due to illness or disease, is prescribed by a physician, reusable, able to stand repeated use, and appropriate for use in the home. Some examples include, but are not limited to: Walkers, wheelchairs, hospital beds and mattresses. The waivers will not cover variations of items considered durable medical equipment that are used primarily for the comfort or convenience of the individual such as specialized strollers.
 - Hearing aids for children under 21 years of age;
 - Air conditioning systems or units, heating systems or units, water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
 - Recreational or exercise equipment; and
 - Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships.

- Assistive technology has a lifetime limit of \$10,000 per individual except when the limit is extended by ODP using for #DP1023 “*Request for exception to established service limits or maximum number of service units*”. The lifetime limit of \$10,000 applies to a single procedure code (medical/non-medical) or for the accumulated total of both procedure codes.
- There is also a lifetime limit of \$5,000 for generators purchased as Assistive Technology. While generators have a separate lifetime limit, the amount spent on a generator is included in the overall Assistive Technology lifetime limit of \$10,000.

SC documentation requirements:

- When Assistive Technology is utilized to meet a medical need, documentation must be obtained stating that the service is medically necessary and not covered through the MA State Plan which includes EPSDT, Medicare, and/or private insurance. When Assistive Technology is covered by the MA State Plan, Medicare, and/or private insurance, documentation must be obtained showing that limitations have been reached before the Assistive Technology can be covered through the waiver.
- The assistive technology device was recommended by an independent evaluation of the individual’s assistive technology needs. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the individual. The least expensive option from the list must be selected for inclusion on the ISP.
- The specific necessary device, technology or equipment must be documented.
- Documentation of the individual’s informed consent must be obtained prior to authorization of independent living technology devices.
- A summary of the documentation must be included in the *Service Details* page of the ISP.

The procedure codes and service units for Assistive Technology Services:

Assistive Technology Service:

Provider Type **55** - Vendor

Specialty **552** – Adaptive Appliances/Equipment

Adaptive Appliances/Equipment:

Provider Type **54** - Intermediate Services Organization

Specialties: **541** - ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDS may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old;

Base Funding: 0 – 120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2028* (For non-medical Assistive Technology)	SE	Assistive Technology	The purchase or modification of assistive technology for increased functional involvement of individuals with intellectual disability in their activities of daily living.	Outcome based
T2029* (For medical Assistive Technology)	SE			

Section 13.2: Behavioral Support

This is a service that includes functional assessment; the development of strategies to support the individual based upon assessment; and the provision of interventions and training to individuals, staff, parents, and caregivers. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

The service is performed by a professional with a Master's Degree in Human Services (or a closely related field) or an individual under the supervision of a professional who is licensed or has a Master's Degree in Human Services (or a closely related field), and is limited to the following:

- Collection and evaluation of behavioral data;
- Observation of the individual in various settings for the purpose of developing a behavior support plan;
- Collaboration with the individual, his or her family, and ISP team for the purpose of developing a behavior support plan that must include positive practices and may not include restraint procedures (physical, chemical, or mechanical) as support strategies;
- Conducting comprehensive functional assessments of presenting issues (e.g. aggression, self-injurious behavior, law offending behavior [sexual or otherwise]);
- Development and maintenance of behavior support plans, which utilize positive strategies to support the individual, based on functional behavioral assessments;
- Conducting training related to the implementation of behavior support plans for the individual, family members, staff, and caregivers;
- Implementation of activities and strategies identified in the individual's behavior support plan, which may include educating and/or counseling the individual and supporters regarding the underlying causes/functions of behavior and modeling and/or coaching of supporters to carry out interventions;
- Monitoring implementation of the behavior support plan, and revising as needed;
- Collaboration with the individual, his or her family, and ISP team in order to develop positive interventions to address specific presenting issues; and
- Completion of required paperwork related to data collection, progress reporting, and development of annual planning material.

Services may be provided in the office of the Behavioral Support professional, the individual's home or service location, or in local public community environments necessary for the provision of the Behavioral Support services. Direct services must be provided on a one-on-one basis.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Determining the need for services:

- Behavioral Support must be based on an assessment and the strategies to support the individual based on that assessed need.

Service limit:

- Behavioral Support services may be provided during the same day and time as other waiver services, but may not duplicate other waiver services.

✍ SC documentation requirements:

- Summary of the behavior support plan in the section of the ISP to include:
 - Current need for Behavioral Support.
 - Specific activities that the behavior support professional will be completing to support the outcome of the Behavioral Support service.
 - The formal or informal needs assessment that establishes the need for Behavioral Support.
 - Documentation related to direct and indirect activities.

The procedure code and service unit for Behavioral Support Services:

Provider Type **51** - Home & Community Habilitation
Specialty **508** – Behavioral Support

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3-120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7095		Behavioral Support	This service includes functional assessment; the development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, relatives, and caregivers. This is a 1 individual to 1 Behavioral Support direct professional service. The individual's family members, staff, or others involved in the individual's life may be included in Behavior Support activities.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.3: Companion Services

Companion services are provided to individuals living in private homes for the limited purposes of providing supervision and assistance that is focused solely on the health and safety of the individual. Companion services are used in lieu of Home and Community Habilitation Services to protect the health and welfare of the individual. This service can be used for asleep hours when only supervision or non-medical or non-habilitative care is needed to protect the safety of the individual. For example, a companion can be used during overnight hours for an individual who lives on his or her own but does not have the ability to safely evacuate in the event of an emergency.

Companions may supervise and provide assistance in carrying out the functions of daily living, including grooming, health care, household care, meal preparation and planning, and socialization. This service can also be used to accompany individuals to the community to ensure the individual's health and safety. This service is not available to individuals when a legally responsible person is required to provide supervision or assistance or when the service is a covered service under the MA State Plan.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Determining the need for services:

- Determine that companions are either supervising or providing care and assistance that is focused solely on the health and safety of the individual.
- Companion services are used when there are non-habilitative Outcome Actions for the individual associated with the delivery of the service. The individual is not acquiring, maintaining or improving a skill.
- The Outcome Actions related to Companion services only relate to assistance to and supervision of the individual to ensure health and welfare.
- Are Companion services to be used during overnight hours? If so, does the individual require supervision or non-medical or non-habilitative care to protect the safety of the individual?

Service limit:

- Companion services are only available to individuals who are age 18 and older. Individuals who are age 18 to 20 may not receive medically necessary personal care services as part of Companion services. All medically necessary personal care services are provided through Medical Assistance as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for individuals under the age of 21.
- Companion services are not available for individuals residing in agency-owned, rented/leased, or operated homes (unlicensed and licensed residential habilitation settings).
- Companion Services and Home and Community Habilitation have a maximum limit of 24 hours (96 15-minute units) per individual per calendar day whether used in combination or alone.

- Companion services that are approved in an ISP may be provided by the individual's relatives and legal guardians. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized Companion or a combination of Home and Community Habilitation and Companion (when both services are authorized in the ISP). Further, when multiple relatives and/or legal guardians provide the service(s) each individual may receive no more than 60 hours per week of authorized Companion or a combination of Home and Community Habilitation and Companion (when both services are approved in the ISP) from all relatives and legal guardians.

An exception may be made to the limitation on the number of hours of Home and Community Habilitation and Companion provided by relatives and legal guardians at the discretion of the employer when there is an emergency or an unplanned departure of a regularly scheduled worker for up to 90 calendar days in any fiscal year. Additional guidance can be found in Section 14: Policy for Waiver Services Provided by Relatives, Legal Guardians and Legally Responsible Individuals.

- Companion Services may not be provided at the same time as any of the following: Home and Community Habilitation, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Transitional Work Services.
- Transportation necessary to participate in Companion activities in the community is provided as a component of this service and the cost of this transportation is included in the rate paid to agency providers. For this reason, waiver Transportation services may not be authorized as a separate service for transportation related to Companion activities supported by an agency provider. Transportation is not a component of the Companion service and is not included in the rate paid to individual providers. For this reason, waiver Transportation services as defined in this waiver (trip, mile and public transportation) may be authorized as a separate service for transportation related to Companion activities supported by an individual provider.

SC documentation requirements:

- The Outcomes section of the ISP must include supervision and/or care the companion will be providing and why it is necessary. This includes documentation regarding whether the direct support professional will be awake or asleep overnight and how the asleep direct support professional will assure the individual's health and safety during those overnight hours.

The procedure codes, modifiers, and service units for Companion services:

Provider Type **51** - Home & Community Habilitation
Specialty **363** - Companion Service

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(Provider type 51 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541 for the asterisked procedure code below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 18-120 years old

Base Funding: 18-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W1724		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W1725		Staff Support Level 1	The provision of the service at a staff-to-individual ratio of <1:6 to 1:3.5.	15 minutes
W1726		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of <1:3.5 to >1:1.	15 minutes
W1727*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type **54** - Intermediate Service OrganizationSpecialty **540** - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4 Only used with W1727	No benefit allowance	This modifier is to be used with the noted procedure code by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage.	15 minutes
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.4: Education Support Services

Education Support Services consist of special education and related services as defined in sections (16) and (17) of the Individuals with Disabilities Education Act (IDEA) to the extent that they are not available under a program funded by IDEA or available for funding by the Office of Vocational Rehabilitation (OVR). Education Support Services may consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a General Educational Development (GED) degree, and support to participate in an apprenticeship program.

This service can be delivered in Pennsylvania, Washington DC, Virginia, and in states contiguous to Pennsylvania.

Additional Service Definition Clarification:

Teaching American Sign Language or another form of communication is covered for adults (individuals who are 21 years of age or older) and children (individuals under the age of 21) who have graduated from high school. There must be documentation for each individual that verifies he or she is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication. To qualify to teach American Sign Language or another form of communication through this service the provider must have at least Intermediate Plus sign language skills on the Sign Language Proficiency Interview and meet all other qualification criteria for Education Support Services.

The Centers for Medicare and Medicaid Services (CMS) issued regulations regarding Home and Community-Based Settings that were effective March 17, 2014. According to 42 CFR 441.301 (c)(4)(i), home and community-based settings must meet the following standard, "The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." Further, 42 CFR 441.301 (c)(5)(v) states that settings are not home and community-based when the setting "has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS". To ensure compliance with these federal regulations, Consolidated and P/FDS waiver funding for Education Support can only be used to pay for tuition for adult education classes offered by a college, community college, or university (institution of higher postsecondary education) when at least 75% of the time the individual spends on campus is integrated with the general student population.

On campus peer support may also be provided through Education Support services. This is support provided by the institution of postsecondary education's staff (they cannot be contracted staff) or other students attending the institution of postsecondary education. The support assists the individual to learn roles or tasks that are related to the campus environment such as homework assistance, interpersonal skills and residential hall independent living skills. When on campus peer support is offered by the institution of postsecondary education and authorized in the ISP as Education Support, Home and Community Habilitation and Companion cannot be provided at the same time as the on campus peer support.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does the individual have an employment Outcome Statement or other Outcome Actions related to skill attainment or development in the ISP related to the Education Support Service need?
- Does the Education Support Service relate directly to the Outcome selected by the individual?
- Is the individual age 21 or younger? If yes, why isn't this service provided for the individual through the Department of Education?
- Did the individual graduate from high school before the age of 21? If yes, OVR should be contacted prior to payment for this service under the waivers.

Service limits:

- Individuals authorized for Education Support Services must have an employment Outcome Statement or other Outcome Actions related to skill attainment or development in the ISP related to the Education Support Service Need.

✍ SC documentation requirements:

- Documentation of verification that services are not available for funding through OVR or available through IDEA for individuals still in school.
- A summary of the documentation must be included in the *Service Details* page of the ISP.
- Documentation to support the continued need for service re-authorization (i.e. to train on a new skill or progress demonstrated on current Outcome Actions to date).

The procedure code and service units for Education Support Services:

Provider Type **55** - Vendor
Specialty **533** - Educational Service

Provider Type **54** - Intermediate Services Organization
Specialties: **541** - ISO-Fiscal/Employer Agent; **540** - ISO-Agency with Choice

(A provider agency functioning as an OHCDS may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:
Consolidated & P/FDS Waivers: 18 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7284*		Education Support Services	Education Support Services consist of general adult educational services including community college, university or other college-level courses, classes, tutoring to receive a General Educational Development (GED) degree, and assistance necessary for the person to participate in apprenticeship programs.	Outcome based
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.5: Employment Services

The first consideration and preferred outcome for individuals enrolled or enrolling in the Consolidated and P/FDS Waivers is competitive integrated employment. ODP expects AEs and SCOs to institute standard practices to promote employment through the ISP. AEs and SCOs shall ensure that individuals are:

- Advised about the importance of employment and encouraged to pursue it.
- Advised about the availability of employment services and the difference between services that promote competitive integrated employment and those that do not.
- Given the opportunity to choose employment services.
- Given the opportunity to meet with employment providers and people who have jobs if they so choose.

The SC should discuss employment and the availability of employment supports and services at every annual review update meeting. If the individual is working, the SC should ask if he or she needs additional supports to keep the job or if he or she wants to pursue a new job.

Achieving and maintaining competitive integrated employment and community inclusion are cornerstones of ODP policies, principles, and practices. Achieving these results requires individuals to be engaged with community resources on an ongoing and consistent basis. Employment practices must ensure that individuals receive information about feasible employment opportunities and services. The purpose of prevocational, vocational, adult training and supported employment services is to promote a competitive integrated employment outcome.

✍ SC documentation requirements for employment:

- The SC shall document all discussions regarding employment in a service note in HCSIS.
- The Employment Screen in the ISP should be filled out for all individuals who have employment services (job finding, job support, transitional work).

Supported Employment

Supported Employment Services are direct and indirect services that are provided in a variety of community settings for the purposes of supporting individuals in obtaining and sustaining competitive integrated employment. Competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with coworkers without disabilities.

This service is provided to individuals who need support to perform work in a competitive, integrated work setting. Supported Employment services include activities such as training and additional supports including worksite orientation, job aide development, coordination of accommodations and ensuring assistive technology that may be needed by the individual in order to obtain and sustain competitive integrated employment is utilized as specified in the ISP. Payment will be made only for the training and supports required by the individual and will not include payment for the supervisory activities rendered as a normal part of the employment setting. Supported Employment services do not include facility based, or other similar types of

vocational services furnished in specialized facilities that are not integrated or part of the general workforce.

Supported Employment services can be provided for two different purposes:

1. Vocational Skill Development which includes assisting individuals in acquiring, maintaining or improving job skills; and
2. Rehabilitation which includes assisting individuals in regaining lost skills or functioning due to illness or injury.

Supported Employment Services consist of two components: job finding and job support.

Job finding

Job finding may include interview assistance, employer outreach and orientation, resume preparation, job searching, and preparation for job tasks. Other examples of activities that may be associated with job finding include participation in individual planning for employment; development of job seeking skills; development of customer-specific job skills; job analysis; support to learn job tasks; consultation with OVR, benefits counseling agencies, and provider networks under Ticket to Work on behalf of an individual; assistance in beginning a business; and outreach with prospective employers on behalf of the individual including consultation on tax advantages and other benefits.

Job support

Job support consists of training the individual on job assignments, periodic follow-up or ongoing support with individuals and their employers. The service must be necessary for individuals to maintain acceptable job performance and work habits including assistance in learning new work assignments, maintaining job skills, and achieving performance expectations of the employer. Other examples of activities that may be associated with job support include participation in individual planning for employment, direct intervention with an employer, employment related personal skills instruction, support to relearn job tasks, training to assist individuals in using transportation to and from work, worksite orientation, job aide development, coordination of accommodations, ensuring assistive technology is utilized as specified in the ISP, maintenance of appropriate work and interpersonal behaviors on the job, follow-along services at the work site after OVR funded services are discontinued, and technical assistance and instruction for the individual's coworkers that will enable peer support.

Supported Employment can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Additional Service Definition Clarification:

Individuals may not volunteer as part of Supported Employment services.

Determining the need for services:

The following additional questions should be used to determine a need for this service:

- Is this individual interested in competitive integrated employment?
- Is this individual currently meeting or exceeding Outcome actions in a prevocational or transitional work environment? If not, how will supported employment ensure the individual can meet or exceed outcome actions in competitive employment?
- If the individual is not already employed, can the individual successfully maintain competitive integrated employment with support?

Service limits:

- When Supported Employment Services are provided alone or in conjunction with Prevocational, Transitional Work or Licensed Day Habilitation services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- The job support component of supported employment activities is a direct service to one individual at a time.
- For job support, the individual must receive minimum wage or higher.
- The direct portion of Supported Employment may not be provided at the same time as any of the following: Companion Services, Home and Community Habilitation, Licensed Day Habilitation, Prevocational Services and Transitional Work Services.
- This service may not occur in a 55 Pa. Code Chapter 2390 (licensed prevocational) facility or setting.
- Supported Employment Services may not be rendered under the waiver until it has been verified that the services are not available in the student's complete and approved Individualized Education Program (IEP) developed pursuant to IDEA. Supported Employment services can be used to find or support employment that occurs outside of school hours and is not included in the student's complete and approved IEP.
- The travel time for Supported Employment services is built into the existing rate for the service, thus cannot be billed as a discrete service.
- Ongoing use of Supported Employment services is limited to support that cannot be provided by the employer through regular supervisory channels, natural supports and/or on-the-job resources that are available to employees who do not have a disability.
- Supported Employment does not include incentive payments, subsidies, or unrelated vocational expenses such as the following:
 - Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
 - Payments that are passed through to individuals receiving Supported Employment; or
 - Payments for vocational training that are not directly related to an individual's Supported Employment Program.

SC documentation requirements:

- The provision of job finding services will be evaluated during individual monitoring by the SC to assess the continued need for the service and whether the service is assisting the individual with the outcome of finding community employment. If the service is not assisting the individual with this outcome, the SC will convene an ISP team meeting to identify changes to the Supported Employment service to realize this outcome or other service options to meet the individual's needs. The provision of job support services

must be evaluated at least annually, as part of the ISP process, to determine whether the individual continues to require the current level of authorized services. The ISP must be updated, if necessary, to reflect the team's determination.

- Individuals must be referred to OVR prior to receiving Supported Employment services except if there is documentation of any one of the following:
 - The individual is competitively employed and solely needs extended supports.
 - The individual is utilizing Supported Employment for vocational skill development purposes.
 - The individual has an ineligibility determination from OVR. The determination of ineligibility for OVR services remains valid unless the individual wants to be referred to OVR again.
 - OVR has previously closed the individual's case. An OVR case closure remains valid unless the individual wants to be referred to OVR again due to a change in circumstances.

The SC shall not make a referral to OVR simply to obtain an ineligibility determination and/or denial in order to get Supported Employment services through the waiver. The referral is made to ensure the individual has availed him or herself of the expertise of OVR in the pursuit of the goal that competitive integrated employment is the first consideration and preferred outcome for the individual.

- To make a referral to OVR and to help expedite the eligibility process, the SC must complete the "OVR-ODP Interagency Referral Form", OVR-172 and submit the form and any relevant referral information to the appropriate OVR District Office. The SC must then document the date that the OVR-172 was submitted to OVR in the ISP.
- When an OVR referral has been made, the SC must keep a copy of the letter from OVR that documents whether the individual is eligible or ineligible for OVR services in the individual's file.

The procedure code and service unit for Supported Employment Services:

Provider Type **53** - Employment-Competitive

Specialties: **530** - Job Finding; **531**-Job Support

Provider Type **54** - Intermediate Services Organization

Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(Provider type 53 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541 for the asterisked procedure codes below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 16-120 years old;

Base Funding: 16-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7235		Supported Employment	The provision of 1:1 services by a staff member with the training and experience to appropriately address the needs of an individual.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type 54 - Intermediate Service Organization
Specialty 540 - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4	No benefit allowance	This modifier is to be used with the noted procedure code by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage.	15 minutes
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – U4
- 2nd – U1

Transitional Work Services

Transitional Work services consist of supporting individuals in transitioning to integrated, competitive employment through work that occurs in a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations. Transitional Work service options include mobile work force, work station in industry, affirmative industry, and enclave.

A Mobile Work Force uses individuals who are supervised by a training/job supervisor. The Mobile Work Force will conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the individuals are paid by the provider. A Work Station in Industry involves individual or group training of individuals at an industry site. Training is

conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrates job expertise and meets established production rates. Affirmative Industry is a business that sells products or services where at least 51% of the employees do not have a disability and where the individual receives minimum wage or higher. Enclave is a business model where individuals with a disability are employed by a business/industry to perform specific job functions while working alongside workers who do not have a disability. The goal for Transitional Work is competitive employment.

The service also includes transportation that is an integral component of the service, for example, transportation to a work site. The Transitional Work provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provider in the individual's ISP. In this case, the transportation service must be authorized and billed as a discrete service.

Transitional Work services can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Additional Service Definition Clarification:

Individuals engaged in Transitional Work Services must receive payment in accordance with federal and state laws for work performed. Individuals may not volunteer as part of Transitional Work services.

Determining the need for services:

The following additional questions should be used to establish a determination of need for transitional employment services:

- Is this individual interested in transitional or competitive employment?
- Is this individual currently successful (meeting or exceeding outcome actions) in a prevocational environment?
- Would the individual benefit from a supportive environment to increase appropriate work skills?

Service limits:

- Transitional Work services may not be rendered under the waiver until it has been verified that the services are not available in the student's complete and approved Individualized Education Plan (IEP) developed pursuant to IDEA.
- When Transitional Work services are provided alone or in conjunction with Prevocational, Licensed Day Habilitation or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- Transitional Work services may be provided without referring an individual to OVR unless the individual is under the age of 24. When an individual is under the age of 24, Transitional Work services may only be authorized as a new service in the ISP when documentation has been obtained that OVR has closed the individual's case or that the individual has been determined ineligible for OVR services.

- Transitional Work services may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Home and Community Habilitation Services.

✍ SC documentation requirements:

- Individuals receiving this service must have an employment outcome included in their ISP.
- Progress needs to be documented such that the trainer is phased out as the individual meets established production goals in work station and affirmative industry.
- The employment screen must be completed for individuals receiving employment services and at least for all individuals from 16 to 26 years of age.

The procedure codes and service units for Transitional Work Services:

Provider Type **51** - Home & Community Habilitation
Specialty **516** - Transitional Work Services

Age Limits & Funding:

Consolidated & P/FDS Waivers: 16-120 years old;

Base Funding: 16-120 years old

Allowable Place of Service: 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7237		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:10 to >1:6.	15 minutes
W7239		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7241		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7245		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Prevocational Services

This service is provided to assist individuals in developing skills necessary for placement into competitive integrated employment. Prevocational services focus on the development of competitive worker traits through the use of work as the primary training method. The service may be provided as:

- Occupational training which is used to teach skills for a specific occupation in the competitive labor market, and includes personal and work adjustment training that is designed to develop appropriate worker traits and teach the understanding of the expectations of a work environment.
- Work-related evaluation which involves the use of planned activities, systematic observation, and testing to accomplish a formal assessment of the individual, including identification of service needs, potential for employment, and identification of employment objectives.

The service must be reviewed at least every six months or more frequently as needed to assess the need for the service and progress on the employment outcome.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

The service also includes transportation that is an integral component of the service, for example, transportation to a work activity. The prevocational provider is not, however, responsible for transportation to and from an individual's home.

Additional Service Definition Clarification:

Individuals may volunteer as part of Prevocational services.

Determining the need for services:

The following additional questions should be used to determine a need for this service:

- Does the individual have an outcome for employment?
- Is the individual interested in learning work skills to obtain competitive employment?
- Does the individual have a formal prevocational assessment that includes the use of planned activities, observation and testing, potential for employment and identification of employment objectives, by the provider to assure that the individual can be appropriately supported in this type of environment?

Service limits:

- Prevocational Services may not be funded through the waiver if they are available to individuals through program funding under the IDEA. Documentation must be maintained in the individual's file to satisfy assurances that the service is not otherwise available through a program funded under the IDEA.
- When Prevocational services are provided alone or in conjunction with Licensed Day Habilitation services, Transitional Work or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one

another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.

- Prevocational services may not be provided at the same time as any of the following: Companion services, the direct portion of Supported Employment, Licensed Day Habilitation, Home and Community Habilitation and Transitional Work services.
- The use of enhanced levels of service is based on the individual's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.
- Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the Waiver.
- Prevocational services may be provided without referring an individual to OVR unless the individual is under the age of 24. When an individual is under the age of 24, Prevocational services may only be authorized as a new service in the ISP when documentation has been obtained that OVR has closed the individual's case or that the individual has been determined ineligible for OVR services.

SC documentation requirements:

- Individuals receiving Prevocational services must have an outcome for employment included in their ISP.
- Prevocational services for an individual under 22 years of age and still in school are funded under the Individuals with Disabilities Education Act (IDEA).
- The SC shall indicate the appropriate staffing ratio in the *Supervision Care Needs* section of the ISP, under Staffing Ratio – Day.

The procedure codes, modifiers, and service units for Prevocational Services:

Provider Type **51** - Home & Community Habilitation
Specialty **515** - Pre-Vocational-2390

Age Limits & Funding:

Consolidated & P/FDS Waivers: 16-120 years old;

Base Funding: 16-120 years old

Allowable Place of Service: 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7087		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:15.	15 minutes
W7088		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:15 to 1:7.5.	15 minutes
W7089		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:7.5 to >1:1.	15 minutes
W7090		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes

W7091		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7092		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7093		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are degreed.	15 minutes
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD or TE
- 2nd - U1

Section 13.6: Home and Community Habilitation (Unlicensed)

This is a direct (face-to-face) service provided in home and community settings to assist individuals in acquiring, maintaining, and improving the skills necessary to live and participate fully in community life. To the extent that Home and Community Habilitation is provided in community settings, the settings must be integrated in the general community.

Services consist of assistance, support, and guidance (physical assistance, instruction, prompting, modeling and reinforcement) in the general areas of self-care, health maintenance, decision making, home management, managing personal resources, communication, mobility and transportation, relationship development and socialization, personal adjustment, participating in community functions and activities, and use of community resources.

The type and amount of assistance, support and guidance are informed by the assessed need for physical, psychological, and emotional assistance established through the assessment and person-centered planning processes. The type and amount of assistance are delivered to enhance the autonomy of the individual, in line with their personal preference and to achieve their desired outcomes.

Through the provision of this service individuals will acquire, maintain, or improve skills necessary to live in the community, to live more independently, and to participate meaningfully in community life.

Individuals receiving Residential Habilitation services may elect to receive Home and Community Habilitation services as an alternative to a licensed Day Habilitation or Prevocational services. Under these circumstances the Home and Community Habilitation service must occur anytime during the hours of 8:00 am – 5:00 pm, Monday through Friday. Refer to the service limit section below for information related to unit limitations when this occurs.

Home and Community Habilitation services may provide the following supports to meet individuals' habilitative outcomes as documented in the ISP:

1. Assistance, support, and guidance (prompting, instruction, modeling, reinforcement) that enables the individual to carry out activities of daily living such as personal grooming and hygiene, dressing, making meals, and maintaining a clean environment.
2. Assistance, support, and guidance that enables the individual to learn and develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying through prescribed therapy exercises, awareness and avoidance of risk including environmental risks, exploitation or abuse; responding to emergencies in the home and community such as fire or injury; knowing how and when to seek assistance when needed.
3. Assistance, support, and guidance that enables the individual to manage his or her medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, and keeping health logs and records.
4. Assistance, support, and guidance that enables the individual to manage his or her emotional wellness including self-management of emotional stressors and states such as disappointment, frustration, anxiety, anger, depression, PTSD and accessing mental

health services. The service may include implementation of behavioral intervention plans as developed by other consulting professionals.

5. Assistance, support, and guidance to enable the individual to fully participate, and when preferred, to direct the person-centered planning process including identifying who should attend and what the desired outcomes are.
6. Assistance, support, and guidance in decision making including guidance in identifying options/choices and evaluating options/choices against a set of personal preferences and desired outcomes. This includes assistance with identifying supports available within the community.
7. Assistance, support, and guidance that enables the individual to manage his or her home including arranging for utility services, paying bills, home maintenance, and home safety.
8. Assistance, support, and guidance that enables the individual to achieve financial stability through managing personal resources general banking and balancing accounts, record keeping and managing savings accounts and programs such as ABLE accounts.
9. Assistance, support, and guidance that enables the individual to communicate with providers, care givers, family members, friends, and others face-to-face and through use of the telephone, correspondence, the internet, and social media. The service may require knowledge and use of sign language or interpretation for individuals whose primary language is not English.
10. Assistance, support, and guidance that enables individual mobility by assisting them to use a range of transportation options including buses, trains, cab services, driving, and joining car pools, etc.
11. Assistance, support, and guidance that enables an individual to develop and maintain relationships with members of the broader community (examples include but are not limited to: neighbors, coworkers, friends and family) and to manage problematic relationships.
12. Assistance, support, and guidance that enables the individual to exercise rights as a citizen and fulfill their civic responsibilities such as voting and serving on juries; attending public community meetings; to participate in community projects and events with volunteer associations and groups; to serve on public and private boards, advisory groups, and commissions, as well as develop confidence and skills to enhance their contributions to the community.
13. Assistance, support, and guidance that encourage the development of the individual's personal interests, such as hobbies, appreciation of music, and other experiences the individual enjoys or may wish to discover.
14. Assistance, support, and guidance that enables the individual to participate in preferred activities of community life such as shopping, going to restaurants, museums, movies, concerts, dances, and faith based services.

15. Identification of risk to the person and the implementation of actions such as reporting incidents as required by ODP, the Older Adults Protective Services Act, the Adult Protective Services Act and the Child Protective Service Law, and/or calling emergency officials for immediate assistance.

Home and Community Habilitation may also include elements of Companion services as long as these elements do not constitute more than half of the Home and Community Habilitation service.

The staff providing the Home and Community Habilitation service must be awake during overnight hours for the purpose of performing tasks that require continual assistance as identified in the ISP to ensure medical or behavioral stability and which are able to be performed by a non-licensed worker. These tasks include the following:

- Taking vital statistics when monitoring has been prescribed by a licensed professional, such as post-surgical care;
- Positioning the individual;
- Performing range of motion exercises as directed by a licensed professional;
- Administering prescribed medications (other than over the counter medications);
- Applying prescribed treatments;
- Monitoring for seizure activity for an individual with convulsive (grand mal) epilepsy that is not able to be controlled by medication;
- Maintaining the functioning of devices whose malfunction would put the individual at risk of hospitalization; and
- Crisis intervention for an individual in accordance with his or her behavior support plan.

If the individual only needs supervision or assistance with evacuation in the event of an emergency during overnight hours, the appropriate service during this time period is Companion services.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Additional Service Definition Clarification:

Home and Community Habilitation services shall not be rendered in a building or a room owned, rented, or leased by providers with the purpose of providing services solely to individuals with a disability. This does not preclude this service from being utilized to assist an individual to volunteer in a nursing facility or hospital or visit a friend or family member in a licensed setting or unlicensed residential setting. If a provider is rendering Home and Community Habilitation to four or more individuals with a disability in a building or room, the provider may be subject to licensing requirements under 55 Pa. Code 2380 (relating to adult training facilities). Providers may contact the Bureau of Human Services Licensing at 1-866-503-3926, if they have questions regarding the licensure requirements.

When an individual residing in a licensed Residential Habilitation setting elects to receive Home and Community Habilitation services as an alternative to a licensed Day Habilitation or Prevocational service, the Home and Community Habilitation service must occur in the community. Home and Community Habilitation cannot be provided in a licensed setting or camp. If it is determined that an individual needs to receive additional day services in a licensed

Residential Habilitation setting, residential enhanced staff through Supplemental Habilitation or Additional Individualized Staff should be explored.

Teaching American Sign Language or another form of communication is covered under Home and Community Habilitation for adults (individuals who are 21 years of age or older) and children (individual who are under the age of 21) who have graduated from high school. There must be documentation for each individual that verifies he or she is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication. The person who will be teaching the individual must be fluent in the communication mode to be taught and meet all other Home and Community Habilitation qualification criteria.

Determining the need for services:

- Is the result of this service for the individual to acquire, maintain and/or improve a skill?
- What are the specific skills the individual needs to acquire, maintain or improve?
- Are Outcome Actions for habilitation measurable?
- If the measurable Outcome Actions only relate to supervision or minimal assistance, then Companion is the appropriate service.
- If the individual only needs supervision during overnight hours, the appropriate service is Companion Services.

Service Limits:

- This service is provided in the individual's private home or other unlicensed residential or community setting. This service can be used to assist an individual to volunteer in a nursing facility or hospital or visit a friend or family member in a licensed setting or unlicensed residential setting.
- The use of enhanced levels of service is based on the individual's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.
- Home and Community Habilitation may not be provided at the same time as any of the following: Companion services, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational services and Transitional Work services. Home and Community Habilitation may be provided at the same time as any other waiver service not included in this list.
- Home and Community Habilitation and Companion services have a maximum limit of 24 hours (96 15-minute units) per individual per calendar day whether used in combination or alone.
- For individuals residing in residential settings, Home and Community Habilitation Services may be used as an alternative either part-time or full-time for a Licensed Day Habilitation service or a Prevocational service. When this occurs the Home and Community Habilitation units are included in the combined unit limit for services that may not exceed 40 hours (160 15-minute units) per individual, per calendar week based on a 52 week year (Transitional Work Services, Supported Employment services, Licensed Day Habilitation services and Prevocational services).

- Supplemental habilitation staff available through the licensed residential habilitation service may not be used to provide the separate and discrete service of Home and Community Habilitation an individual may be authorized to receive.
- Transportation necessary to participate in Home and Community Habilitation activities in the community is provided as a component of this service and the cost of this transportation is included in the rate paid to agency providers. For this reason, waiver Transportation services may not be authorized as a separate service for transportation related to Home and Community Habilitation activities supported by an agency provider. Transportation is not a component of the Home and Community Habilitation service and is not included in the rate paid to individual providers. For this reason, waiver Transportation services as defined in this waiver (trip, mile and public transportation) may be authorized as a separate service for transportation related to Home and Community Habilitation activities supported by an individual provider.
- Home and Community Habilitation and Companion services that are authorized on an ISP may be provided by relatives/legal guardians of the individual. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized Home and Community Habilitation or a combination of Home and Community Habilitation and Companion (when both services are authorized in the ISP). Further, when multiple relatives and/or legal guardians provide the service(s), each individual may receive no more than 60 hours per week of authorized Home and Community Habilitation or a combination of Home and Community Habilitation and Companion (when both services are authorized in the ISP) from all relatives and legal guardians. An exception may be made to the limitation on the number of hours of Home and Community Habilitation and Companion provided by relatives and legal guardians at the discretion of the employer when there is an emergency or an unplanned departure of a regularly scheduled worker for up to 90 calendar days in any fiscal year. Additional guidance can be found in Section 14: Policy for Waiver Services Provided by Relatives, Legal Guardians and Legally Responsible Individuals.

SC documentation requirements:

- If Home and Community Habilitation is being requested at an average of 16 or more hours daily, the SC should complete the required section of the ISP Review Checklist.
- If Home and Community Habilitation is being utilized for someone living in a residential habilitation setting, as a non-traditional day service, the SC should document the Outcome Actions of the Home and Community Habilitation being provided and monitor that those Outcome Actions are being worked on in accordance with the ISP.

The procedure codes, modifiers, and service units for Home and Community Habilitation Unlicensed Services:

Provider Type **51** - Home & Community Habilitation
Specialty **510** – Home & Community Habilitation

Provider Type **54** – Intermediate Service Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(Provider type 51 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 – 120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7057		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7058		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7059		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7060*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7061*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7068*		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7069*		Staff Support Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type **54** - Intermediate Service OrganizationSpecialty **540** - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W7060 W7061 W7061 TD or TE W7068 W7069 W7069 TD or TE	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage. If a nurse renders the service, the modifier is used after the TD or TE modifier when submitting a claim.	15 minutes
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd - U1

OR

1st – TD or TE

2nd – U4

OR

1st – U4

2nd – U1

Section 13.7: Home Accessibility Adaptations

Home Accessibility Adaptations consist of certain modifications to the private home of the individual (including homes owned or leased by parents or other relatives with whom the individual resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the individual's disability, to ensure the health, security of, and accessibility for the individual, or which enable the individual to function with greater independence in the home. This service may only be used to adapt the individual's primary residence, may not be furnished to adapt homes that are owned, rented, leased, or operated by providers except when there is a needed adaptation for individuals residing in a Family Living setting and the life sharing host home is owned, rented or leased by the host and not the Family Living Provider Agency.

Home accessibility adaptations must have utility primarily for the individual, be an item of modification that the family would not be expected to provide to a family member without a disability, be an item that is not part of general maintenance of the home, and be an item or modification that is not part of room and board costs as defined in 55 Pa. Code Chapter 6200. Home modifications consist of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition.

All modifications shall meet the applicable standards of manufacture, design, and installation. Modifications shall be specific to the individual's needs and not be approved to benefit the public at large, staff, significant others, or family members; modifications or improvements to the home that are of general utility are excluded. Modifications not of direct medical or remedial benefit to the individual are excluded.

Modifications to a household subject to funding under the waivers are limited to the following:

- Ramps for street, sidewalk, or house.
- Vertical lifts.
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a "track" in the ceiling for moving an individual with a disability from one location to another.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors, and security systems in their room, home, or other surroundings.
- Outside railing from street to home.
- Widened doorways, landings, and hallways.
- An additional doorway needed to ensure the safe egress of the individual during emergencies, when approved by the ODP Regional Office.
- Swing clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Replacement of glass window panes with a shatterproof or break resistant material for individuals with behavioral issues as noted in the individual's ISP.
- Slip resistant flooring.
- Kitchen counter, major appliance, sink and other cabinet modifications.

- Bathroom modifications to existing bathrooms for bathing, showering, toileting, and personal care needs.
- Bedroom modifications of bed, wardrobe, desks, shelving, and dressers.
- Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.
- Workroom modifications to desks and other working areas.

All adaptations to the household shall be provided in accordance with applicable building codes. This service may not be furnished to adapt homes that are owned, rented, or leased by a provider agency.

This service must be delivered in Pennsylvania.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is the modification included in the exclusive list in the service definitions for this service?
- Is the modification of direct medical or remedial benefit to the individual?
- Does the modification have a primary benefit to the individual and not the public at large, staff, significant others or families?
- Was there a recommendation obtained from an appropriate professional?
- Do the modifications meet the applicable standards of manufacture, design and installation?
- Are these modifications cost effective?
- Is the modification consistent with the needs of the individual based on an assessment or evaluation?

Service limits:

- Maximum state and federal funding participation is limited to \$20,000 per individual during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new \$20,000 limit can be applied when the individual moves to a new home. In situations of joint custody (as determined by an official court order) or other situations where an individual divides their time between official residences, the adaptations must be allowable services and must be completed within the overall monetary limit of \$20,000.
- Building a new room is excluded.
- Home Accessibility Adaptations may not be used in the construction of a new home.
- Durable medical equipment, as defined by 55 Pa. Code Chapter 1123 and the MA State Plan, is excluded. Some examples include, but are not limited to: walkers, wheelchairs, hospital beds and mattresses. The waivers will not cover variations of items considered durable medical equipment that are used primarily for the comfort or convenience of the individual such as specialized strollers.
- Home Accessibility Adaptations are limited to individuals residing in private homes and family living homes that are privately owned, rented, or leased by the host family.
- Home modifications that the family would be expected to provide to a family member without a disability are excluded.

- Items or modifications that are part of room and board costs are excluded.
- Adaptations that add to the total square footage of the home are excluded from this benefit. The only exceptions are those adaptations to bathrooms that are necessary to accommodate a wheelchair.
- Modifications or improvements to the home that are of general utility are excluded.
- Modifications must increase accessibility and must not be restrictive.
- Modifications not of direct benefit to the individual are excluded.

✍ SC documentation requirements:

- The SC will document in the *Physical Development* field, the adaptation, the purpose of the adaptation, the cost of the adaptation and the formal/informal assessment that identifies the individual's need for the adaptation.
- The SC should document how the modification will be used when there are multiple qualified providers supporting the person.

The procedure code and service unit for Home Accessibility Adaptations Services:

Provider Type **55** - Vendor
Specialty **543**, Environmental Accessibility Adaptations

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDS may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 12-Home

Procedure Code	Service Level	Service Description	Service Unit
W7279*	Home Accessibility Adaptations	Adaptations to homes for improved access and/or safety for individuals with an intellectual disability. Maximum limit for home adaptations is \$20,000 per individual for a 10-year period. A new \$20,000 limit can be applied when the individual moves to a new home or when the individual transfers to a different intellectual disability waiver.	Outcome based

Section 13.8: Homemaker/Chore Services

Homemaker services consist of services to enable the individual or the family member(s) or friend(s) with whom the individual resides to maintain their primary private home. This service can only be provided when a household member is temporarily absent or unable to manage the home, or when no landlord or provider agency staff is responsible to perform the homemaker activities. This service can only be provided in the following situations:

- Neither the individual, nor anyone else in the household, is capable of performing and financially providing for the function; and
- No other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision.

Chore services consist of heavy household activities such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; ice, snow, and/or leaf removal; and yard maintenance. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Maintenance in the form of upkeep and improvements to the individual's home is excluded from federal financial participation.

This service must be delivered in Pennsylvania in the individual's private home.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is there any other household member who manages the home or provides homemaker activities?
- Is the individual, family member, friend or anyone else in the household capable of performing or financially providing for the function?
- Is any other relative, caregiver, landlord, community/volunteer agency or third party payer capable of or responsible for their provision?
- Financial inability to provide homemaker/chore services can be calculated at the same threshold as waiver services (at or less than 300% of the Social Security Income maximum with less than \$8,000 in resources).

Service limits:

- This service is limited to 40 hours per individual per fiscal year when the individual or family member(s) or friend(s) with whom the individual resides is temporarily unable to perform and financially provide for the homemaker/chore functions.
- A person is considered permanently unable when the condition or situation that prevents him or her from performing and financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform and financially provide. There is no limit when the individual lives independently or with family member(s) or friend(s) who are permanently unable to perform and financially provide for the homemaker/chore functions.

- A person is considered permanently unable when the condition or situation that prevents him or her from performing and financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform and financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the ISP. The ISP team's determination should be documented in the ISP.
- Services are not available to individuals residing in agency owned, rented, leased or operated homes.
- Services do not include maintenance in the form of upkeep and improvements to the individual's residence.

SC documentation requirements:

- Homemaker/Chore services: The ISP team must determine, and the SC will document in the *Outcome Summary Section* of the ISP, whether a person is temporarily or permanently unable to perform or financially provide for the homemaker functions. See the service limits section for more guidance.
- Homemaker services: The SC will document what the homemaker will be doing and continue to monitor that the tasks are occurring.
- Chore services: The SC will document what the chore service provider will be doing and continue to monitor that the tasks are occurring.
- For rental properties, the SC should examine the lease agreement and document any findings of that examination.

The procedure code and service unit for Homemaker/Chore Services:

Provider Type **51** - Home & Community Habilitation

Specialties: **431** - Homemaker/Chore Services; **430** - Homemaker Services

Provider Type **54** - Intermediate Services Organization

Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old;

Base Funding: 0 – 120 years old

Allowable Place of Service: 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7283*	UA	Homemaker / Chore (Temporary)	Indirect services including household cleaning and maintenance and homemaker activities. This service may only be provided when the individual, or	Hour

			anyone else in the household, is temporarily incapable of physically performing and financially providing for the function; and no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. This service is limited to 40 hours per fiscal year for temporary situations.	
W7283*		Homemaker / Chore (Permanent)	Indirect services including household cleaning and maintenance and homemaker activities. This service may only be provided when the individual, or anyone else in the household, is permanently incapable of physically performing and financially providing for the function; and no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. There is no limit to the service when the individual lives independently or the caregiver is permanently unable to perform and financially provide for the functions.	Hour

Provider Type **54**, Intermediate Service Organization
Specialty **540**, ISO-Agency With Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W7283	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage.	15 minutes

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – UA
- 2nd – U4

Section 13.9: Licensed Day Habilitation

Licensed Day Habilitation is a direct service (face-to-face) that consists of supervision, training, and support in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development.

The service also includes transportation that is an integral component of the service; for example, transportation to a community activity. The Licensed Day Habilitation provider is not, however, responsible for transportation to and from an individual's home.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Determining the need for Services:

The team must address the following additional question when determining the extent to which Licensed Day Habilitation services are necessary and appropriate:

- Does this individual need to have supervision, training and support during the day to learn a skill or participate in an activity?
- Individual needs are related to the Licensed Day Habilitation general skill areas listed above and are most appropriately addressed through day habilitation services rather than a prevocational or vocational service.

Service Limits:

- When Licensed Day Habilitation services are provided alone or in conjunction with Prevocational, Transitional Work or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- Licensed Day Habilitation may not be provided at the same time as any of the following: Companion services, the direct portion of Supported Employment, Home and Community Habilitation, Prevocational services and Transitional Work services.
- The use of enhanced levels of service is based on the individual's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.
- Licensed Day Habilitation services must be provided in a licensed setting. However, this does not preclude the Licensed Day Habilitation provider from taking individuals into the community to provide the service.
- The Licensed Day Habilitation provider is responsible to provide 1:1 or 2:1 staffing or 1:1 or 2:1 enhanced staffing as authorized in the ISP. Needed staffing may not be provided by the individual's residential habilitation staff, Home and Community Habilitation (Unlicensed) provider, or other non-day habilitation providers, and may not be used to supplement the Licensed Day Habilitation service. The continued need for enhanced staffing should be reviewed in accordance with the timeframe set forth in the ISP and annually as part of the ISP process.

✍ SC documentation requirements:

- The SC shall use the ISP review checklist to determine if Licensed Day Habilitation services are needed at a 1:1 or 2:1 staffing ratio.

The procedure codes, modifiers, and service units for Licensed Day Habilitation at an Adult Training Facility:

Provider Type **51** - Home & Community Habilitation
Specialty **514** - Adult Training-2380

Age Limits & Funding:
Consolidated & P/FDS Waivers: 18-120 years old;
Base Funding: 18-120 years old
Allowable Place of Service: 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7072		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7073		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7074		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7075		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7076		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7035		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7036		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1 with staff members who are degreed.	15 minutes
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies	

			that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	
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Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD or TE
- 2nd - U1

The procedure code and service unit for Licensed Day Habilitation in an Older Adult Daily Living Centers:

Provider Type **51** - Home & Community Habilitation
Specialty **410** - Adult Day Services

Age Limits & Funding:
Consolidated & P/FDS Waivers: 18-120 years old;
Base Funding: 18-120 years old
Allowable Place of Service: 99-Other (Community)

Procedure Code	Allowable Modifier	Service Level	Service Description	Service Unit
W7094		Licensed Day Habilitation Services – Older Adult Daily Living Centers (6, Pa. Code Chapter 11)	This service is made available to individuals with an intellectual disability in licensed Older Adult Daily Living Centers.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.10: Nursing

49 Pa. Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing:

"Diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Determining the need for services:

The following additional questions should be used to establish a determination of need:

- Does this individual have an unstable airway that without immediate intervention could cause respiratory arrest (stop breathing)?
- Does this individual need clinical treatment that either requires the presence of a nurse or that can be taught to a lay person and monitored by a nurse?
- Does this individual have someone supporting him or her that can be taught treatment techniques and maintain equipment and service in a home program?
- Is the service appropriate for nursing? The changing of new tracheostomy and gastrostomy tubes requires treatment by a health care practitioner (physician, physician's assistant, certified nurse practitioner) and not a nurse.
- Can care be safely and effectively administered in the home setting and can life-supporting equipment be managed?
- Does the nursing documentation support the continued need for this service? The need for the service must be evaluated on a periodic basis, at least annually, as part of the ISP process. This evaluation must review whether the service continues to produce a positive result for the individual.

Service limit:

- The service must be provided by a licensed registered nurse (RN) or a licensed practical nurse (LPN).
- Home Biphasic Intermittent Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP) do not require nursing presence.
- Extended state plan nursing services can only be provided to adults (individuals age 21 and older).

- Children aging out of EPSDT (reaching their 21st birthday) and receiving home health services will be assessed for their current service needs through the waivers. They will not automatically receive nursing services through ODP.
- Children aging out of the school system (IDEA) and receiving nursing services must be re-evaluated for service needs.

✍️ SC documentation requirements:

- An evaluation indicating the need for Nursing services, specifying the need for services by a RN or a LPN.
- The supports to be provided by each nursing professional must be determined to arrive at the appropriate units of service.
- Documentation, including the most recent nursing care plan, from the nursing service provider to confirm that nursing care continues to be appropriate.
- An emergency action and transportation plan consistent with the individual's condition is present prior to the beginning of service.
- Document how Nursing services support the individual's Outcome Statement in the Outcome Actions.
- Nursing services may only be funded for adults through the waivers if documentation is secured by the SC that shows the service is medically necessary (i.e functions that can only be provided by a registered nurse or licensed practical nurse) and there is documentation of one of the following: the nursing service is not covered by the individual's insurance, nursing services have been denied by the insurance carrier or insurance limitations for nursing services have been reached. While written documentation from insurance carriers of limitations, lack of coverage for services and denials must be requested; ODP will also accept the following documentation when insurance carriers decline to provide written documentation:
 - A copy of the policy or some other written statement documenting that the service, item or amount requested exceeds the allowable service limit or that the service is not covered.
 - Individuals who are adults are not entitled to private duty nursing/shift nursing through the Medical Assistance program's fee-for-service or managed care delivery systems. The Medical Assistance program's Adult Benefit Package Chart indicates that home health care is the only service available in the individual's home with a nursing and/or therapy component. This chart is available at the end of OMAP Bulletin 99-15-05 which can be accessed at http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf. This chart should be printed and kept in each individual's file as documentation that private duty nursing/shift nursing is not available for individuals 21 years of age and older.
 - Written confirmation of information received verbally from an insurance carrier should the insurance carrier decline to send a denial letter is acceptable only when it: a) is sent to the insurance carrier, b) identifies the item or service in question, and c) requests that the insurance carrier advise the writer of any inaccuracy.

The procedure code, modifiers, and service units for Nursing Services:**Nursing Services--RN**

Provider Type **16** - Nurse
Specialty **160** - Registered Nurse

Provider Type **05** - Home Health
Specialty **051** - Private Duty Nursing

Age Limits & Funding:
Consolidated & P/FDS Waivers: 21-120 years old;
Base Funding: 3-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2025	TD	Nursing Service – RN	This service consists of Nursing services within scope of practice.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code and modifier above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD
- 2nd - U1

Nursing Services--LPN

Provider Type **16** - Nurse
Specialty **161** - Licensed Practical Nurse

Provider Type **05** - Home Health
Specialty **051** - Private Duty Nursing

Age Limits & Funding:
Consolidated & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2025	TE	Nursing Service – LPN	This service consists of Nursing services within scope of practice.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code and modifier above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TE

2nd - U1

Section 13.11: Residential Habilitation Services (Licensed) Consolidated Waiver

These are direct (face-to-face) and indirect services provided to individuals who live in licensed and unlicensed provider owned, rented/leased, or operated (i.e. licensed and unlicensed Family Living homes) residential settings. Residential Habilitation services are provided to protect the health and welfare of individuals who reside at the residential setting by assisting them in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Services consist of support in the general areas of self-care, communication, fine and gross motor skills, mobility, personal adjustment, relationship development, socialization, and use of community resources. Residential Habilitation may be provided up to 24 hours a day based on the individual's needs.

This service also includes transportation services that are necessary to enable the individual to access services and resources outlined in the ISP, including transportation to and from day or employment services. The Residential Habilitation provider is not responsible for transportation services for which another provider is responsible.

Residential Habilitation services may not be provided in Personal Care Homes licensed by the Department (55 Pa. Code Chapter 2600). Residential Habilitation services may only be provided in Domiciliary Care Homes if the home is licensed by the Department (55 Pa. Code 6400, 6500, 5310 and 3800) and is certified by the local Area Agency on Aging (6 Pa. Code Chapter 21).

The residential home must be located in Pennsylvania, and must be one of the following eligible settings:

1. Child Residential Services (the residential section of 55 Pa. Code Chapter 3800, Child Residential and Day Treatment Facilities).
2. Community Residential Rehabilitation Services for the Mentally Ill (CRRS), (55 Pa. Code Chapter 5310)
3. Family Living Homes (55 Pa. Code Chapter 6500)
4. Community Homes for Individuals with an Intellectual Disability (55 Pa. Code Chapter 6400)
5. Unlicensed Residential Habilitation
 - 55 Pa. Code §6400.3(f)(7) (for Community Homes), excludes community homes that serve three or fewer individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct staff contact per week per home; or
 - 55 Pa. Code §6500.3(f)(5) (for Family Living Homes) excludes Family Living Homes that provide room and board for one or two individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct training and assistance per week per home from the Family Living Provider agency.

All residential habilitation settings in which Residential Habilitation services are provided must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. To meet this requirement, the location of each residential habilitation setting must be separate from any other ODP-funded residential habilitation setting and must be dispersed in the community and not surrounded by, other ODP-funded residential habilitation settings. Locations that share only one common party wall are not considered contiguous. Residential habilitation settings where Residential Habilitation services are provided should be located in the community and surrounded by the general public. New residential

habilitation settings or changes to existing residential habilitation settings must be approved by ODP or its designee utilizing the ODP residential habilitation setting criteria.

Residential Habilitation services must be delivered in Pennsylvania. During temporary travel, however, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Additional Service Definition Clarification:

Residential Habilitation service providers, the individual and ISP team can consider the following to best meet the individual's transportation needs in the most cost-effective manner:

- Continue providing or begin providing transportation by use of agency staff and agency vehicles.
- Continue to subcontract with the current transportation entity that meets the qualification criteria and has been providing the transportation to the individual.
- Establish a subcontract with a transportation entity that meets the qualification criteria (if the AE was paying separately for transportation in a separate contract).
- Ensure that individuals who are eligible for or are currently accessing other transportation services, such as Medical Assistance Transportation Program, city and regional transportation, and the like, continue to access those services.
- Explore the use of other generic public transportation services with the cost paid by the Residential Habilitation service provider.
- Explore natural supports.

Determining the need for the service:

- This service is authorized as a day unit. A day is defined as a period of a minimum of 12 hours of non-continuous care rendered by a residential habilitation provider within a 24-hour period beginning at 12:00 a.m. and ending at 11:59 p.m. The exception to this rule, effective July 1, 2015, occurs when an individual is admitted to a hospital or nursing facility. When this occurs the residential habilitation provider may not bill for the day the individual is admitted regardless of how many hours of care the residential habilitation provider has rendered during the 24-hour period. When an individual is discharged from a hospital or nursing facility the residential habilitation provider may bill for the discharge day of service regardless of how many hours of care the residential habilitation provider has rendered during the 24-hour period.

Service limits:

- Prior to Residential Habilitation services being authorized, the SC and ISP team and AE must utilize the ODP Residential Habilitation service criteria.
- Residential Habilitation services are only available for individuals who are enrolled in the Consolidated Waiver.
- The following services may not be authorized for individuals who receive Residential Habilitation Services: Companion, Transportation, Homemaker/Chore, Supports Broker, Specialized Supplies and Home and Vehicle Accessibility Adaptations. The only exceptions are:
 - Home and Vehicle Accessibility Adaptations that may be authorized for individuals residing in licensed and unlicensed family living homes when the home or vehicle being adapted and utilized by the individual is not owned, rented or leased by the family living provider agency.

- Supports Broker services may be provided for individuals in a waiver residential habilitation setting when the individual has a plan to transition from a residential setting to a private residence, and has a plan to self-direct their services through an AWC or VF/EA FMS once they are in a private residence.
- Licensed residential habilitation may not include other home and community services, for example, discrete Physical Therapy or Nursing. These other services must be included separately on the individual's ISP.

SC documentation requirements:

- SCs should review and check off the sections in the ISP checklist that pertain to the residential habilitation service criteria and one person home setting size guidelines if applicable.
- SCs are required to document planned therapeutic and medical leave days in the ISP through an Outcome action related to the residential service in the frequency and duration of the actions needed field. The information on the service details page of the ISP should reflect the total number of residential habilitation days, including therapeutic and medical leave. The SC should update the ISP through a general update as a result of planned or unplanned therapeutic and/or medical leave, and indicate any changes resulting from the leave.

Child Residential Services

Child Residential Services (The residential section of 55 Pa. Code Chapter 3800, Child Residential and Day Treatment Facilities): The 55 Pa. Code Chapter 3800 services that may be funded through the waiver are limited to residential service settings. Child residential services provided in secure settings, detention centers, mobile programs, outdoor programs, and residential treatment facilities accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) may not be funded through the Waiver.

The procedure codes and service units for Licensed Residential Habilitation—Child Residential Services:

Provider Type **52** - Community Residential Rehabilitation
Specialty **520** - Child Residential Services - 3800

Age Limits & Funding:
Consolidated Waiver: 3-21 years old;
Base Funding: 0-21 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7010		One-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a one-individual home.	Day
W7011		One-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a one-individual home.	Day

W7012		Two-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a two-individual home.	Day
W7013		Two-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a two-individual home.	Day
W7014		Three-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a three-individual home.	Day
W7015		Three-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a three-individual home.	Day
W7016		Four-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a four-individual home.	Day
W7017		Four-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a four-individual home.	Day
W7018		Five-to-Eight-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a five-to-eight-individual home.	Day
W7019		Five-to-Eight-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a five-to-eight-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Community Residential Rehabilitation Services for the Mentally III

Community Residential Rehabilitation Services for the Mentally III (CRRS), (55 Pa. Code Chapter 5310): CRRS are characterized as transitional residential programs in community settings for individuals with chronic psychiatric disabilities. This service is full-care CRRS for individuals age 18 and older with an intellectual disability and mental illness. Full-care CRRS is a program that provides living accommodations for individuals who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. Host homes, as defined in section 5310.6 are excluded.

The procedure codes and service units for Licensed Residential Habilitation— Community Residential Rehabilitation Services for the Mentally III:

Provider Type **52** - Community Residential Rehabilitation
Specialty **456** - CRR-Adult

Age Limits & Funding:

Consolidated Waiver: 18 – 120 years old;

Base Funding: 18 - 120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7020		One-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a one-individual home.	Day
W7021		One-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a one-individual home.	Day
W7022		Two-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a two-individual home.	Day
W7023		Two-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a two-individual home.	Day
W7024		Three-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a three-individual home.	Day
W7025		Three-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a three-individual home.	Day
W7026		Four-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a four-individual home.	Day
W7027		Four-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a four-individual home.	Day
W7028		Five-to-Eight-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a five-to-Eight individual home.	Day
W7029		Five-to-Eight-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a five-to-Eight-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Family Living Homes

Family Living Homes (55 Pa. Code Chapter 6500): Family Living Homes are somewhat different than other licensed homes as these settings provide for life sharing arrangements. Individuals live in a host life sharing home and are encouraged to become contributing members of the host life sharing unit. The host life sharing arrangement is chosen by the individual, his or her family and ISP team, the life sharing host, and Family Living Provider Agency in accordance with the individual's needs. Licensed Family Living Homes are limited to homes in which one or two individuals with an intellectual disability who are not family members or relatives of the life sharing host reside. The primary life sharing host caregiver is able to receive relief based on the needs of the individual and caregiver.

The procedure codes and service units for Licensed Residential Habilitation—Family Living Homes (Adult):

Provider Type **52** - Community Residential Rehabilitation
Specialty **522** - Family Living Homes - 6500

Age Limits & Funding:

Consolidated Waiver: 18 - 120 years old;

Base Funding: 18 - 120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
		Adult Family Living		
W7291		One-Individual Home, Eligible	The eligible portion of the licensed family living provided in a one-individual home.	Day
W7292		One-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a one-individual home.	Day
W7293		Two-Individual Home, Eligible	The eligible portion of the licensed family living provided in a two-individual home.	Day
W7294		Two-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a two-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Licensed Residential Habilitation—Family Living Homes (Child)

Provider Type **52** - Community Residential Rehabilitation
Specialty **522** - Family Living Homes - 6500

Age Limits & Funding:

Consolidated Waivers: 3 - 21 years old;

Base Funding: 0 - 21 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
		Child Family Living		
W7295		One-Individual Home, Eligible	The eligible portion of the licensed family living provided in a one-individual home.	Day
W7296		One-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a one-individual home.	Day
W7297		Two-Individual Home, Eligible	The eligible portion of the licensed family living provided in a two-individual home.	Day
W7298		Two-Individual Home, Ineligible	The ineligible portion of the licensed family living provided in a two-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Community Home Services for Individuals with an Intellectual Disability

Community Homes for Individuals with Intellectual Disability: A licensed Community Home is a home licensed under 55 Pa. Code Chapter 6400 where services are provided to individuals with an intellectual disability. A community home is defined in regulations as, "A building or separate dwelling unit in which residential care is provided to one or more individuals with intellectual disability...." For Community Homes, services may be provided up to the approved program capacity of the home. Approved program capacity is established by ODP for each licensed service location based on the maximum number of individuals who may be authorized to receive services at that service location. There may be situations in which a site's licensed capacity is greater than the approved program capacity. In these situations, the site may only provide residential habilitation services up to the approved program capacity.

The procedure codes and service units for Licensed Residential Habilitation in Community Homes:

Provider Type **52** - Community Residential Rehabilitation
Specialty **521** - Adult Residential - 6400

Age Limits & Funding:

Consolidated Waiver: 3 - 120 years old;

Base Funding: 0 - 120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W6090		One-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a one-individual home.	Day
W6091		One-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a one-individual home.	Day
W6092		Two-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a two-individual home.	Day
W6093		Two-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a two-individual home.	Day
W6094		Three-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a three-individual home.	Day
W6095		Three-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a three-individual home.	Day
W6096		Four-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a four-individual home.	Day
W6097		Four-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a four-individual home.	Day
W6098		Five-to-Eight-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a five-to-eight-individual home.	Day
W6099		Five-to-Eight-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a five-to-eight-individual home.	Day
	UA	Semi Independent Living Modifier	The provision of the licensed residential service provided in a semi-independent living home as defined by 55 Pa. Code §6400.271-275.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a	

			contract being created in HCSIS for the service with the U1 modifier.	
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Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – UA

2nd - U1

Section 13.12: Residential Enhanced Staffing (Add-ons to the Residential Habilitation Service)

Residential Enhanced Staffing may be utilized for individuals receiving Residential Habilitation Services. There are three possible add-ons to the Residential Habilitation Service based on the assessed need(s) of the individual:

- The provision of the Residential Habilitation Service by licensed nurses for individuals living in licensed and unlicensed residential habilitation settings. The need for an enhanced level of service must be due to the individuals need for staff that is licensed nurses;
- The provision of Supplemental Habilitation staffing may be provided as part of the Residential Habilitation Service for individuals living in licensed residential habilitation settings , to meet the temporary medical or behavioral needs of the individuals when those needs cannot be met as a part of the usual residential habilitation staffing pattern; and/or
- Additional Individualized Staffing may be provided as a part of the Residential Habilitation Service for individuals living in licensed residential habilitation settings to meet the long-term individualized staffing needs of the individual when those needs cannot be met as a part of the usual residential habilitation staffing pattern.

Determining the need for Services:

The determination of need is specific for each residential enhanced staffing:

- For short-term Supplemental Habilitation staff, the team must identify the initial need supported by the recommendations of appropriate professionals.
- The continued need for residential enhanced staffing should be reviewed in accordance with the timeframes set forth in the ISP and annually as part of the ISP process.

Service Limits:

- Residential Enhanced Staffing through Supplemental Habilitation or Additional Individualized Staffing must be prior authorized by ODP.
- If the residential habilitation service is provided by licensed nurses, the individual's ISP must accurately reflect the residential habilitation service by including the correct procedure code for the enhanced staffing component eligible costs. Procedure codes for the ineligible costs of the residential habilitation service will not include the nursing modifiers.

SC documentation requirements

- All requests for prior authorization of waiver-funded Supplemental Habilitation or Additional Individualized Staffing, are completed by using the ISP review Checklist.
- Supplemental Habilitation is used to temporarily meet the **short-term** unique *behavioral* or *medical* needs of an individual who resides in a Consolidated Waiver-Funded licensed residential habilitation setting.
- Supplemental Habilitation may be authorized for a maximum of 12 consecutive calendar months.

- The individual's ISP must include both a Consolidated Waiver-Funded licensed residential habilitation procedure code and Supplemental Habilitation procedure code.
- Permanent or long-term needs should be met through Additional Individualized Staffing which meets the unique **long-term** additional individualized staffing needs of an individual who resides in a Consolidated Waiver-Funded licensed residential habilitation setting when the individual's staffing needs can no longer be met as part of the regular and routine licensed residential habilitation staffing pattern.
- The individual's ISP must include both the Consolidated Waiver-Funded licensed Residential habilitation service and the Additional Individualized Staffing procedure codes.
- Prior authorization requests for Supplemental Habilitation or Additional Individualized Staffing waiver funded services should be made in a timely manner. ODP will only approve these services retroactively for a period no longer than 30 calendar days from the date the ODP regional office receives the request. After receiving an e-mail notification from the provider that there is a need for Supplemental Habilitation or Additional Individualized Staffing services, the SC will convene the ISP team to discuss the need for these services and document the meeting in a service note.
- All other service provided by the residential provider must be included on the ISP as a separate service and billed discretely. The provider must be qualified to deliver each discrete service.

The procedure codes, modifiers, and service units for Residential Enhanced Staffing by a Nurse:

Provider Type **52** – Community Residential Rehabilitation

Specialties: **520** - Child Residential Services – 3800; **456** - CRR-Adult; **522** - Family Living Homes-6500; **521** - Adult Residential-6400; **524** - Unlicensed

Age Limits & Funding:

Consolidated Waiver - Age is based on the applicable residential habilitation service

Base Funding - Age is based on the applicable residential habilitation service

Allowable Place of Service: 12-Home; 99-Other (Community)

Allowable Modifiers	Service Level	Service Description	Service Unit
TD (For habilitation provided by RNs)	Nursing Modifier	The provision of habilitation by nursing staff due to medical needs of the individual. To bill this service, the modifier can be used in concert with the procedure code for the eligible portion of the residential habilitation service.	Day
TE (For habilitation provided by LPNs)			
U1		Enhanced Communication Service – The provision of habilitation by nursing staff who are proficient in Sign Language due to the medical and communication needs of the individual. To bill this service, the	

		modifier can be used in concert with both the procedure code for the eligible portion of the residential habilitation service and the modifier for habilitation by nursing staff. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	
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Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd - U1

Supplemental Habilitation (Licensed Residential Habilitation Services only).

The individual's ISP must reflect the licensed Residential Habilitation Service and the Supplemental Habilitation procedure codes.

The procedure codes and service unit for Supplemental Habilitation:

Provider Type **52** – Community Residential Rehabilitation

Specialties: **520** - Child Residential Services – 3800; **456** - CRR-Adult; **522** - Family Living Homes-6500; **521** - Adult Residential-6400

Age Limits & Funding:

Consolidated Waivers: 3-120 years

Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7070		Supplemental Habilitation	The provision of 1:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the short-term unique behavioral or medical assessed needs of the individual.	15 Minutes
W7084		Supplemental Habilitation	The provision of 2:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the short-term unique behavioral or medical assessed needs of the individual.	15 Minutes
	U1		Enhanced Communication Service –This modifier can be utilized with all of the Waiver Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Additional Individualized Staffing (Licensed Residential Habilitation Services Only).

The individual's ISP must reflect the licensed Residential Habilitation Services and the Additional Individualized Staffing procedure codes.

The procedure codes and service units for Additional Individualized Staffing:

Provider Type **52** - Community Residential Rehabilitation

Specialties: **520** - Child Residential Services – 3800; **456** - CRR-Adult; **522** - Family Living Homes-6500; **521** - Adult Residential-6400

Age Limits & Funding:

Consolidated Waivers: 3-120 years

Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7085		Additional Individualized Staffing 1:1	The provision of 1:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the unique long-term needs of the individual.	15 Minutes
W7086		Additional Individualized Staffing 2:1	The provision of 2:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the unique long-term needs of the individual.	15 Minutes
	U1		Enhanced Communication Service –This modifier can be utilized with all of the Waiver Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.13: Residential Habilitation Services (Unlicensed) - Consolidated Waiver Only

Unlicensed Residential Habilitation may be provided to individuals who live in unlicensed provider-owned, rented, leased or operated homes:

- 55 Pa. Code §6400.3(f)(7) (for Community Homes), excludes community homes that serve three or fewer individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct staff contact per week per home; or
- 55 Pa. Code §6500.3(f)(5) (for Family Living Homes) excludes Family Living Homes that provide room and board for one or two individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct training and assistance per week per home from the Family Living Provider agency.

Determining the need for services:

This service is authorized as a day unit. Effective July 1, 2015, the unlicensed residential habilitation provider may not bill for the day that an individual is admitted to a hospital or nursing facility. The provider may bill for the day that the individual is discharged from the hospital or nursing facility.

The team must address the following additional questions:

- Does the individual require habilitation provided in a residential setting?
- Would the setting the individual needs comply with the exemption from licensure set forth in 55 Pa. Code Chapters 6400.3 or 6500.3?

Service limits:

- Prior to Residential Habilitation Services being authorized, the SC and ISP team and AE must utilize the ISP review checklist, which includes the ODP Residential Habilitation service criteria.

SC documentation requirements:

- Document information on the ISP review checklist.
- SCs are required to document planned therapeutic and medical leave days in the ISP through an Outcome action related to the residential service in the Frequency and duration of the actions needed field. The information on the service details page of the ISP should reflect the total number of residential habilitation days, including therapeutic and medical leave. The SC should update the ISP through a general update as a result of planned or unplanned therapeutic and/or medical leave, and indicate any changes resulting from the leave.

The procedure codes and service units for Unlicensed Residential Habilitation Services in Community Homes:

Provider Type **52** - Community Residential Rehabilitation
Specialty **524** - Unlicensed

Age Limits & Funding:

Consolidated: 3–120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7078		One-Individual Home, Eligible	The eligible portion of the unlicensed community Residential Habilitation Service provided in a one-individual home.	Day
W7079		One-Individual Home, Ineligible	The ineligible portion of the unlicensed community Residential Habilitation Service provided in a one-individual home.	Day
W7080		Two-Individual Home, Eligible	The eligible portion of the unlicensed community Residential Habilitation Service provided in a two-individual home.	Day
W7081		Two-Individual Home, Ineligible	The ineligible portion of the unlicensed community Residential Habilitation Service provided in a two-individual home.	Day
W7082		Three-Individual Home, Eligible	The eligible portion of the unlicensed community Residential Habilitation Service provided in a three-individual home.	Day
W7083		Three-Individual Home, Ineligible	The ineligible portion of the unlicensed community Residential Habilitation Service provided in a three-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

The procedure codes and service units for Unlicensed Residential Habilitation in Family Living Homes:

Provider Type **52** - Community Residential RehabilitationSpecialty **524** - Unlicensed

Age Limits & Funding:

Consolidated: 3 – 120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7037		One-Individual Home, Eligible	The eligible portion of the unlicensed family living provided in a one-individual home.	Day
W7038		One-Individual Home, Ineligible	The ineligible portion of the unlicensed family living provided in a one-individual home.	Day
W7039		Two-Individual Home, Eligible	The eligible portion of the unlicensed family living provided in a two-individual home.	Day
W7040		Two-Individual Home, Ineligible	The ineligible portion of the unlicensed family living provided in a two-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.14: Respite

Respite services are direct services that are provided to supervise and support individuals living in private homes on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work.

The provision of Respite services does not prohibit supporting individuals' involvement in activities in the community during the period of respite. The provision of 24-hour Respite Services does not prohibit individuals' involvement in Day and Employment services.

Individuals can receive two categories of Respite Services: 24-hour respite and 15-minute respite. 24-hour respite is provided for periods of more than 16 hours, and is billed using a daily unit. 15-minute respite is provided for periods of 16 hours or less, and is billed using a 15-minute unit. Please see the following section for limitations on these services.

Room and board costs are included in the fee schedule rate solely for Respite provided in a licensed residential setting or in camp settings that are licensed or accredited. There may not be a charge for room and board to the participant for Respite that is provided in a licensed residential setting or in camp settings that are licensed or accredited.

Respite Services may only be provided in the following location(s):

- Individual's private home or place of residence located in Pennsylvania.
- Licensed Family Living Home (55 Pa. Code Chapter 6500) located in Pennsylvania.
- Licensed Community Home (55 Pa. Code Chapter 6400) located in Pennsylvania within the home's approved program capacity. ODP may approve the provision of Respite Services above a home's approved program capacity on a case-by-case basis.
- Licensed Child Residential Service Home (55 Pa. Code Chapter 3800) located in Pennsylvania.
- Licensed Community Residential Rehabilitation Services for the Mentally Ill Home (55 Pa. Code Chapter 5310) located in Pennsylvania.
- Unlicensed home of a provider or a private home that is located in Pennsylvania or a contiguous state.
- Other community settings such as camp where the setting meets applicable state or local codes and the provider of service meets the provider qualifications established by DHS.

When Respite is provided in a licensed residential setting, the settings must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings. Exceptions to these criteria can be requested in accordance with ODP policy.

Respite services may not be provided in Nursing Homes, Hospitals, Personal Care Homes or ICFs/ID.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Determining the need for services:

The team must address the following additional questions when determining the extent to which respite is necessary:

- What are the specific supports the individual needs during respite?
- Has the availability of informal/natural supports been discussed and utilized?
- Is this service necessary due to the caregiver's absence or need for relief?
- Is the level of services provided directly related to the intensity of the physical, behavioral or personal care needs of the individual served and the availability of natural supports?

Service limits:

- Respite services are limited to:
 - Individuals residing in a private home. The only exception is for an emergency circumstance approved by ODP for individuals who receive Residential Habilitation Services.
 - 30 units (days) of 24-hour Respite Services per individual in a period of one fiscal year except when extended by ODP using the standard ODP exception process.
 - 480 (15 minute) units in the Consolidated Waiver and 1440 (15 minute) units in the P/FDS Waiver per individual in a period of one fiscal year except when extended by ODP using the DP #1023 Request for exception to established service limits or maximum number of service units.
- The number of units on an ISP may not go over the service unit limitations indicated in the service definitions without ODP prior approval.
- Respite may be provided in hospitals and nursing homes only with base funding under Base Funded Respite Care.
- Waiver-funded licensed 6400 community homes may provide respite in a vacant bed within the established approved program capacity without ODP approval. On a case-by-case basis, ODP may approve the provision of respite services above a service location's approved program capacity and the provision of respite to a waiver individual in a non-waiver funded licensed residential setting for emergency situations only. Written emergency approval to provide respite services must be obtained from the ODP regional Waiver Capacity Manager (WCM) before the provision of respite occurs using DP # 1037 *Request for provision of emergency respite services*.
- If Respite in a non-waiver funded licensed residential setting is being considered for a waiver individual, DP#1023 *Request for exception to established service limits or maximum number of service units* must be completed. If approval has already been granted by ODP (via the DP 1037 form for emergency respite, the DP 1023 form need not be completed in its entirety. The AE should note that approval was previously granted and attach that documentation (a copy of the completed DP 1037 form).
- Respite services should not be used to provide scheduled and ongoing services to the individual (this would be either Companion or Home and Community Habilitation services).
- Respite services are not to provide recreational or social opportunities to the individual.

✍ SC documentation requirements:

- The SC will document the assessment upon which the need for service was determined and any specific training (beyond orientation to the individual to be served) and/or skills needed to provide this service.
- Activities expected of the respite provider beyond supervision must be identified in the ISP.

The procedure codes, modifiers, and service units for In-Home Respite – 24 Hour Service:

Provider Type **51** - Home & Community Habilitation

Specialty **512** - Respite Care-Home Based

Provider Type **54** - Intermediate Services Organization

Specialties: **541** - ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(Provider type 51 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7247		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7248		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7250*		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7251*		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7252*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7253*		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	Day

	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type **54** - Intermediate Service Organization
Specialty **540** - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W7250 W7251 W7252 W7253	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage. When a nurse renders the service, the modifier is used after the TD or TE modifier when submitting a claim.	Day
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd - U1

OR

1st – TD or TE

2nd – U4

OR

1st – U4

2nd – U1

When billing for three modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd – U4

3rd – U1

The procedure codes, modifiers, and service units for In-Home Respite – 15 Minute Services:

Provider Type **51** - Home & Community Habilitation
Specialty **512** - Respite Care-Home Based

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(Provider type 51 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below).

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7255		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W7256		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W7258*		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7264*		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7265*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7266*		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service	

			by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	
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Provider Type **54** - Intermediate Service Organization
Specialty **540** - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W7258 W7264 W7265 W7266	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage. When a nurse renders the service, the modifier is used after the TD or TE modifier when submitting a claim.	15 minutes
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD or TE
- 2nd - U1

OR

- 1st – TD or TE
- 2nd – U4

OR

- 1st – U4
- 2nd – U1

When billing for three modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD or TE
- 2nd – U4
- 3rd – U1

The procedure codes, modifiers, and service units for Respite – Unlicensed Out-of-Home, 24 Hours Service:

Provider Type **51** - Home & Community Habilitation
Specialty **513** - Respite Care-Out of Home

Provider Type **54** - Intermediate Services Organization
Specialties: **541** - ISO-Fiscal/Employer Agent; **540** - ISO-Agency with Choice

(Provider type 51 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W8000		Basic Staff Support	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of 1:4.	Day
W8001		Staff Support Level 1	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W8002*		Staff Support Level 2	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1.	Day
W8003*		Staff Support Level 2 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W8004*		Staff Support Level 3	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1.	Day
W8005*		Staff Support Level 3 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1 with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type **54** - Intermediate Service Organization
Specialty **540** - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W8002 W8003 W8004 W8005	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage. When a nurse renders the service, the modifier is used after the TD or TE modifier when submitting a claim.	Day
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD or TE
- 2nd - U1

OR

- 1st – TD or TE
- 2nd – U4

OR

- 1st – U4
- 2nd – U1

When billing for three modifiers for this service they must be listed in the following order for the claim to process correctly:

- 1st – TD or TE
- 2nd – U4
- 3rd – U1

The procedure codes, modifiers, and service units for Unlicensed Out-of-Home Respite – 15 minutes Service:

Provider Type **51** - Home & Community Habilitation
Specialty **513** - Respite Care-Out of Home

Provider Type **54** - Intermediate Services Organization
Specialties: **541** - ISO-Fiscal/Employer Agent; **540** - ISO-Agency with Choice

(Provider type 51 may submit a claim for all the procedure codes listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W8010		Basic Staff Support	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W8011		Staff Support Level 1	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W8012*		Staff Support Level 2	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1.	15 minutes
W8013*		Staff Support Level 2 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W8014*		Staff Support Level 3	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1.	15 minutes
W8015*		Staff Support Level 3 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1 with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type **54** - Intermediate Service OrganizationSpecialty **540** - ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W8012 W8013 W8014 W8015	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage. When a nurse renders the service, the modifier is used after the TD or TE modifier when submitting a claim.	15 minutes
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd - U1

OR

1st – TD or TE

2nd – U4

OR

1st – U4

2nd – U1

When billing for three modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd – U4

3rd – U1

The procedure codes, modifiers, and service units for Respite—Licensed Out-of-home, 24 Hours Services:

Provider Type **51** - Home & Community Habilitation
Specialty **513** - Respite Care-Out of Home

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7259		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7260		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day

W7262		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7263		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7299		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7300		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U2	Respite – Emergency	Emergency Respite rendered in a licensed Waiver-funded 6400 home in which ODP permitted the provision of respite services beyond the approved program capacity of the home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd - U1

OR

1st – TD or TE

2nd – U2

OR

1st – U2

2nd – U1

When billing for three modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE

2nd – U2

3rd – U1

The procedure codes, modifiers, and service units for Licensed Out-of-Home Respite – 15 minutes Services:

Provider Type **51** - Home & Community Habilitation
Specialty **513** - Respite Care-Out of Home

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7267		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W7268		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W7270		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7400		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7401		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7402		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with at least one staff member who has at a minimum a four year degree or who is a licensed nurse. The second staff member must have at least a high school diploma.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for two modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE
2nd - U1

The procedure codes and service unit for Waiver Respite Camp, 24 hours Services:

Provider Type **55** - Vendor
Specialty **554** - Respite, Overnight Camp

Provider Type **54** - Intermediate Services Organization
Specialties: **541** - ISO-Fiscal/Employer Agent; **540** - ISO-Agency with Choice

(A provider agency functioning as an OHCDs may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7285*		Respite – Camp, 24 hours, Eligible	The eligible portion of the Waiver Respite Camp service provided in segments of day units in residential camp settings. Respite Camp Services may not be used for emergency respite situations.	Day
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

The procedure code and service unit for Waiver Respite Camp, 15 minutes Services:

Provider Type **55** - Vendor
Specialty **555** - Respite, Day Camp

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDs may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7286*		Respite – Camp, 15 minutes, Eligible	This Respite Camp service is provided in segments of 16 hours or less in day camp settings. Respite Camp Services may not be used for emergency respite situations.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.15: Specialized Supplies

Specialized Supplies consist of incontinence supplies that are medically necessary and are not a covered service through the MA State Plan, Medicare, or private insurance. Services must be provided under the MA State Plan, Medicare, and/or private insurance plans until the plan limitations have been reached. Supplies are limited to diapers, incontinence pads, cleansing wipes, under pads, and vinyl or latex gloves.

During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy. Refer to the Provider Specification section below for criteria on provider requirements.

Service limits:

- This service is not available to individuals who reside in licensed or unlicensed residential habilitation settings.
- Limited to \$500 per individual per fiscal year.
- The Specialized Supplies service is available for adults (individuals age 21 and older). All medically necessary Specialized Supplies for children under age 21 are covered under Medical Assistance pursuant to the EPSDT benefit.

SC documentation requirements:

- Specialized Supplies may only be funded for adults if documentation is secured by the SC that shows the supplies are medically necessary and either not covered by the individual's insurance or insurance limitations have been reached. An individual's insurance includes Medical Assistance (MA), Medicare and/or private insurance.

The procedure code and service unit for Specialized Supplies:

Provider Type **55** - Vendor
Specialty **553**, Habilitation Supplies

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDs may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 12-Home; 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W6089*	Specialized Supplies	Incontinence supplies not available through the State Plan or private insurance, limited to diapers, incontinence pads, cleansing wipes, under pads, and vinyl or latex gloves. This service is limited to \$500 per individual per fiscal year.	Outcome based

Section 13.16: Supports Broker Services

The Supports Broker service is available to individuals who elect to self-direct their own services utilizing one of the individual directed options outlined in Appendix E-1 of the waiver. The Supports Broker service is designed to assist individuals or their designated surrogate with employer-related functions in order to be successful in self-directing some or all of the individuals needed services.

This service is limited to the following list of activities:

- Explaining and providing support in completing employer-or managing employer related paperwork.
- Participating in FMS orientation and other necessary trainings and interactions with the FMS provider.
- Developing effective recruiting and hiring techniques.
- Determining pay rates for workers.
- Providing or arranging for worker training.
- Developing worker schedules.
- Developing, implementing and modifying a back-up plan for services, staffing for emergencies and/or worker absences.
- Scheduling paid and unpaid supports.
- Developing effective management and supervision techniques such as conflict resolution.
- Developing proper procedures for termination of workers in the VF/EA FMS option or communication with the Agency with Choice regarding the desire for removal of the workers from working with the individual in the AWC FMS option.
- Reviewing of workplace safety issues and strategies for effective management of workplace injury prevention.
- Assisting the individual or their designated surrogate in understanding and/or fulfilling the responsibilities outlined in the Common Law Employer Agreement form and the Managing Employer Agreement form.
- Facilitating a support group that helps to meet the individual's self-direction needs. These support groups are separate and apart from the ISP team meetings arranged and facilitated by the SC.
- Expanding and coordinating informal, unpaid resources and networks within the community to support success with individual direction.
- Identifying areas of support that will promote success with self-direction and independence and share the information with the team and SC for inclusion in the ISPs.
- Identifying and communicating any proposed modifications to the individual's ISP.
- Advising and assisting with the development of procedures to monitor expenditures and utilization of services.
- Complying with the standards, regulations, policies and the waiver requirements related to self-direction.
- Advising in problem-solving, decision-making, and achieving desired personal and assessed outcomes related to the individual directed services.
- When applicable, securing a new surrogate and responding to notices for corrective action from the FMS, SC, AE or ODP.

- All functions performed by a Supports Broker must be related to the personal and assessed outcomes related to the individual directed services in the ISP.

Supports Brokers must work collaboratively with the individual's SC and ISP team. Supports Brokers may not replace the role of, or perform the functions of a SC. The role of the SC continues to involve providing the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists individuals or their designated surrogate with assistance with the above noted functions. No duplicate payments will be made.

Supports Broker Services may be provided by individual and agency providers that provide other waiver or ID services but the Supports Broker provider must be conflict free. In order to be conflict free, the Supports Broker provider may not provide other direct or indirect waiver services or base funded ID services when authorized to provide Supports Broker services to the waiver individual. In addition, Supports Broker providers may not provide administrative services such as HCQU, AE functions or IM4Q Program.

The AWC FMS providers are in a unique circumstance in that they are required to provide the AWC FMS administrative services in addition to all identified individual directed waiver services authorized for an individual who is self-directing and enrolled with the AWC FMS provider. As such, the AWC FMS provider will be able to provide both supports broker services and other individual directed waiver services to the same individual but only as an AWC FMS Provider Type (PT) 54.

The VF/EA FMS is required to provide the VF/EA FMS administrative service and pay for all identified individual directed services authorized for an individual who is self-directing and enrolled with the VF/EA FMS as a PT 54.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Additional Service Definition Clarification

When Supports Broker services are provided in a waiver residential habilitation setting (see below), progress towards transitioning to a private residence should be reviewed on an annual basis to ensure the effectiveness of the service in meeting this goal. Remember that unsuccessful attempts to transition (e.g. a situation where transition plans are made but ultimately fail) are not indicative of lack of progress. However, the absence of transition planning or use of the service to support an individual who plans to remain in a residential habilitation setting is not permitted and does not support ongoing provision of the service. Documentation to this effect should be maintained.

Determining the need for services:

The following additional questions should be used to determine a need for this service:

- The individual, and/or surrogate, is self-directing the individual's services.
- The purpose of the Supports Broker service is to assist the individual and provide training and support, not to actually perform the activities.

- Determine what assistance or support is needed for the individual to perform the managing employer or common law employer functions and define the timeframe and activities to be provided.
- Documentation to support the continued need for service as necessary for service re-authorization (i.e. to train on a new skill or progress demonstrated to date on current Outcome Actions).
- Supports Brokers should assist individuals with the functions and activities utilized to manage or co-manage their support service workers.

Service Limit:

- This service is limited to a maximum of 1040 (15-minute) units per individual per fiscal year based on a 52-week year. This service is limited to individuals who are self-directing their services through an AWC or VF/EA FMS.
- Supports Broker services may be provided for individuals in a waiver residential habilitation setting in the following circumstances:
 - The individual has a plan to transition from a residential setting to a private residence, and
 - The individual has a plan to self-direct their services through an AWC or VF/EA FMS once they are in a private residence.

SC documentation requirements:

- That the individual is or has elected to self-direct services and that each role the Supports Broker will perform is vital to the support of the individual in self-directing those services.
- The specific activities that the Supports Broker will be completing to support the outcome of the service.

The procedure code and service unit for Supports Broker Services:

Provider Type **51** - Home & Community Habilitation
Specialty **509** - , Supports Broker

Provider Type **54** - Intermediate Services Organization
Specialties: **541** - ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(Provider type 51 may submit a claim for the procedure code listed in the box below. In addition, for individuals who self-direct their services, claims may be submitted by provider type 54, specialties 540 and 541 for the asterisked procedure code below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3-120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7096*		Supports Broker Services	Direct and indirect services to individuals who are self-directing their services through either employer authority or budget authority. This service is limited to a maximum of 1,040 units	15 minutes

			or 260 hours per individual per fiscal year based on a 52-week year.	
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Provider Type **54** - Intermediate Service Organization
 Specialty **540**, ISO-Agency with Choice

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Used with W7096	No benefit allowance	This modifier is to be used with the noted procedure code by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage.	15 minutes
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.17: Supports Coordination

Supports Coordination is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for individuals enrolled in a waiver (see requirements in Appendix D). Locating services and supports consists of assistance to the individual and his or her family in linking, arranging for, and obtaining services specified in an ISP, including needed medical, social, habilitation, education, or other needed community services. Activities included under the function of locating services and supports include all of the following, as well as the documentation of the activities:

- Participate in the ODP standardized needs assessment process to inform development of the ISP, including any necessary ISP updates;
- Facilitate the completion of additional assessments, based on individuals' unique strengths and needs, for planning purposes and ISP development in order to address all areas of needs and the individual's strengths and preferences;
- Locate resources for the development of the ISP;
- Assist the individual in identifying people to serve as part of the ISP team, and offer support to invite other people who may contribute valuable information during the planning process;
- Assist the individual and his or her family in identifying and choosing willing and qualified providers;
- Inform individuals about the use of unpaid, informal, generic, and specialized services and supports that are necessary to address the identified needs of the individual and to achieve the outcomes specified in the ISP;
- Provide information to individuals on fair hearing rights and assist with fair hearing requests when needed and upon request; and
- Assist individuals in gaining access to needed services and to exercise their civil rights.

Coordinating consists of development and ongoing management of the ISP in cooperation with the individual, his or her family, members of the ISP team, and providers of service. Activities included under the coordinating function include all of the following, as well as the documentation of the activities:

- Use a person centered planning approach and a team process to develop the individual's ISP to meet the individual's needs in the least restrictive manner possible;
- Use information from the ODP standardized needs assessment, as well as any additional assessments completed based on the unique needs of the individual, to develop the ISP to address all of the individual's needs;
- Periodic review of the ISP with the individual, including update of the ISP at least annually and whenever an individual's needs change;
- Periodic review of the standardized needs assessment through a face-to-face visit with the individual, at least annually or more frequently based on changes in an individual's needs, to ensure the assessment is current;
- Coordinate ISP planning with providers of service to ensure consistency of services;
- Coordinate with other entities, resources and programs as necessary to ensure all areas of the individual's needs are addressed;
- Contact with family, friends, and other community members to facilitate coordination of the individual's natural support network;

- Facilitate the resolution of barriers to service delivery; and
- Disseminate information and support to individuals and others who are responsible for planning and implementation of services.
- Monitoring consists of ongoing contact with the individual and his or her family, to ensure services are implemented as per the ISP. Activities included under the monitoring function include all of the following, as well as the documentation of the activities:
 - Monitor the health and welfare of individuals through regular contacts at the minimum frequency outlined in Appendix D-2-a of the waiver;
 - Monitor ISP implementation through monitoring visits with the individual, at the minimum frequency outlined in Appendix D-2-a of the waiver;
 - Visit with the individual's family, when applicable, and providers of service for monitoring of health and welfare and ISP implementation;
 - Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of individuals;
 - Review individual progress on outcomes and initiate ISP team discussions or meetings when services are not achieving desired outcomes;
 - Monitor individual and/or family satisfaction with services;
 - Arrange for modifications in services and service delivery, as necessary to address the needs of the individual, and modify the ISP accordingly;
 - Ensure that services are identified in the ISP;
 - Work with the authorizing entity regarding the authorization of services on an ongoing basis and when issues are identified regarding requested services;
 - Communicate the authorization status to ISP team members, as appropriate;
 - Validate that service objectives and outcomes are consistent with the individual's needs and desired outcomes;
 - Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and individual rights; and
 - Participate in activities related to Independent Monitoring for Quality, such as obtaining consent to participate from the individual, preparing survey information, and follow up activities ("closing the loop") and other activities as identified by ODP.

In addition to locating, coordinating, and monitoring, Supports Coordination also includes providing information and assistance in order to help individuals transition to the community or, in accordance with Appendix E, decide whether to select individual direction of services, and assistance for individuals who opt to direct services. Activities include all of the following, in addition to the documentation of activities:

- Provide individuals with information on participant direction, including the potential benefits and risks associated with directing services, during the planning process and upon request;
- Assist with the transition to the participant direction service delivery model if the individual is interested in this model, and ensure continuity of services during transition;
- Assist the individual in designating a surrogate, as desired, as outlined in Appendix E-1-f of this Waiver; and
- Provide individuals with the standard ODP information about participant direction, an explanation of the options and the contact information for the Financial Management Services provider.

The following activities are excluded from Supports Coordination as a billable waiver service:

- Outreach that occurs before an individual is enrolled in the waiver;
- Intake for purposes of determining whether an individual has an intellectual disability and qualifies for Medical Assistance;
- Direct Prevention Services, which are used to reduce the probability of the occurrence of an intellectual disability resulting from social, emotional, intellectual, or biological disorders;
- General information to individuals, families, and the public that is not on behalf of a waiver individual, such as school fairs;
- Travel time incurred by the SC may not be billed as a discrete unit of service;
- Services otherwise available under the MA State Plan and other programs;
- Services that constitute the administration of foster care programs;
- Services that constitute the administration of another non-medical program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, and special education;
- Direct delivery of medical, educational, social, or other services;
- Delivery of medical treatment and other specialized services including physical or psychological examinations or evaluations;
- The actual cost of the direct services other than Supports Coordination that the SC links, arranges, or obtains on behalf of the individual;
- Transportation provided to individuals to gain access to medical appointments or direct Waiver services other than Supports Coordination;
- Representative payee functions;
- Conducting Medicaid eligibility certification or recertification, intake processing, Medicaid pre-admission screening for inpatient care, prior authorization for Medicaid services, and Medicaid outreach (methods to inform or persuade individuals to enter into care through the Medicaid system); and
- Assistance in locating and/or coordinating burial or other services for a deceased individual.

During temporary travel Supports Coordination may be provided in Pennsylvania or other locations as per the ODP travel policy.

Service Limits:

- Supports Coordination services may not duplicate other direct waiver services.

The procedure code and service units for Waiver Funded Supports Coordination Services:

Provider Type **21** - Case Manager
Specialty **218**, ID Case Management

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7210	Waiver-Funded Supports Coordination	Locating, coordinating, and monitoring needed services and supports for waiver individuals.	15 minutes

Section 13.18: Therapy Services

Therapy services are direct services provided to assist individuals in the acquisition, retention, or improvement of skills necessary for the individual to live and work in the community, and must be attached to an individual's outcome as documented in his or her ISP. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Therapy services. The need for the service must be documented by a professional as noted above for each service and must be evaluated at least annually, or more frequently if needed, as part of the ISP process. This evaluation must review whether the individual continues to require the current level of authorized services and that the service continues to result in positive outcomes for the individual. It is recognized, however, that long-term Therapy services may be necessary due to an individual's extraordinary medical or behavioral conditions. The need for long-term Therapy services must be documented in the individual's ISP.

Additional Service Definition Clarification

Implementation of a Home Therapy Program can be done by the individual and those people that support the individual. A Home Therapy Program is a set of activities for an individual designed to reach particular goals and taught to the individual and his or her caregivers by a therapist; performed at home by the individual and caregivers on a regular basis (often daily); and monitored by a therapist. Home programs require infrequent, periodic monitoring by the appropriate therapist to assure that progress is being made and that the program continues to be appropriate for the needs of the person. Evaluation, development, training, and monitoring of a home program should be done by the appropriate licensed therapist.

All individual, families and staff share in the responsibility to reinforce independence and skills that the individuals are learning. Successful therapy results require implementation and repetition of the learned skills outside of the therapy sessions.

Service limits:

- Extended state plan therapy services are only available to adult participants (individuals age 21 and older).
- Children aging out of EPSDT (reaching their 21st birthday) or the school system (IDEA) and receiving therapy services must be re-evaluated by a physician, physician's assistant, or certified nurse practitioner to determine his or her need for therapy services. They will not automatically receive therapy services through ODP.

✍️ SC documentation requirements:

- Therapy services may only be funded for adults through the waivers if documentation is secured by the SC that shows the service is medically necessary and there is documentation of one of the following: either the Therapy service is not covered by the individual's insurance, Therapy services have been denied by the insurance carrier or insurance limitations for Therapy services have been reached. An individual's insurance includes Medical Assistance (MA), Medicare and/or private insurance. While written documentation from insurance carriers of limitations, lack of coverage for services and denials must be requested; ODP will also accept the following documentation when insurance carriers decline to provide written documentation:
 - A copy of the policy or some other written statement documenting that the service, item or amount requested exceeds the allowable service limit or that the service is not covered.

- Written confirmation of information received verbally from an insurance carrier should the insurance carrier decline to send a denial letter is acceptable only when it: a) is sent to the insurance carrier, b) identifies the item or service in question, and c) requests that the insurance carrier advise the writer of any inaccuracy.

Behavior Therapy

The treatment, by psychological means, of the problem of an emotional nature in which a licensed psychologist or psychiatrist deliberately establishes a professional relationship with a individual, in an attempt to alleviate or ameliorate the emotional distress disturbances, reverse or change maladaptive patterns of behavioral challenges, and promote positive personality growth and development. Such therapy must take place at the psychologist or psychiatrist's office and may take the form of either individual therapy with the individual and the psychologist or psychiatrist, or group therapy with the individual and other individuals receiving therapy that is supervised and directed by the psychologist or psychiatrist.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does this individual have a clinical diagnosis of a mental illness?
- Has a licensed psychologist or psychiatrist recommended behavioral therapy for this individual based on an evaluation?

Service limits:

- This service can be provided by either a licensed psychologist or psychiatrist.
- Behavior therapy is not Behavioral Support, nor does it include the development of a behavioral support plan.
- Behavior therapy must be listed on the ISP as a discrete service.

SC documentation requirements:

- Mental Health diagnosis made by a clinician.
- Evaluation recommending behavioral therapy.

The procedure code, modifier, and service unit for Behavior Therapy Services:

Provider Type **19** - Psychologist
Specialty **208**, Behavioral Therapist Consultant

Age Limits & Funding:

Consolidated & P/FDS Waivers: 21 - 120 years old;

Base Funding: 0 - 120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2025	HE	Behavior Therapy, Individual	Individual therapy which consists of sessions with the psychologist or psychiatrist designed to increase insight, modify behavior, and provide positive support to the individual to improve social interaction and adjustment.	15 minutes
T2025	HE, HQ	Behavior Therapy, Group	Interactive group psychotherapy consists of group interaction under the supervision and direction of the psychologist or psychiatrist, designed to increase insight, modify behavior and provide positive support for improved social interaction.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for Individual Behavior Therapy the modifiers must be listed in the following order for the claim to process correctly:

- 1st – HE
- 2nd - U1

When billing for Group Behavior Therapy the modifiers must be listed in the following order for the claim to process correctly:

- 1st – HE
- 2nd – HQ
- 3rd – U1

Occupational Therapy

The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows: “The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person’s developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and implementing activity programs to improve sensory and motor functioning at the level of performance for the individual’s stage of development; (2) Teaching skills, behaviors and attitudes crucial to the individual’s independent, productive and satisfying social functioning; (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment; and (4) Analyzing, selecting and adapting activities to maintain the individual’s optimal performance of tasks to prevent disability.”

Occupational Therapy by a registered occupational therapist is based on a prescription for a specific therapy program by a physician.

Determining the need for services:

This service is designed to do the following:

- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring fine motor function.
- Enhance skills that can be incorporated into everyday life for improvement in the independence and performance of Activities of Daily Living (ADLs) or for prevention of the complications of motor disorders.

The following additional questions should be used to establish a determination of need for this service:

- Does the individual have a prescription for this service?
- Is there a formal assessment by an occupational therapist that establishes a need for occupational therapy?
- Does this individual have fine motor limitations?
- Does this individual have a diagnosis of a clinical condition known to have an impact on fine motor skills (e.g. cerebral palsy, hemiplegia or quadriplegia)?
- Does this individual need to work on specific skills in the areas listed above?
- Does this individual need to have regular stretching to prevent contractures because of increased or decreased muscle tone?
- Is this individual capable of, or does he or she have someone supporting him or her who can maintain, working on a home program?
- Does this individual have a degenerative condition that impacts on their fine motor skills and abilities to perform ADLs?
- Does this individual have a feeding problem (dysphasia) and is it safe for the person to eat by mouth?
- Has this individual recently had an injury, stroke, surgery or other occurrence that precipitated the need for therapy? In this case, the therapy may be medically necessary under their health insurance plan (e.g. Access or managed care company).
- How long has the individual been receiving Occupational Therapy?
- How has the individual benefited from Occupational Therapy?
- How are families and staff implementing learned skills outside of the Occupational Therapy sessions?

Service limits:

- Occupational Therapy must be ordered by a healthcare practitioner under the scope of his or her practice. This includes physicians (MDs or Dos), physician's assistants (PAs) or certified registered nurse practitioners (CRNPs). Occupational therapists may not order their own treatment.

 SC documentation requirements:

- Functional limitation in fine motor skills.

- Evaluation of the need for Occupational Therapy.
- Need for Occupational Therapy.
- Ability to benefit from Occupational Therapy.
- How Occupational Therapy supports outcome statements (e.g. to increase range of motion or to lean to feed self either independently or with an assist).

The procedure code, modifier, and service unit for Occupational Therapy Services:

Provider Type **17** - Therapist
Specialty **171**, Occupational Therapist

Age Limits & Funding:

Consolidated & P/FDS Waivers: 21-120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2025	GO	Occupational Therapy	Occupational Therapy service delivered under an outpatient occupational therapy plan of care.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for Occupational Therapy by a person proficient in Sign Language the modifiers must be listed in the following order for the claim to process correctly:

1st – GO

2nd - U1

Physical Therapy

The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows:

“...means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function.”

Physical Therapy provided by a licensed physical therapist is based on a prescription for a specific therapy program by a physician.

Determining the need for services:

Physical therapy is a service designed to do the following:

- Help the individual to acquire, maintain, and improve skills.
- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring gross motor function.
- Enhance skills that can be taught and incorporated into everyday life to improve performance and independence in ADLs or to prevent the complications of motor disorders.

The following additional questions should be used to establish a determination of need for this service:

- Does this individual have a prescription for Physical Therapy?
- Is there a formal assessment by a physical therapist that establishes a need for Physical Therapy?
- Does this individual have gross motor limitations (e.g. difficulty navigating, getting around or moving around?)
- Does this individual have a diagnosis of a clinical condition known to have an impact on gross motor skills (e.g. cerebral palsy, hemiplegia or quadriplegia)?
- Does this individual need to work on specific skills in the areas listed above?
- Does this individual need to have regular stretching to prevent contractures because of increased or decreased muscle tone?
- Is this individual capable of or does he or she have someone supporting him or her that can maintain a home program?
- Does this individual have a degenerative condition that impacts his or her gross motor skills including balance and coordination?
- Has this individual recently had an injury, stroke, surgery or other occurrence that precipitated the need for therapy? In this case, the therapy may be medically necessary under their health insurance plan (e.g. Private health insurance, access or managed care company).
- How long has the individual been receiving Physical Therapy?
- How has the individual benefitted from Physical Therapy?
- How are families and staff implementing learned skills outside of the Physical Therapy sessions?

Service limit:

- Evaluation, development, training and monitoring of physical therapy completed at home should be done by a licensed physical therapist.

 SC documentation requirements:

- Functional limitation in gross or fine motor skills.
- Evaluation of need for Physical Therapy.
- Ability to benefit from Physical Therapy.

- How Physical Therapy supports Outcome Statements (e.g. to increase range of motion or teach to do stand pivot transfer either independently or with an assist).
- Physical Therapy must be ordered by a health care practitioner under the scope of his or her practice. This includes physicians (MDs or Dos), physician's assistants (PAs) or certified registered nurse practitioners (CRNPs).

The procedure code, modifier, and service unit for Physical Therapy Services:

Provider Type **17** - Therapist
Specialty **170**, Physical Therapist

Age Limits & Funding:

Consolidated & P/FDS Waivers: 21-120 years old

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2025	GP	Physical Therapy	Physical Therapy service delivered under an outpatient physical therapy plan of care.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for Physical Therapy by a person proficient in Sign Language the modifiers must be listed in the following order for the claim to process correctly:

1st – GP

2nd - U1

Speech and Language Therapy

Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech-language system, and including the examination for, and adapting and use of augmentative and alternative communication strategies, including, assistive devices and assistive technology.

Provided by an ASHA certified and state licensed speech-language pathologist. This service requires an evaluation and recommendation by an ASHA certified and state licensed speech-language pathologist or a physician.

Additional Service Definition Clarification:

Teaching American Sign Language or another form of communication to an adult waiver individual (an individual who is 21 years of age or older) who is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication is covered under Speech and Language Therapy. To teach American Sign Language or another form of communication, the Speech Language Pathologist must have at least Intermediate Plus sign language skills on the Sign Language Proficiency Interview.

Consultation regarding the communication needs of waiver individuals who are deaf is also covered under Speech and Language Therapy. The person who will be providing the consultation must have expertise in deafness in addition to all the other qualification criteria in order to provide the consultation.

Determining the need for services:

This service is designed to do the following:

- Help the individual to acquire, maintain and improve skills.
- Help the individual live more independently in the community or be more productive and participatory in community life.
- Enhance skills requiring communication functions.
- Enhance skills that can be incorporated into everyday life to improve the ability of the individual to communicate and participate in community life.

The following additional questions should be used to establish a determination of need for this service:

- Does this individual have a prescription for Speech and Language therapy?
- Is there a formal assessment by a speech and language pathologist that establishes a need for speech and language therapy?
- Does this individual have communication limitations (e.g. lack of language or inability to communicate)?
- Does this individual need to work on specific skills in the areas listed above?
- Is this individual capable of or does he or she have someone supporting them that can maintain working on a home program?
- Has this individual recently had an injury, stroke, surgery or other occurrence that precipitated the need for therapy? In this case, the therapy may be medically necessary under their health insurance plan (e.g. Access or managed care company).
- How long has the individual been receiving Speech and Language therapy?
- How has the individual benefited from Speech and Language therapy?
- How are families and staff implementing learned skills outside of the speech and language therapy sessions?

Service limit:

- Evaluation, development, training and monitoring of Speech and Language Therapy completed at home should be done by an ASHA certified and state licensed speech-language pathologist.

SC documentation requirements:

- Functional limitation in communication skills.
- Evaluation of need for Speech and Language Therapy.
- Need for Speech and Language Therapy.
- Ability to benefit from Speech and Language Therapy.
- How Speech and Language Therapy supports Outcome Statements (e.g. to increase ability to communicate using words, gestures or assistive communication devices).

The procedure code, modifier, and service unit for Speech and Language Therapy Services:

Provider Type **17** - Therapist
Specialty **173**, Speech/Hearing Therapist

Age Limits & Funding:

Consolidated & P/FDS Waivers: 21-120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
T2025	GN	Speech and Language Therapy	Speech/Language Therapy service provided by an ASHA certified and state licensed speech-language pathologist.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Please Note: When billing for Speech and Language Therapy by a person proficient in Sign Language the modifiers must be listed in the following order for the claim to process correctly:

1st – GN

2nd - U1

Orientation, Mobility and Vision Therapy

This therapy is for individuals who are blind or have visual impairments. The provision of therapy is for the purpose of increasing individuals' travel skills and/or access to items used in activities of daily living. This service may include evaluation and assessment of individuals and the environments in which they interact, direct service (face-to-face) to individuals, and training of support individuals. The provision of this service may result in recommendations for adapting environments or purchasing assistive technology.

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

Employees (direct, contracted, or in a consulting capacity) providing Orientation, Mobility and Vision therapy must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as one of the following:

- Certified Low Vision Therapist;
- Certified Orientation and Mobility Specialist; or
- Certified Vision Rehabilitation Therapist.

Additional Service Definition Clarification

This service is designed to do the following:

- Develop skills needed to move as safely and independently as possible in home, school, work and community environments.
- Enhance skills that can be incorporated into everyday life to improve the performance and independence in ADLs or to prevent the complications of motor disorders.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is this individual blind or does he or she have a visual impairment that impacts on his or her ability to navigate his or her environment?
- Is there a formal or informal assessment by an ACVREP certified professional that establishes a need for orientation, mobility and vision therapy?

✍️ SC documentation requirements:

- Blindness or visual impairment.
- Denial from blind and visual services.
- Difficulty getting around in the environment related to the visual problems.
- Evaluation from an ACVREP certified professional that specifies:
 - Ability to benefit from orientation, mobility and vision therapy.
 - Need for orientation, mobility and vision therapy to help the individual navigate his or her environment.
 - Outcome actions related to navigating in his or her environment.

The procedure code and service unit for Orientation, Mobility and Therapy Services:

Provider Type **51** - Home & Community Habilitation
Specialty **517**, Visual & Mobility Therapist

Age Limits & Funding:

Consolidated & P/FDS Waivers: 21-120 years old;

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7246		Visual/Mobility Therapy	Visual/Mobility Training for individuals with intellectual disability who are blind or have visual impairments.	15 minutes
	U1		Enhanced Communication Service - This modifier can be utilized with the Waiver Procedure Code in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.19: Transportation

Transportation is a direct service that enables individuals to access services and activities specified in their approved ISP.

Additional Service Definition Clarification:

Waiver transportation services may not be substituted for the transportation services that a state is obligated to furnish under the requirements of 42 CFR §431.53 regarding transportation to and from providers of Medical Assistance services. For example: waiver transportation services cannot be utilized to transport an individual to and from a doctor's appointment when the doctor's appointment will be paid for by Medical Assistance. Transportation of an individual to receive medical care that is provided through the Medical Assistance state plan must be billed as a state plan transportation service, not as a waiver service. Payment for transportation under the waiver is limited to the costs of transportation needed to access a waiver service included in the individual's ISP or access other activities and resources identified in the ISP.

Service limits:

- This service does not include transportation that is an integral part of the provision of another discrete waiver service, nor does it include transportation associated with Residential Habilitation services, as transportation in these situations is built into the rate for the other waiver services.

Public Transportation

Public transportation services are provided to or purchased for individuals to enable them to gain access to services and resources specified in their ISPs. The utilization of public transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities. Public transportation may be purchased by an OHCDs for individuals who do not self-direct or Financial Management Service Organizations for individuals who are self-directing when the public transportation vendor does not elect to enroll directly with ODP. Public transportation purchased for an individual may be provided to the individual on an outcome basis.

Additional Service Definition Clarification:

Waiver funding can be used to pay an individual's copay for public transportation programs such as Pennsylvania Department of Transportation's Rural Transportation Program for Persons with Disabilities (PwD). However, using waiver to pay for transportation co-pays is not allowed when the provision of transportation is built into the service which the participant is receiving (e.g., prevocational, day habilitation, residential habilitation, etc.)

The procedure code and service unit for Public Transportation Services:

Provider Type **55** - Vendor
Specialty **267**, Non-Emergency

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDS may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old;

Base Funding: 0 – 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7272*	Public Transportation	Public transportation costs to enable individuals with an intellectual disability to access services and resources specified in the individual's approved and authorized individual support plan.	Outcome based

Transportation Mile

This transportation service is delivered by providers, family members, and other licensed drivers. Transportation Mile is used to reimburse the owner of the vehicle or other qualified licensed driver who transports the individual to and from services and resources specified in the individual's ISP. The unit of service is one mile. Mileage will be paid round trip. A round trip is defined as from the point of first pick-up to the service destination and the return distance to the point of origin.

When transportation is provided to more than one individual at a time, the provider will divide the shared miles equitably among the individuals to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the VF/EA model) to track mileage, allocate a portion to each individual and provide that information to the SC for inclusion in the individual's ISP. This will be monitored through routine provider monitoring activities.

The procedure code and service unit for Transportation Mile Services:

Provider Type **55** - Vendor
Specialty **267**, Non-Emergency

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDS may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old;

Base Funding: 0 – 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7271*	Transportation Mile	Transportation by providers, family members, surrogates who are the employer or managing employer, and other qualified licensed drivers for using vehicles to transport the individual to and from services specified in the individual's approved individual support plan. Round trip mileage is eligible for reimbursement. When Transportation Mile is provided to more than one individual at a time, the total number of units of service provided is equitably divided among the people for whom transportation is being provided. Mileage reimbursement to providers is limited to situations where transportation costs are not included in the provider's rate for other services.	Per mile

Transportation Trip

This service is transportation provided to individuals for which costs are determined on a per trip basis. A trip is defined as transportation to a waiver service from an individual's private home, from the waiver service to the individual's home or from one waiver service to another waiver service. Taking an individual to a waiver service and returning the individual to his/her home is considered two trips or two units of service. Trip distances are defined by ODP through the use of zones. Zones are defined as follows: Zone 1 – greater than 0 and up to 20 miles; Zone 2 – greater than 20 and up to 40 miles; and Zone 3 – greater than 40 and up to 60 miles.

Determining the need for the service:

- Providers that transport more than six individuals are required to have an aide on the vehicle. The six individuals riding on the vehicle can be supported by different funding streams. This requirement is based solely on the amount of individuals in the vehicle. If a provider transports six or fewer individuals, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the individuals, the provider's ability to ensure the health and welfare of individuals and be consistent with ODP requirements for safe transportation. Providers that bill the transportation trip service and use an aide will be required to bill using a U2 modifier. The U2 modifier will not be present in the ISP, as it is use for billing purposes only.

Service Limits:

- The mileage that determines a trip zone is calculated by determining the distance from each specific individual's private home, from the service to the individual's private home, or from one waiver service to another waiver service. The amount of miles calculated to arrive at a particular zone is calculated by taking the most direct route from the individual's home to the service. Each transportation provider must have the data to support each individual's trip: (start point is the individual's home for pick up and address of drop off will determine the number of miles and which zone). The mileage that determines the zone for each person does not take into account the total miles a person

may be on a vehicle going to pick other individuals up, only the miles from each individual's home to their service location as indicated above. Taking an individual to a service and returning the individual to his/her home is considered two trips or two units of service. (Note: Individuals within different zones may ride the same vehicle).

This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania. During temporary travel, this service may be provided in Pennsylvania or other locations as per the ODP travel policy.

The procedure codes and service units for Transportation Trip Services:

Provider Type **26** - Transportation

Specialty **267**, Non-Emergency

Age Limits & Funding:

Consolidated & P/FDS Waivers: 3 - 120 years old;

Base Funding: 0 – 120 years old

Allowable Place of Service: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7274	Zone 1	Zone 1 – greater than 0 and up to 20 miles.	Per trip
W7275	Zone 2	Zone 2 – greater than 20 and up to 40 miles.	Per trip
W7276	Zone 3	Zone 3 – greater than 40 and up to 60 miles.	Per trip

Section 13.20: Vehicle Accessibility Adaptations

Vehicle accessibility adaptations consist of certain modifications to the vehicle that the individual uses as his or her primary means of transportation to meet his or her needs. The modifications must be necessary due to the individual's disability. The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives, or a non-relative who provides primary support to the individual and is not a paid provider agency of services. This service may also be used to adapt a privately owned vehicle of a life sharing host when the vehicle is not owned by the Family Living provider agency.

Vehicle modifications consist of installation, repair, maintenance, and extended warranties for the modifications. Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle, except for upkeep and maintenance of the modifications, is excluded.

The waiver cannot be used to purchase vehicles for waiver recipients, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

These adaptations funded through the waiver are limited to the following:

- Vehicular lifts.
- Interior alterations to seats, head and leg rests, and belts.
- Customized devices necessary for the individual to be transported safely in the community, including driver control devices.
- Raising the roof or lowering the floor to accommodate wheelchairs.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is the modification specifically designed to address the needs of the individual?
- Does the modification have a primary benefit to the individual and not the public at large, staff, significant others or families?
- Was there a recommendation obtained from an appropriate professional?
- Do the modifications consist only of vehicular lifts, interior alterations to seats, head and leg rests, belts, customized devices necessary for the individual to be transported safely in the community, including driver control devices and/or raising the roof or lowering the floor to accommodate wheelchairs?
- Are these modifications cost effective?

Service limits:

- Only modifications listed in the service definition may be funded through the waivers.
- Maximum state and federal funding participation is limited to \$10,000 per individual during a five-year period. The five-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations.

✍ SC documentation requirements:

- The SC will document in the *Physical Development* field, the adaptation, the purpose of the adaptation, the cost of the adaptation and the formal/informal assessment that identifies the individual's need for the adaptation.
- This service can be used to fund the portion of a new or used vehicle purchase that is related to the cost of accessibility adaptations (in order to fund this type of adaptation, a clear breakdown of the purchase price versus the adaptation is required).
- This service cannot be used to purchase vehicles for individuals, their families or legal guardians.
- Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle, are excluded.

The procedure code and service unit for Vehicle Accessibility Adaptations Services:

Provider Type **55** - Vendor
Specialty **543**, Environmental Accessibility Adaptations

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

(A provider agency functioning as an OHCDS may submit a claim for the vendor service below or the rendering vendor may submit a claim directly. In addition, individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure code below).

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7278*	Vehicle Accessibility Adaptations	Adaptations to vehicles for improved access and/or safety for individuals with intellectual disability. Maximum limit for vehicle adaptations is \$10,000 per individual every 5 years.	Outcome based

Section 14: Policy for Waiver Services Provided by Relatives, Legal Guardians and Legally Responsible Individuals

Relatives or legal guardians may be paid to provide services funded through the Waivers on a service-by-service basis. A relative is any of the following for the individual with an intellectual disability: a spouse, a parent of an adult son or daughter, a stepparent of an adult son or daughter, grandparent, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, adult son or daughter or stepchild of a parent with an intellectual disability, or adult grandchild of a grandparent with an intellectual disability. For the purposes of this policy, a legal guardian is a person who has legal standing to make decisions on behalf of a minor or adult (for example, a guardian who has been appointed by the court). Relatives and legal guardians may be paid to provide waiver services when the following conditions are met:

- The individual has expressed a preference to have the relative/legal guardian provide the service(s);
- The service provided is not a function that the relative or legal guardian would normally provide for the individual without charge in the usual relationship among members of a nuclear family.
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver.
- The service is provided by a relative or legal guardian who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved waivers.

Services that relatives or legal guardians can provide are limited to the following: Home and Community Habilitation (Unlicensed), Companion, Supported Employment, Nursing and Transportation (Mile). Relatives or legal guardians who are the individual's common law employer or managing employer may not receive payment for any services with the exception of Transportation Mile.

Relatives who are not the individual's primary caregiver may provide Supports Broker services and waiver funded Respite services when the conditions in the bulleted list above are met. The primary caregiver is the person who normally provides care to the individual. Relatives or legal guardians may also provide base-funded respite services only when the relative or legal guardian does not live in the same household as the individual, and when the conditions in the bulleted list above are met.

Home and Community Habilitation and Companion services that are authorized on an ISP may be provided by relatives and legal guardians of the individual. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized Home and Community Habilitation, Companion or a combination of Home and Community Habilitation and Companion (when both services are authorized in the ISP). Further, when multiple relatives and/or legal guardians provide the service(s) each individual may receive no more than 60 hours per week of authorized Home and Community Habilitation, Companion or a combination of Home and Community Habilitation and Companion (when both services are authorized in the ISP) from all relatives and legal guardians³.

³ Please note that there was an error in how this information is written in Appendix C-2-e of the Waivers because Companion as the sole service was inadvertently left out of the limitations. The information in the service definitions for Home and Community Habilitation and Companion are accurate as is the information above.

An exception may be made to the limitation on the number of hours of Home and Community Habilitation and Companion provided by relatives and legal guardians at the discretion of the employer when there is an emergency or an unplanned departure of a regularly scheduled worker for up to 90 calendar days in any fiscal year.

All individuals are required to have a back-up plan to address situations when a paid relative or legal guardian does not report to work. ODP recognizes, however, that there may be extenuating circumstances that cannot be addressed through the plan. In general, these situations include, but are not necessarily limited to:

- Unexpected circumstances such as inclement weather, sudden illness, or the unplanned extension of medical leave, that prevent a regularly scheduled worker from arriving at the job site and where another worker/caregiver is not immediately available to work;
- Situations where a regularly scheduled worker is terminated or refuses to provide care without providing adequate notice (e.g. the worker notifies the employer that he or she refuses to work on the day he or she is scheduled to provide the service or is dismissed due to gross non-compliance or misconduct); or
- The sudden loss of a caregiver who provided uncompensated support that kept the provision of services by relatives at or below 40/60 hours per week.

In the event that any of the above situations occur, ODP requires the back-up plan to be reviewed and revised as necessary to prevent recurrence of the above.

When the maximum number of hours per week are worked, either the 40 hours per week or the 60 hours per week, and the relative or legal guardian continues to work, the entire work week in which the limit was exceeded will be counted towards the allowable 90-day exception maximum.

Example:

Days in the Work Week	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours Worked in the Week
Hours of Home and Community Habilitation worked by one Relative	0	8	8	8	12	12	0	48

In this example the relative exceeds the maximum of 40 hours per week on Friday. All seven calendar days during that week (Sunday through Saturday) are counted toward the 90 day limit.

Legally responsible individuals may be paid to provide services funded through the waivers on a service-by-service basis. A legally responsible individual is a person who has legal obligation under the provisions of law to care for another person, including parents of minors and legally-

assigned relative caregivers of minor children. These individuals may be paid to provide waiver services when the following conditions are met:

- The service is considered extraordinary care, which means it is not part of the supports the legally responsible individual is ordinarily obligated to provide.
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver.
- The service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved waivers.

Services that legally responsible individuals can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment, Transportation (Mile) and Supports Broker services. Legally responsible individuals who are the individual's common law employer or managing employer may not receive payment for any services with the exception of Transportation Mile.

Section 15: Waiver Travel Policy Related To Service Definitions

Travel Policy: The following services may occur during temporary travel (as defined below):

- Home and Community Habilitation (Unlicensed).
- Residential Habilitation (licensed and unlicensed).
- Nursing.
- Therapy.
- Supports Coordination.
- Supports Broker.
- Behavioral Support.
- Companion.
- Transportation mile and public.

These services may be provided anywhere during temporary travel.

Temporary travel is defined as a period of time in which the individual goes on vacation or on a trip. The following conditions apply to the travel situation:

- The provision of home and community-based services during travel is limited to no more than 30 calendar days per fiscal year.
- The travel plans are reviewed and discussed as part of an ISP team meeting, and the team identifies safeguards to protect the individual's health and welfare during travel.
- The roles and responsibilities of the individual receiving services and the staff person(s) for home and community-based services are the same during travel as at home.
- The Waivers will not fund the travel costs of the individual, the agency or the individual provider:
 - The individual is responsible to fund their own travel costs through private or non-system funds.
 - Travel costs for agency staff or contracted personnel or individual providers may be funded through private funds of family members of the individual receiving services or non-intellectual disability-system funds generated through fundraising efforts or other means.
 - If the individual decides to pay for the travel costs, there must be documented team consensus that this was the voluntary and willful decision of the individual.
- An individual cannot exceed the authorized units for a service while on temporary travel.
- All service and program requirements, such as provider qualification criteria and documentation of services, apply during the period of travel.
- The location for temporary travel is not limited to Pennsylvania. Temporary travel can occur anywhere as long as the individual's health and welfare can be met during the temporary travel.

AEs shall ensure that this travel policy is explained to all individuals at the time of waiver enrollment and reviewed annually at the time of the ISP meeting. The SC shall document this annual review in a service note in HCSIS.

Section 16: Base-Funded Services

Base-Funded Individual: Base funding is utilized as per the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101-4704), subject to available funding.

- If the change in need impacts the current services and funding, the SC must create a critical revision.
- The County Program must approve and authorize or deny the revised ISP, including the attached funding, within 14 calendar days.
- If the new service(s) or funding is denied, the individual must be provided with his or her due process rights by the County Program.

Respite Care, 24 hours (Base-Funded)

Respite Care services are direct services that are provided to supervise and support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. Respite services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work. Services are limited to individuals residing in private homes (that is, their own home or the home of a relative or friend). Respite Care services must be required to meet the current needs of the individual, and the needed services and supports must be documented and authorized in ISPs.

Individuals can receive Respite Care 24-hour for a period of more than 16 hours to 24 hours. Base-Funded Respite Care is limited to a **total** of four weeks (28 days) per individual per fiscal year, except when DHS grants a waiver of the limit to a County Program.

The provision of Respite Care services does not prohibit supporting individuals' participation in activities in the community during the period of respite.

Base-Funded Respite may be provided in the following locations:

- Individual's private home or place of residence located in Pennsylvania.
- Licensed or approved foster family home located in Pennsylvania.
- Licensed community (55 Pa. Code Chapter 6400) or family living (55 Pa. Code Chapter 6500) home located in Pennsylvania.
- Unlicensed home of a provider or family that the County Program has approved.
- Medical facilities, such as hospitals, nursing homes, or ICFs/ID when there is a documented medical need and the County Administrator approves the Respite service in a medical facility.
- State-operated ICFs/ID when the individual has documented medical or behavioral needs and is unable to locate a respite provider to render services in a community setting. ODP must provide approval prior to the individual receiving Respite in a State-operated ICF/ID.

The procedure codes, modifiers, and service units for Overnight Respite Care – (Base-Funded) follow:

Provider Type **51** - Home & Community Habilitation
Specialty **513**, Respite Care-Out of Home

Provider Type **03** - Extended Care Facility
Specialty **036**, Respite Care

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7287		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7288		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7290		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7099		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7100		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7101		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are degreed.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	
	U2	Respite–Emergency	Emergency Respite rendered in a licensed Waiver-funded 6400 home in which ODP permitted the provision of respite services beyond the approved program capacity of the home. When applicable, the modifier is to be used by Provider Type 51 Specialty 513 only.	Day

Support (Medical Environment)

This service may be used to provide support in general hospital or nursing home settings, when there is a documented need and the County Program Administrator or Director approves the support in a medical facility. The service is intended to supply the additional support that the hospital or nursing home is unable to provide due to the individual's unique behavioral or physical needs. This service is available using base (non-waiver) funds to Waiver individuals and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated, owned, leased, or rented settings. Base services are provided through non-waiver funding, and are available to all individuals with intellectual disability in need of services.

The procedure codes, modifiers, and service units for Support (Medical Environment) Services:

Provider Type **51** - Home & Community Habilitation
Specialty **510**, Home & Community Habilitation

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7305		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7306		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7307		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7309		Staff Support Level 3	The provision of the service at a staff-to-individual ratio range of 1:1.	15 minutes
W7321		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7322		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7323		Staff Support Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff member are licensed nurses.	

Licensed Residential Services (Base-Funded)

Child Residential Services (the residential section of 55 Pa. Code Chapter 3800, Child Residential and Day Treatment Facilities)

The procedure code and service unit for Residential Habilitation—Child Residential Services (9+ Individuals):

Provider Type **52** - Community Residential Rehabilitation
Specialty **520**, C & Y Licensed Group Home

Age Limits & Funding: Base Funding: 0-21 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7098	Child Residential Services	Child residential services that are not eligible for Consolidated Waiver funding due to the size of the home (home serves 9 or more individuals).	Day

Community Residential Rehabilitation Services for the Mentally III (CRRS) (55 Pa. Code Chapter 5310)

CRRS are characterized as transitional residential programs in community settings for people with chronic psychiatric disabilities. This service is full-care CRRS for adults with intellectual disability and mental illness. Full-care CRRS for adults is a program that provides living accommodations for people who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. Host homes are excluded.

The procedure code and service unit for Residential Habilitation—Community Residential Rehabilitation Services for the Mentally III (9+ Individuals):

Provider Type **52** - Community Residential Rehabilitation
Specialty **456** CRR-Adult

Age Limits & Funding: Base Funding: 18-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7203	Community Residential Rehabilitation Services	Community residential rehabilitation services that are not eligible for Consolidated Waiver funding due to the size of the home (home serves 9 or more individuals).	Day

Community Home Services for Individuals with Intellectual disability (55 Pa. Code Chapter 6400)

A licensed community home is a home licensed under 55 Pa. Code Chapter 6400 where services are provided to people with intellectual disability. A community home is defined in regulations as, "A building or separate dwelling unit in which residential care is provided to one or more individuals with intellectual disability...."

The procedure code and service unit for Residential Habilitation - Community Homes for Individuals with Intellectual disability (9+ Individuals):

Provider Type **52** - Community Residential Rehabilitation

Specialty **521** Adult Residential-6400

Age Limits & Funding: Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7221	Community Home Services	Community residential services that are not eligible for Consolidated Waiver funding due to the size of the home (home serves 9 or more individuals).	Day

Family Aide Services

Family Aide services are direct services provided in segments of less than 24 hours to supervise or support individuals on a short-term basis due to the absence or need for relief of those persons normally providing care. The family aide may also be responsible for the care and supervision of family members other than the individual with intellectual disability.

This service is limited to a recommended maximum of four sessions per month (one session is equal to a period of time less than 24 hours), but may be adjusted by the County Program based on individual needs.

The procedure codes, modifiers, and service units for Family Aide Services:

Provider Type **51** - Home & Community Habilitation
Specialty **519**, FSS/Consumer Payment

Provider Type **51** - Home & Community Habilitation
Specialty **362**, Attendant Care/Personal Support Service

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 11 – Office; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7310		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7311		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7312		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7314		Staff Support Level 3	The provision of the service at a staff-to-individual ratio range of 1:1.	15 minutes
W7324		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7325		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7326		Staff Support Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 where both staff members are licensed nurses.	

Special Diet Preparation

This service provides individuals with assistance in the planning or preparation of meals when needed due to a significant modification to a routine diet.

The procedure code and service unit for Special Diet Preparation Services:

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 11- Office; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7315	Special Diet Preparation	This service provides individuals with an intellectual disability with assistance in the planning or preparation of meals when needed due to a significant modification to a routine diet.	Outcome based

Recreation/Leisure Time Activities

This service is provided to enable individuals to participate in regular community activities that are recreational or leisure in nature. Participation in activities with non-related people, within the community, is encouraged. Entrance and membership fees may be included in the cost of recreation/leisure time activities. This service is available to individuals enrolled in a waiver and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated, owned, leased, or rented settings. In addition, this service may be used to provide Overnight Camp and Day Camp services to individuals who receive base-funding who live at home or who reside in provider-operated, owned, leased, or rented settings.

The procedure code and service unit for Recreation/Leisure Time Activity Services:

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 12- Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7316	Recreation/Leisure Time Activities	This service is provided to enable individuals with an intellectual disability to participate in regular community activities that are recreational or leisure in nature.	Outcome based

Home Rehabilitation

The Home Rehabilitation service provides for minor renovations to an individual's or family's home where the individual lives to enable the continued care and support of the individual in the home. A renovation is defined for reimbursement purposes as minor if the cost is \$10,000 or less, as per 55 Pa. Code § 4300.65(1). This service is available to individuals enrolled in a waiver and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated, owned, leased, or rented settings.

The procedure code and service unit for Home Rehabilitation Services:

Provider Type **55** - Vendor

Specialties: **519** - FSS/Consumer Payment; **543** - Environmental Accessibility Adaptations

Provider Type **54** - Intermediate Services Organization

Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old

Allowable Place of Service: 12-Home; 11- Office; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7317	Home Rehabilitation	This service provides for minor renovations to an individual's or family's home to enable the continued care and support of the individual with an intellectual disability in the home.	Outcome based

Family Support Services (FSS)/Individual Payment

FSS/Individual Payment provides an indirect service to assist individuals in the employment and management of providers of the non-waiver service of their choice.

The procedure code and service unit for FSS/Individual Payments:

Provider Type **51** - Home & Community Habilitation
Specialty **519**, FSS/Consumer Payment

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7320	FSS/Individual Payment	This is an indirect service to allow cash and/or voucher payments to individuals and families for FSS	Dollar

Base Service not Otherwise Specified

This service is provided through base funds and is designed to meet the unique needs of the individual receiving services and/or their family. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

The procedure code and service unit for Base Service not Otherwise Specified:

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

Provider Type **54** - Intermediate Services Organization
Specialties: **541**, ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice

Age Limits & Funding:

Base Funding: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W7219	Base Service Not Otherwise Specified	This service is provided through base funds and is designed to meet the unique needs of the individual receiving services and/or their family.	Outcome-based

Section 17: Resources

Section 17.1: Prioritization of Urgency of Need for Services (PUNS)

PUNS is the process for categorizing an individual's urgency of need for services. PUNS focuses on the existing services and supports received by the individual, the categories of services requested, and the urgency of need for requested services. This information is used by AEs, SCOs, and ODP to prioritize waiting lists. The following are the PUNS categories of need:

- Emergency Need – Indicated a need for services within the next six months.
- Critical Need – Indicates a need for services greater than six months but less than two years in the future.
- Planning Need – Indicates a need for services greater than two years but less than five years in the future.

The PUNS should be reviewed at every ISP meeting and updated as necessary based on changes in the individual's needs. The ISP team determines if the individual will have any anticipated unmet needs in the next five years and also identifies any natural supports that might help address these unmet needs. Individuals enrolled in the Consolidated Waiver are entitled to have assessed needs addressed through the use of non-waiver services and supports and through the waiver within the allowable service limits identified in the waiver. If an individual has unaddressed needs, the SC must complete or update the PUNS to reflect current needs of the individual as per the current ODP bulletin *Prioritization of Urgency of Need for Services (PUNS) Manual*, or any approved revisions. The PUNS must be completed and/or updated with the individual or family at every annual review update meeting. It is recommended that anyone in the emergency status in PUNS should have a full ISP, not an abbreviated ISP.

SC service note documentation requirements for PUNS:

- Date of meeting/conversation when form was completed.
- Date mailed to the individual/family.
- If it is recommended that a form not be completed due to no anticipated supports need within five years.
- The request for completion over the phone.
- If individual/family refuses to sign and reason for refusal.

Section 17.2: Independent Monitoring for Quality (IM4Q)

IM4Q is the method that Pennsylvania has adopted to independently review the quality of services individuals receive statewide in the intellectual disabilities services system. Focusing on the individual's satisfaction and outcomes, IM4Q is one of the few statewide programs of this kind in the country, pioneering community participation in the quality improvement process. Community participation is promoted by having individuals with disabilities, family, and interested citizens as part of each IM4Q survey team. Such participation also helps to ensure the independence of the IM4Q survey process since team members are not affiliated with any services that the individual receives.

Independent monitoring is one of a number of monitoring components with the intellectual disabilities services system. IM4Q also helps to:

- Provide a more comprehensive view of quality by engaging individuals with disabilities, families and citizens as stakeholders in the lives of people in their community.
- Strengthen the advocacy base for individuals with disabilities in the community.
- Reinforce to the community what human services professionals already know about the individual or raise issues that the community would want to know.
- Offer an additional safeguard for the health and well-being of individuals receiving services.

When an individual receiving services participates in an IM4Q interview, the individual may choose whether to share the information supplied with the appropriate AE or SCO. If the individual chooses not to share the information, the survey data is entered into HCSIS for its aggregate value only. If the individual chooses to share the information with the AE, then the IM4Q program forwards any considerations or issues to the AE, which then forwards the report to the SCO. A consideration is a suggestion of something the individual could need or that could improve the quality of life. The consideration may be offered by the individual, a family member, a paid staff, or a survey team member. Actions to address considerations are developed with the individual and his or her ISP team. SCOs and provider agencies are involved to the extent necessary to address service and outcome-related issues and concerns. Considerations are linked to the ISP process when there is a change in services stemming from the IM4Q consideration, or when the individual or family wants the ISP team to be involved in decisions related to a consideration.

 SC service note documentation requirements for IM4Q:

- Considerations are now stored in HCSIS and responded to directly through the HCSIS module. SC activities that are related to the IM4Q considerations should be documented by the SC in a service note in HCSIS. Not all considerations need to be included in the ISP.

Section 17.3: Positive Practices Resource Team (PPRT)

In July 2006 DHS initiated a partnership with ODP and the Office of Mental Health and Substance Abuse Services (OMHSAS) for the development of the Positive Practices Resource Allocation Process (PPRT).

Purpose of PPRT:

- Provide a fresh perspective by an outside and independent team.
- Promotes, encourages, and supports efforts that result in improved service capacity.
- Assist the provider or family to continue to support the person in his or her community environment resulting in diversion to a State Center or State Hospital.

Criteria for Referral to PPRT: A person with a developmental/intellectual disability (i.e., determined to be eligible for ID services by the MH/ID County Office) who is demonstrating escalating behavioral challenges and who the support team determines may be at risk for needing enhanced levels of support.

More information on the PPRT process including the PPRT Brochure can be found at:
<http://www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/positivepracticesresourcesteampprt/> and <http://www.odpconsulting.net/topic-info/positive-practices/#>

Section 18: ISP Key Terms

Abbreviated Individual Support Plan (ISP) – A shortened ISP that may be used for and individual who is not eligible for Medical Assistance and receives non-waiver services that cost less than \$2,000 in a Fiscal Year (FY).

Administrative Entity (AE) – A county/joinder or non-governmental entity that performs waiver operational and administrative functions delegated by the Department, under the Department's approved Consolidated and P/FDS Waivers and Administrative Entity Operating Agreement.

Agency with Choice (AWC) – A type of Financial Management Services (FMS) Provider acting as the Common-Law-Employer which provides an administrative service that supports a Individual or Individual's Surrogate acting as the Managing Employer in the management of the Individual's Support Service Worker (SSW) and supports and services authorized in the Individual's Individual Support Plan (ISP).

Amount (of service) – The total volume of funded services (measured in units) that are authorized in the ISP and rendered to the individual.

Annotated ISP – An ISP template that contains ODP's expectations of required documentation and recommended best practices for each section of the ISP. The Annotated ISP is located in Learning Management System (LMS).

Annual Review ISP Meeting – A team meeting held annually to review and update necessary information in the individual's ISP.

Annual Review Update Date - The Annual Review Update Date is the end date of the current plan ISP. The team and the AE must ensure that an Annual Review ISP is completed, approved, and services authorized by the Annual Review Update Date.

Assessed Needs – Needs of individuals identified through the Statewide Needs Assessment or other valid assessments and identified as a required need by the individual's ISP team.

Assessments – Instruments and documents used by the ISP team to identify an individual's needs for Home and Community Based Services (HCBS).

Base Funding Services - A state funded HCBS

Bridge Plan – A term used to describe an individual's initial ISP, which has a timeline shorter than the Fiscal Year to accommodate varying timelines for initial annual review meetings.

Bureau of Hearings and Appeals (BHA) – The DHS entity charged with conducting administrative hearings and timely adjudication of appeals.

Center for Medicare and Medicaid Services (CMS) – The agency in the federal Department of Health and Human Services that is responsible for federal administration of the Medicaid, Medicare and State Children's Health Insurance Programs (CHIP).

Common-Law Employer – The person under the VF/EA FMS option who is responsible for some employer-related responsibilities.

Consent to Share ISP – A field on the ISP in HCSIS that identifies that the individual and his or her family, guardian, surrogate, or advocate provide consent to share the ISP with qualified providers online in HCSIS after it is approved and services are authorized.

Consolidated Waiver - A Federally-approved 1915(c) waiver program designed to help individuals with intellectual disabilities age 3 and older to live more independently in their homes and communities

Direct Service – The provision of a service where the staff is in the same service location as the individual(s) and ensures the health and safety needs of the individual(s).

Draft Plan – An ISP in HCSIS that can be edited or used for adding, deleting or revising information in that ISP.

Duration (of a service) – The length of time that a service will be provided.

Fiscal Year – The period of time extending from July 1 of one calendar year through June 30 of the next calendar year.

Financial Management Services (FMS) – A type of provider (either AWC or VF/EA) that provides administrative support to an individual who self-directs all or some of their services. A FMS provider processes payments for delivered services and performs some financial functions on behalf of the individual. A FMS provider may also process payments on behalf of an individual who is not self-directing but who requires a one-time vendor payment.

Frequency (of a service) – How often a service will be rendered to an individual.

Home and Community Services Information System (HCSIS) – The secure Internet information system serving the DHS state program offices that oversee Medicaid Waivers.

Independent Monitoring for Quality (IM4Q) – A survey and interview instrument focusing on the quality of services and supports for individuals with intellectual disabilities which provides a source of data to support ODP initiatives.

Individual Monitoring Tool – The regularly scheduled and ongoing monitoring of an individual's ISP to ensure that ISPs are implemented as written, including that services are provided as indicated in the ISP.

Individual Provider - A person who is not employed by an agency and who directly provides the service. This term includes an individual practitioner, independent contractor or Support Service Worker through the Vendor Fiscal/Employer Agent model or Agency With Choice model.

Individual Support Plan (ISP) – An individual's summary of planned services (as well as preferences, outcomes, health, safety and medical information), identified as a result of review by the individual, family and plan team members.

Intermediate Care Facility for persons with an Intellectual Disability (ICF/ID) – A state-operated or privately operated facility, licensed by DHS, providing a level of care specially designed to meet the needs of individuals who have an intellectual disability, who require specialized health and rehabilitative services.

Invitation to ISP – The letter sent by the SC which invites members of the individual's plan team to the plan meeting.

ISP Review Checklist (DP 1050) – Required form that is used as a tool in the review of the completed ISP for identified services. The ISP Review Checklist can be used by SCO management, AEs, and ODP reviewers.

ISP Signature Form (DP 1035) – Required form used to document attendance and review of required waiver compliance elements at the time of the annual review meeting and during team meetings that result in critical revisions to ISPs.

Legal Guardian – A person not affiliated with a provider agency who has legal standing to make decisions on behalf of a minor or adult (for example, a guardian who has been appointed by the court).

Legally Responsible Individual – A person who has a legal obligation under the provisions of the law to care for another person, including parents of minors and legally-assigned relative caregivers of minor children.

LMS – Learning Management System – Contains a variety of information about HCSIS including instructional web-based courses and job aids.

Natural Supports – Unpaid assistance to an individual, such as friends, family, neighbors, businesses, schools, civic organizations and employers, as well as other non-waiver funding streams, such as the Pennsylvania Medical Assistance State Plan, Behavioral Health, OVR and the Department of Education.

Outcome Actions – The team's plan to achieve what the individual considers important to him or her, including natural supports and paid services.

Outcome Statements – Levels of achievement and personal preferences the individual chooses to acquire maintain or improve.

Participant -Directed Services (PDS) – The list of identified services in the service definitions and approved waivers that are available to self-direct.

Pending Revision - The screen used to review ISPs that have been disapproved and require revision. An ISP will appear on this screen only if it has been disapproved, which means the ISP has the status of pending revision. The screen contains a hyperlink to comments entered by the ISP Approval role and explains why the ISP was not approved. The SC reviews the comments and converts the ISP back to a draft status so the appropriate changes can be made to the plan. A plan will not appear on this screen if it is in draft status, approved status, or pending approval status.

Person/Family Directed Support (P/FDS) Waiver - A Federally-approved 1915(c) waiver program designed to help individuals with intellectual disabilities age 3 and older to live more independently in their homes and communities.

P/FDS Cap – The per individual limitation for waiver services funded through P/FDS Waiver during a state FY, excluding costs for supports coordination and supports broker services and other administrative costs of administrative services.

Pennsylvania Guide to Participant Directed Services – A guide developed to help people understand what PDS means and what PDS services they can self-direct. It is located on the odpconsulting.net website under *ODP Topic Information*.

Prioritization of Urgency of Needs for Services (PUNS) –The current process for categorizing an individual's need for services. PUNS focuses on the existing services and supports received by the individual, the prioritization of urgency of need for requested services and the categories of services needed. This information is used by AEs, County Programs and ODP to prioritize waiting lists and for budgeting. The following are the PUNS categories of need:

- Emergency Need – Indicates a need for services within the next six months.
- Critical Need – Indicates a need for services greater than six months but less than two years in the future.
- Planning Need – Indicates a need for services greater than two years but less than five years in the future.

Private Home - A home that is owned or leased by the individual, his or her family or another person with whom the individual lives. Homes owned, rented, leased or operated by a provider are not private homes. Homes owned, rented, leased or operated by a provider and subsequently leased to an individual or his or her family are also not private homes.

Qualified Provider – A provider who meets applicable qualification criteria and agrees to provide services to an individual as stated in his or her ISP. Waiver providers must meet qualification criteria included in the approved Consolidated and P/FDS Waivers.

Relative – Any of the following who have not been assigned as legal guardian for the individual with an intellectual disability: a spouse, a parent of an adult son or daughter, a stepparent of an adult son or daughter, grandparent, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, adult son or daughter or stepchild of an individual with an intellectual disability and adult grandchild of an individual with an intellectual disability.

Self-Directed Services – This means the individual or his or her surrogate (representative) manages and directs the supports and services in the individual's ISP. In order to self-direct, they must become either a Common Law Employer or Managing Employer, use one of the FMS options, and must live in their own private residence or the residence of family.

Services and Supports Directory (SSD) – An online database of all the qualified service providers registered in HCSIS that is accessible to individuals and families during the registration process to locate qualified providers within a geographic area. The directory is intended to expand individuals' ability to make informed choices. This is the section of HCSIS where SC's choose qualified service providers and attach them to the ISP.

Statutory – The monitoring frequency as specified in the waivers.

Supports Coordinators (SC) – A SCO employee whose primary functions are to locate, coordinate and monitor services provided to an individual.

Supports Coordination Organization (SCO) – A provider qualified to deliver the services of locating, coordinating and monitoring services provided to an individual.

Section 19: General Billing Terms

15 Minute Unit of Service: The 15 minute unit of service will be comprised of 15 minutes of continuous or non-continuous service within the same calendar day. The full 15 minutes of service does not need to be provided consecutively, but must be rendered within the same calendar day in order to be billed.

Day Unit of Service: The day service unit is defined in each actual service definition to which it relates. A provider must meet the requirements of the definition contained in the narrative in order to submit a claim for the rendered unit of service.

Eligible and Ineligible Procedure Codes: There are two types of procedure codes that are used for Residential Habilitation services: eligible and ineligible. Eligible procedure codes are used to claim the portion of the cost for the service that is eligible for federal financial participation (for example, staffing). Ineligible procedure codes are used to claim the portion of the costs for the service that are not eligible for federal financial participation such as room and board for a waiver individual or base funding for a non-waiver individual.

For waiver-funded Residential Habilitation a SC will use both the eligible and ineligible procedure codes, when applicable, when developing the ISP.

For base-funded Residential Habilitation services for eight or fewer individuals, the SC will only use the ineligible procedure code with an individualized rate when developing the ISP. For base-funded Residential Habilitation service for nine or more individuals, the SC will use only the nine or more procedure code when developing the ISP.

Enhanced Levels of Service: Many home and community-based services have enhanced levels of staffing ratios for 1:1 and 2:1 staffing where the service worker must have a license or a degree to render the service. Staff providing enhanced habilitation must meet the following: Licensed Nurse (LN) or a professional with at least a 4four-year degree. For the 2:1 staffing level, at least one worker must meet the licensed or degree criteria.

The use of enhanced levels of service is based on the individual's assessed need for staff that has a license or degree as indicated by the SIS or County Program assessment process, not the service worker's personal qualifications.

Nursing modifiers are used with the enhanced levels of service procedure codes to indicate when the home and community habilitation service is rendered by a nurse. The modifiers are for information purposes only and do not affect the rate of the home and community-based service. Modifier TD will be used to indicate that a Registered Nurse (RN) renders the service. Modifier TE will be used to indicate that a Licensed Practical Nurse (LPN) renders the service.

Hour Unit of Service: The hour unit of service will be comprised of 60 minutes of continuous or non-continuous service within the same calendar day. This means the full 60 minutes of service does not need to be provided consecutively, but must be rendered within the same calendar day in order for a unit of service to be billed.

Organized Health Care Delivery System (OHCDs): An arrangement in which a provider that renders at least one direct MA waiver service also chooses to offer a different vendor HCBS by

subcontracting with a vendor to facilitate the delivery of vendor goods or services to an individual.

Outcome-Based Unit: A service unit that is outcome based is tied to the actual cost of a purchased good.

Per Mile Unit of Service: Each unit of service equals one mile.

Per Trip Unit: A trip is either transportation to a service from an individual's home or from the service location to the individual's home. The Transportation Trip provider agency decides the geographical area that equals the per trip service unit.

Provider Types, Specialties, and Place of Service: Each service definition includes a list of provider types and specialties that are permitted to render the service or submit a claim for the service. Each service definition includes the allowable places of service where a willing and qualified provider may choose to render the service.

Units of Service: Each procedure code has been assigned a service unit that is used for rate development and billing. Each service unit equals the amount of time that a provider must render the service in order to submit a claim to be paid for the service.

Use of Modifiers: Some services have unique circumstances that require modifiers to be used that identify individual services and account for differences in service delivery regulations or methods specific to different service settings. The modifiers may be used to inform the PROMISe™ system of critical information needed for claims processing.

The following is a list of modifiers that are used in combination with specific procedure codes and listed in the Service Details page of the ISP in HCSIS. When a provider submits a claim for these services, the procedure code and modifier combination in PROMISe™ must match exactly with the procedure code and modifier combination in HCSIS.

- **TD**--Services rendered by a RN.
- **TE**--Services rendered by a LPN.
- **GP**--Services rendered by a Physical Therapist.
- **GO**--Services rendered by an Occupational Therapist.
- **GN**--Services rendered by a Speech and Language Therapist.
- **SE**--Assistive Technology.
- **UA**--Semi-Independent Living (Licensed Chapter 6400 homes only).
- **UA**--Nontraditional day program for an individual who resides in a residential habilitation setting. Used with Home and Community Habilitation (Unlicensed) procedure code W7060 only.
- **U1** – Enhanced Communication Service. Services rendered by staff proficient in Sign Language for individuals enrolled in the Consolidated Waiver who have been assessed as needing this service. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.
- **U2**--One-time vendor payment for Respite-Camp paid by an OHCDs.
- **U2**--Emergency Respite rendered in a waiver-funded licensed Chapter 6400 home in which ODP permitted the provision of respite services beyond the approved program capacity of the home.

- **U2** –Used with transportation trip codes W7274, W7275 and W7276 to indicate the required use of an aide if the provider is transporting more than 6 individuals.
- **U4**--Individual-Directed Services provided that do not include a benefit allowance for the SSWs. This modifier is only used by AWC/FMS providers.
- **ET**: ODP has created the ET modifier to be used with certain procedure codes only when a provider submits a claim to PROMISe™ for an unanticipated emergency. This modifier is not captured in the Service Details page of an ISP.

ODP must approve the use of the ET modifier with a service procedure code in advance.

When a provider submits a claim for the approved emergency service, the “ET” modifier will be used immediately after any other modifier combination. For example, if Home and Community Habilitation (Unlicensed) is approved to meet the emergency need of the individual, and the individual requires a licensed nurse to provide the habilitative service, then the correct way to list the procedure code and modifier sequence when submitting a claim for the service would be W7061 TE ET.

The modifier and service units for Unanticipated Emergencies follow:

Allowable Modifiers	Service Level	Service Description	Service Unit
ET	Unanticipated Emergency	Emergency Funding to meet the unanticipated emergency service needs of an individual.	Service unit will be the one that is used with the needed service

The following are the specific services with which the **ET** modifier may be used:

- Home & Community Habilitation (Unlicensed)
- Unlicensed Residential Habilitation
 - *Community Homes (unlicensed)*
 - *Family Living Homes (unlicensed)*
- Licensed Residential Habilitation
 - *Supplemental Habilitation*
 - *Child Residential Services (licensed under 55 Pa. Code Chapter 3800)*
 - *Community Residential Rehabilitation (licensed under 55 Pa. Code Chapter 5310)*
 - *Family Living Homes (licensed under 55 Pa. Code Chapter 6500)*
 - *Community Homes (licensed under 55 Pa. Code Chapter 6400)*
- Companion Services
- Licensed Day Services (licensed under 55 Pa. Code Chapter 2380 or 6 Pa. Code Chapter 11)
- Therapy Services
- Nursing Services
- Behavior Support
- Transportation Service
- Home Accessibility Adaptations
- Vehicle Accessibility Adaptations

- Assistive Technology
- Homemaker/Chore Services (temporary service only)
- Specialized Supplies
- Respite Care, 24 Hours (Base-Funded)
- Support (Medical Environment)
- Base-Funded Licensed Residential Services
 - *Child Residential Services (licensed under 55 Pa. Code Chapter 3800)*
 - *Community Residential Rehabilitation (licensed under 55 Pa. Code Chapter 5310)*
 - *Community Homes (licensed under 55 Pa. Code Chapter 6400)*
- Family Aide
- Special Diet Preparation
- Home Rehabilitation
- Base Service Not Otherwise Specified