Service Definitions Narrative for the Consolidated Waiver, Person/Family Directed Support Waiver, Administrative Services, and Base-Funded Services, Reissued

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Introduction

This document outlines the services that are available through the Consolidated and Person/Family Directed Support (P/FDS) Waivers (Waivers), administrative funding, and base funding. Waiver services are available to individuals with mental retardation aged three and older who are enrolled in either Waiver. Base-funded services, which are funded through state and county dollars, are available to individuals with mental retardation of any age as authorized by the County Mental Health/Mental Retardation Program (County Program) in accordance with the Mental Health/Mental Retardation Act of 1966 and applicable regulations and policies.

The Office of Developmental Programs (ODP) is the program office within the Pennsylvania Department of Public Welfare with responsibility to administer funding and develop policies and requirements related to mental retardation services. ODP is responsible for the administration and supervision of the Waivers, and for issuance of policies relative to the Waivers.

The cost of P/FDS Waiver services provided to any P/FDS participant within a fiscal year, with the exception of Supports Coordination 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. An individual enrolled in the Consolidated Waiver must have his or her assessed needs met. The need for services must be established through assessment processes and needed services and supports must be identified through a person-centered planning process and documented in Individual Support Plans (ISPs). All services and supports must be cost-effective and efficient.

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 (public or private) Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), except in accordance with ODP's bed reservation policy.

Waiver services *may* be available to individuals who are residing in residential treatment facilities, correctional facilities on a temporary basis[1], 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.

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

Home and Community-Based Services

General Information

Home and community-based services are provided to individuals who need assistance in the acquisition, retention, or improvement of skills related to living and working in the community and to prevent institutionalization. Waiver-funded services must be documented as per bulletin 00-07-01, *Provider Billing Documentation Requirements for Waiver Services*, or any approved revisions.

Services that are solely related to leisure or entertainment activities or recreational in nature are not available through the Waivers. However, habilitative or therapeutic services may be provided in community settings based on the outcome to be achieved and the individual's assessed needs. If a community activity serves a habilitative or therapeutic purpose, home and community-based services may be used to fund the staff coverage necessary for the individual to participate in the activity. The cost of the activity for the individual (for example, entrance fees, tickets, memberships, season passes, and the like) is not eligible for reimbursement as part of the Waiver service, but may be paid for through private funds, individual or family members' personal funds, or non-waiver dollars.

All provider operated, owned, rented or leased Waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations and may not be located on campus settings. Effective July 1, 2010, integrated and dispersed in the community in noncontiguous locations means that the homes are located throughout the community on properties that are not next to each other [side-by-side, back-to-back, etc.]. The location must be completely separate from any other ODP-funded location that the provider owns, operates, rents, or leases, and be surrounded by properties owned, operated, rented or leased by the general public or governmental properties that are used by all peoples (for example, a State Park). This is not to say that individuals with mental retardation cannot rent an apartment in the same apartment building, but it is to say that the apartment building is for anyone who lives in that community, not just individuals with mental retardation. This arrangement should foster each individual's social integration and participation with neighbors and the general population. Current properties that do not meet the definition of integrated and dispersed in the community in noncontiguous locations will be grandfathered into the definition of integrated and dispersed if the property was in operation prior to July 1, 2010 until such time that the property is sold or the property's current business ceases operation.

Licensed Residential Habilitation services, which include Child Residential Services, Community Residential Rehabilitation Services for the Mentally Ill, Community Homes for Individuals with Mental Retardation, and Family Living Homes, are **only** available through the Consolidated Waiver and base funds. Unlicensed Residential Habilitation services, which are exempt from licensure under 55 Pa.Code §6400.3(f)(7) or §6500.3(f)(5), are available through the Consolidated or P/FDS Waiver and base funds.

Waiver-funded services discussed in this document cannot be provided to individuals in their residences if the residences are provider-owned, leased, or rented **and** serve more than ten individuals. Please refer to the section on Residential Habilitation Services (page 20) for more information.

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 ten or fewer unrelated persons and when the home is located in a local community in noncontiguous and non-campus settings as defined above. Home and community-based services may be provided to Personal Care Home (PCH) residents who receive base-funded services and to participants in the P/FDS Waiver with a move-in date prior **to** July 1, 2008. PCH residents with a move-in date on or **after** July 1, 2008, are only eligible for the P/FDS Waiver if the PCH has a licensed capacity of ten or fewer unrelated persons. For example, P/FDS Waiver participants who reside in a PCH or a Domiciliary Care Home who meet the criteria above could be authorized to receive Supported Employment Services funded through the Waiver, based on their assessed needs. 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.

Certain home and community-based services may be provided by qualified providers that are based in Pennsylvania or in states contiguous to Pennsylvania. These services include:

- Home and Community Habilitation (Unlicensed).
- Licensed Day Habilitation.
- Prevocational Services.
- Respite.
- Supported Employment.
- Nursing.
- Therapy Services.
- Supports Broker.
- Behavioral Support.
- Companion.
- Education Support.
- Home Finding.
- Transitional Work Services.
- Transportation.

The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania and may be located anywhere in the 50 United States, the District of Columbia, or the American territories[2]. The following services are considered goods:

[2] The American territories include the following: Guam, Northern Mariana Islands, Puerto Rico, United States Virgin Islands, and American Samoa.

- Assistive Technology.
- Home Accessibility Adaptations.
- Vehicle Accessibility Adaptations.
- Specialized Supplies.

Additional clarification on unique components of home and community-based services is as follows:

Provider Types, Specialties, and Place of Service: Each service definition includes a list of Medical Assistance provider types and specialties that are permitted to render the service or submit a claim for the service. In addition, each service definition includes the allowable places where the service may be rendered.

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.

- ***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 must be rendered within the same calendar day in order for a unit of service to be billed. This applies to all services that use a 15 minute unit.

  An example of non-contiguous service within the same calendar day follows: Ms. Brown renders the job finding portion of the Supported Employment Service. Ms. Brown searches the newspaper to look for a job for John. Ms. Brown finds a job that would meet John's needs and telephones the employer to discuss. However, the employer was not available so Ms. Brown left a message for a return call. The job search and the telephone call took 5 minutes. At this point in Ms. Brown's day, she must attend a meeting outside of the office. When Ms. Brown returns to her office after the meeting, she has a message from the employer mentioned above regarding employment for John. Ms. Brown calls the employer and discusses the duties of the position. The telephone call lasts 10 minutes. Ms. Brown is able to submit a claim for one 15-minute unit of the Supported Employment service that was rendered in the same calendar day on John's behalf.

- ***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. The full 60 minutes of service must be rendered within the same calendar day in order for a unit of service to be billed. This applies to all services that use an hour unit.

- ***Day Unit of Service:*** The day service unit is defined in each actual service definition to which it relates (for example, Residential Habilitation, Respite Services, and Transportation Per Diem). 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.

- ***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.

- ***Outcome-Based Unit:*** A service unit that is outcome based is tied to the actual cost of a purchased good. When a claim is submitted, the amount that is paid to the entity that provided the good will equal the actual cost of the good. For example, if an individual uses public transportation to go to their job each day, then a bus pass is purchased for the individual. The claim that is submitted for the outcome-based service unit for the bus pass will equal the actual cost of the bus pass.

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 or a professional with at least a 4-year Degree. For the 2:1 staffing level, both workers must meet the licensed or degreed criteria.

The use of enhanced levels of service is based on the individual's assessed need as indicated by the Supports Intensity Scale™[3] (SIS) or County Program assessment process, not the service worker's personal qualifications. For example, an individual is medically fragile and requires a nurse to render habilitation because of the individual's medical needs. This is an appropriate use of the enhanced level of service. An example of an inappropriate use of the service would be that an individual requires 1:1 habilitation and the service worker who renders the service has a degree in Marketing. The ISP does not have a habilitation outcome that relates to learning how to promote or start a business. Therefore, the individual's assessed need does not require a licensed or degreed service worker to render the habilitation. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.

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 renders the service. Modifier TE will be used to indicate that a Licensed Practical Nurse renders the service.

[3] Supports Intensity Scale™ 2004 AAIDD

Eligible and Ineligible Procedure Codes: There are two types of procedure codes that are used for Residential Habilitation, Unlicensed Out-Of-Home Respite, or Respite Camp services: eligible and ineligible. Eligible procedure codes are used to claim the portion of the rate for all service costs eligible for federal financial participation (for example, staffing and administrative costs). Ineligible procedure codes are used to claim the ineligible portion of the rate for room and board costs (for example, the cost of occupancy, food, utilities, and the like).

For Waiver-funded Residential Habilitation, Unlicensed Out-Of-Home Respite, or Respite Camp service, a Supports Coordinator (SC) will use both the eligible and ineligible procedure codes, where applicable, when developing the ISP.

For base-funded Residential Habilitation service for 10 or less individuals, the SC will use only the ineligible procedure code with an individualized rate when developing the ISP. For base-funded Residential Habilitation service for 11 or more individuals, the SC will use only the procedure code listed with the service when developing the ISP.

Use of Modifiers: Some services have unique sets of modifiers to individualize services and account for differences in service delivery regulations or methods specific to different service settings. The modifiers consist of support by staff that may have special training or experience, credentials, or licenses; define the service in a slightly different way; or are used to inform the PROMISe™ system of critical information needed for claims processing.

Following is a list of modifiers that are used with the procedure code in the Service Details page of the ISP in the Home & Community Services Information System (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 Registered Nurse (RN).
- **TE**--Services rendered by a Licensed Practical Nurse (LPN).
- **GP**--Services rendered by a Physical Therapist.
- **GO**--Services rendered by an Occupational Therapist.
- **GN**--Services rendered by a Speech and Language Therapist.
- **HE**--Services rendered by a Behavior Therapy provider agency in a one-on-one setting.
- **HE, HQ**-- Services rendered by a Behavior Therapy provider agency in a group setting.
- **SE**--Assistive Technology.
- **UA**--Semi-Independent Living (Licensed Chapter 6400 homes only).
- **UA--**Homemaker/Chore (Temporary).
- **U2**--One-time vendor payment for Respite-Camp paid by a Financial Management Service (FMS) Organization.

- **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.
- **U4**--Participant-Directed Services provided that do not include a benefit allowance for the Support Service Workers (SSWs). This modifier is only used by Agency with Choice FMS providers.

ODP has created modifiers that are used with the procedure code only when a provider submits a claim to PROMISe™ for therapeutic or medical leave days or unanticipated emergencies. Following is a list of modifiers that the providers will use for these circumstances. These modifiers are not captured in the Service Details page of an ISP.

- **UC**--Therapeutic leave.
- **UD**--Medical Leave.
- **ET**--Unanticipated Emergency.

Selecting Home and Community Habilitation (Unlicensed), Respite, or Companion Services as the Correct Service for the Individual: The decision to utilize Home and Community Habilitation (Unlicensed), Respite, or Companion Services is determined by the individual's assessed need. An individual may use one or all of these services as per his or her assessed needs.

If the necessary service is directly related to the individual working toward an outcome that is skill based, then the correct service to choose is Home and Community Habilitation (Unlicensed).

If the adult individual requires supervision and necessary care and minimal assistance to meet their health and welfare needs, then the correct service to choose is Companion Services. Companion Services are used when there is no habilitative outcome for the individual associated with the delivery of the service. The individual is not learning, enhancing, or maintaining a skill. The outcome related to Companion services only relates to assistance to and supervision of the individual to ensure health and welfare.

Respite Services are chosen as the correct service when those persons normally and primarily responsible to provide care to the individual are absent or need relief from providing care on a short-term basis.

Respite in a Larger Setting: ODP recognizes that situations may arise in a Waiver participant's life that results in requests for exceptions regarding the size limitations of a community home so that respite services may be provided in a larger setting. If ODP waives the size limit of the community home based on an individual's circumstances and needs, a larger setting may be used for Waiver-funded Respite Services.

An exception process and Form DP 1023 were developed to grant exceptions on an individual basis. Please refer to ODP Informational Packet 010-09 (issued June 23,

2009) entitled *Draft Process to Request an Exception to the Established Limits or Maximum Number of Service Units*, or any approved revisions to this packet, for more information.

Services by Relatives, Legal Guardians, and Legally Responsible Individuals: Relatives, legal guardians, and legally responsible individuals may be paid to provide certain services funded through the Waivers, including participant-directed services. The policies related to services by relatives, legal guardians, and legally responsible individuals are outlined below. Please note that there is one set of policies that apply to relatives and legal guardians and a separate policy that applies to legally responsible individuals. *Please refer to the Participant-Directed Section for additional policies that apply for individuals who are self-directing services.*

- *Services by Relatives and Legal Guardians*

  Relatives or legal guardians may be paid to provide services funded through the Waivers, including participant-directed services, on a service-by-service basis. A relative is any of the following who have not been assigned as legal guardian for the individual with mental retardation:

  - A parent (natural or adoptive) of an adult.
  - A stepparent of an adult child.
  - Grandparent.
  - Brother.
  - Sister.
  - Half-brother.
  - Half-sister.
  - Aunt.
  - Uncle.
  - Niece.
  - Nephew.
  - Adult child or stepchild of a parent with mental retardation.
  - Adult grandchild of a grandparent with mental retardation.

  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)[4].

  Relatives and legal guardians may be paid to provide Waiver services when the following conditions are met:

  - 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.

[4] This policy does not apply to agency providers that are appointed legal guardians, but does apply to any person who is actually rendering the service to a participant.

- 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.

Waiver services that relatives or legal guardians can provide are limited to the following: Home and Community Habilitation (Unlicensed), Transportation (Mile), Supported Employment, and Home Finding. Relatives or legal guardians who are not the individual's primary caregiver may also provide Supports Broker Services and **waiver-funded** Respite Services when the conditions listed above are met. Relatives and legal guardians may 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 above are met.

The primary caregiver is the person or persons who normally provide care to the individual. For example, an adult individual lives with his or her parents and the parents provide the routine and regular care needed by the individual. A brother of the adult individual also lives with the parents but goes to college each day. Typically, the parents would be considered the primary caregiver. The brother may also provide care to the individual when he is not at college, but providing care to the individual is not the brother's primary responsibility, and he therefore, is not considered a primary caregiver. Another example would be when the individual lives with a mother and a sister. Although the mother is the individual's parent, she is elderly and unable to provide routine and regular care to the individual. The sister provides the regular and routine care to the individual. In this example, the sister is considered the primary caretaker.

- *Services by Legally Responsible Individuals*

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 (natural or adoptive), spouses, and legally-assigned relative caregivers of minor children. Legally responsible individuals may be paid to provide services funded through the Waivers on a service-by-service basis. Legally responsible 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.

Waiver services that legally responsible individuals can provide are limited to the following: Home and Community Habilitation (Unlicensed), Transportation (Mile), Supported Employment, and Home Finding.

Participant-Directed Services (PDS): Individuals who live in a private residence may self direct certain services. Individuals may choose a traditional provider to manage some of their services while they also choose to self direct other services using an FMS option. Home and community-based services that are available as PDS are noted throughout this document by the inclusion of an asterisk next to each service procedure code (for example, Home & Community Habilitation (Unlicensed), W7060*). These PDS are payable through an FMS organization or provider. The asterisk is included in this document for informational purposes only and should not be used with the procedure code on the ISP or when a claim is submitted for payment through PROMISe™.

- ***Transportation Component of PDS:*** For individuals who self direct some or all of their services and supports through a FMS option, transportation may be included as a separate service offering on the ISP. Since the cost for transportation is not included in the established wage ranges and rates for PDS, it may be necessary for Transportation Mile or Public Transportation to be authorized separately on an ISP. Transportation services may occur at the same time as other PDS services.

  When a small unlicensed provider is used to provide services to someone who self directs their services and a particular service includes transportation as a component of the rate, then transportation is included in the provision of that service and would not be authorized separately on the ISP.

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

- Home and Community Habilitation (Unlicensed).
- Residential Habilitation (licensed and unlicensed).
- Respite.
- Nursing.
- Therapy Services.
- Supports Coordination.
- Supports Broker.
- Behavioral Support.
- Companion.
- Specialized Supplies.
- Transportation.

These services may be provided in Pennsylvania or anywhere in the United States, the District of Columbia, or the American territories during temporary travel.

During the temporary travel period, staff that renders these services must be employed by a willing and qualified provider that is based in Pennsylvania or in states that are contiguous to Pennsylvania. For services that are participant directed, the SSWs[5] that render the service while traveling must be a resident of Pennsylvania or of states that are contiguous to Pennsylvania. The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania.

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:

1. 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.
2. 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.
3. ODP bears no responsibility for travel costs of either the individual or the staff person(s):
    a. The individual is responsible to fund their own travel costs through private or non-system funds.
    b. Travel costs for staff person(s) may be funded through private funds of family members of the individual receiving services or non-mental retardation-system funds generated through fundraising efforts or other means.
4. An individual is limited to previously authorized units for each service while on vacation and other temporary travel.
5. All service and program requirements, such as provider qualification criteria and documentation of services, apply during the period of travel. This includes the requirement for licensed residential services that the permanent residential setting must be located and licensed in Pennsylvania.
6. The provision of home and community-based services during travel is limited to a period of no more than 30 consecutive calendar days per travel event.

AEs shall ensure that this travel policy is explained to all Waiver participants 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.

Home and Community Habilitation (Unlicensed)

This is a direct service (face-to-face) provided in home and community settings to assist individuals in acquiring, maintaining, and improving self-help, domestic, 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,

[5] SSWs, or Support Service Workers, are qualified individuals that render services authorized in ISPs.

fine and gross motor skills, mobility, therapeutic activities[6], personal adjustment, relationship development, socialization, and use of community resources. Habilitation may be provided up to 24 hours a day based on the needs of the individual, to protect the individual's health and welfare.

Through the provision of this service individuals learn, maintain, or improve skills through their participation in a variety of everyday life activities These activities must be necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life.

The Home and Community Habilitation service may also be used to provide staff assistance to support individuals in the following ways:

1. Habilitation provided in an individual's own home and family settings that are *not* subject to Department licensing or approval, when the provider of habilitation meets established requirements and qualifications.
2. Support that enables the individual to access and use community resources such as instruction in using transportation, translator and communication assistance related to habilitative outcomes, and services to assist the individual in shopping and other necessary activities of community life.
3. Support that assists the individual in developing or maintaining financial stability and security, such as plans for achieving self-support; general banking; personal and estate planning; balancing accounts; preparing income taxes; and recordkeeping.
4. Support that enables an individual to participate in community projects, associations, groups, and functions, such as support that assists an individual to participate in a volunteer association or a community work project.
5. Support that is related to habilitative outcomes to enable an individual to visit with friends and family in the community.
6. Support that enables an individual to participate in public and private boards, advisory groups, and commissions.
7. Support that enables the individual to exercise rights as a citizen, such as assistance in exercising civic responsibilities.
8. Support provided during overnight hours when the individual needs the habilitation service to protect their health and welfare. If the individual only needs supervision during overnight hours, the appropriate service is Companion Services.

There may be multiple outcomes which are supported by this service with different providers or through self-directed opportunities within an individual's ISP as long as there is documented need with associated outcomes and there are no conflicts or overlaps with regard to day and time of service. For example, an individual may receive Home and Community Habilitation from 6:00 PM to 9:00 PM, Monday through Friday to satisfy an outcome related to participating in activities or utilizing resources that are

[6] Therapeutic activities are those activities designed to help a person acquire, maintain, or improve a skill necessary to live successfully in the home and community.

community-based. The same individual could also be provided with a Home and Community Habilitation service that occurs in the home, scheduled Monday through Friday from 11:30 AM to 12:30 PM to support the individual in achieving an outcome of independent meal preparation.

This service may not overlap with or duplicate Companion Services. Home and Community Habilitation (Unlicensed) and Companion Services have a combined maximum limit of 24 hours (96 15-minute units) per participant per calendar day.

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Home and Community Habilitation (Unlicensed) services may not overlap in terms of day and time.

This service may be provided at the same time as Therapy, Nursing, and Behavioral Support Services. All providers should coordinate schedules and service delivery to ensure consistency in services to individuals across service settings.

Home and Community Habilitation (Unlicensed) may not be provided in licensed service settings, and is a totally separate service from the Residential Habilitation Service; for residential services, see Licensed and Unlicensed Residential Habilitation Services. When an individual in a licensed Residential Habilitation Service is not interested in attending a traditional licensed day program but wants to participate in an integrated community activity with a Home and Community Habilitation (Unlicensed) provider, the Home and Community Habilitation (Unlicensed) service may be rendered to meet this need during the time period usually reserved for participation in a traditional licensed day program (that is, Monday through Friday during the hours of 8:00 a.m. – 5:00 p.m.). The Home and Community Habilitation (Unlicensed) service will be provided:

- By a willing and qualified Home and Community Habilitation (Unlicensed) services provider.
- Outside of the licensed residential habilitation setting (that is, not on the grounds of a residential habilitation setting licensed through 55 Pa.Code Chapters 3800, 5310, 6400, or 6500).
- To accomplish activities and outcomes as determined by the individual's ISP team.

Home and Community Habilitation (Unlicensed) is not to be used to provide camp services. Camp 24-Hour and Camp 15-Minutes services for individuals enrolled in the Waivers may only be provided under Waiver-Funded Respite Services. Camp services funded as a base service must be authorized as Recreation/Leisure Time Activities as per 55 Pa.Code Chapter 6350, Family Resource Services.

Transportation Component of Home and Community Habilitation (Unlicensed):

- Agency-Based Providers:

Agency-based providers of Home and Community Habilitation (Unlicensed) are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their ISPs as they relate to the delivery of the Home and Community Habilitation (Unlicensed) service. For these providers, transportation costs are included in the rate for the service.

The Home and Community Habilitation (Unlicensed) provider is only required to provide the transportation necessary to successfully render the Home and Community Habilitation (Unlicensed) services as authorized in the ISP. For example, the individual's ISP identifies that the Home and Community Habilitation (Unlicensed) provider will teach the individual to shop for groceries at a grocery store. The Home and Community Habilitation (Unlicensed) provider is responsible to provide the transportation to and from the grocery store in order to accomplish the identified outcome in the ISP.

Although the Home and Community Habilitation (Unlicensed) provider is not responsible to transport individuals to other service locations, a Home and Community Habilitation (Unlicensed) provider may offer transportation as a separate service offering. If a provider wishes to provide transportation service as an additional service, the provider would need to complete the process to enroll as a provider or vendor of transportation services. In addition, when the provider offers transportation as an additional service, the provider may consider the option to subcontract with existing transportation entities as long as the provider ensures those entities meet the requirements outlined in the Waivers.

Transportation included in the rate for Home and Community Habilitation (Unlicensed) may NOT be duplicated through the inclusion of the transportation service on an individual's ISP. This means that when Home and Community Habilitation (Unlicensed) services are provided and transportation is integral to the delivery of that service, transportation funding is included in the rate for that service. In these cases, transportation cannot be authorized as a separate service on the ISP or duplicated through the inclusion of a separate transportation service authorized on an individual's ISP to meet the transportation components of the these services.

- Non-Agency-Based Provider:

  Home and Community Habilitation (Unlicensed) services paid through an FMS for self-directing Waiver participants do not include transportation as part of the rate paid for the service. For self-directing Waiver participants, discrete Transportation services may be included on the ISP to meet the transportation needs of the Home and Community Habilitation (Unlicensed) service.

The procedure codes, modifiers, and service units for Home and Community Habilitation (Unlicensed) provided in private homes and unlicensed community settings follow:

Home & Community Habilitation (Unlicensed)

Provider Type **51**, Home & Community Habilitation Specialty **510**, Home & Community Habilitation
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541**, ISO – Fiscal/Employer Agent
(The asterisked services below are applicable to Provider type 54 and specialties 540 and 541).
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 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.	
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 staff members who are degreed.	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.	

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

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used with W7060 W7061 W7068 W7069	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

Residential Habilitation Services

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, therapeutic activities, personal adjustment, relationship development, socialization, and use of community resources. Residential Habilitation is provided for 24 hours a day based on the need of the individual receiving services.

The Residential Habilitation service location of the home may only be located in Pennsylvania. All waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations, and may not be located on campus settings.

For homes licensed under 55 Pa.Code Chapters 3800 and 5310, services may be provided to individuals who live in licensed residential settings established prior to January 1, 1996, with a licensed capacity to provide services to ten or fewer unrelated individuals, or in homes established on or after January 1, 1996, with a licensed capacity to provide services to four or fewer unrelated individuals. Services may be provided to individuals who reside in settings of ten beds or less that were ICF/MRs and were converted to waiver-funded homes.

For homes licensed under 55 Pa.Code Chapter 6400, services may be provided to individuals who live in licensed residential settings established prior to January 1, 1996, if there are 10 or fewer unrelated individuals who receive services in the home, or in homes established on or after January 1, 1996, if there are four or fewer unrelated individuals who receive services in the home. Effective July 1, 2009, these homes licensed under 55 Pa.Code Chapter 6400 may only render services to individuals up to the approved program capacity of the home. Approved program capacity is established by ODP for each service location licensed under 55 Pa.Code Chapter 6400 based on the maximum number of individuals who, on any given day, may be authorized to receive services at that service location. There may be situations in which a service location's licensed capacity is greater than the approved program capacity. In these situations, the service location may only provide services up to the approved program capacity.

For homes licensed under 55 Pa.Code Chapter 6500, services may be rendered to one or two individuals with mental retardation who are not family members or relatives of the host family.

The size limitations do not apply to base-funded residential habilitation services.

The unit of the Residential Habilitation service is 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 care may be provided in non-consecutive hours and may be rendered in the residential habilitation site, in the community, or while traveling, consistent with ODP's travel policy. This definition of a day unit is to be used for planning and billing purposes for the Residential Habilitation Service that is funded through the Waivers or through base funding.

Providers of unlicensed and licensed Residential Habilitation Services are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their ISPs. This includes transportation to and from day habilitation and employment services. Transportation is provided as a component of the Residential Habilitation Service, and is, therefore, reflected in the rate.

The responsibility for the provision of transportation by the residential habilitation provider stops once the individual has been safely transported to another service setting identified in the approved and authorized ISP. The residential habilitation provider's responsibility resumes when the other service ends and the individual requires a ride back home. The residential habilitation provider must ensure transportation is provided to and from other authorized service locations and must ensure transportation is provided during the delivery of the Residential Habilitation Service. The residential habilitation provider is not responsible for transportation needs during the delivery of the other authorized services. An individual receiving Residential Habilitation Services should never have discrete transportation services included and authorized as a separate service offering on their ISP.

The list below outlines options that the Residential Habilitation Service providers, the individual and ISP team can consider to best meet the transportation needs of the individual 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 who meets the qualification criteria (if the Administrative Entity 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.

Residential Enhanced Staffing

Residential Enhanced Staffing may be utilized in Residential Habilitation settings and involves three possible components, which are treated as add-ons to the traditional Residential Habilitation Service:

- The provision of the Residential Habilitation Service by licensed nurses (licensed and unlicensed settings).
- The provision of Supplemental Habilitation staffing, as part of the licensed Residential Habilitation Service, to meet temporary medical or behavioral needs of the individual. **This Consolidated Waiver-funded service must be prior authorized by ODP.** Base-funded services do not need to be prior authorized by ODP, but are authorized at the discretion of the County Program.
- The provision of Additional Individualized Staffing, as part of the licensed Residential Habilitation Service, to meet the long-term individualized staffing needs of the individual when those needs can no longer be met as part of the usual residential habilitation staffing pattern. **This Consolidated Waiver-funded service must be prior authorized by ODP.** Base-funded services do not need to be prior authorized by ODP, but are authorized at the discretion of the County Program.

Individuals living in Residential Habilitation settings may also receive other needed non-habilitative home and community-based services (for example, Physical therapy, Behavior Support, and so on) that are not a required component of the Residential Habilitation Service. See the *Other Home and Community Based Services* section on page 25 for additional information.

The continued need for Residential Enhanced Staff should be reviewed at least annually as part of the ISP process. Each of these types of Residential Enhanced Staffing is accounted for in different ways, as follows:

- **Residential Habilitation Provided by Licensed Nurses** (Licensed and Unlicensed Residential Habilitation Services)

  If the Residential Habilitation Service is provided by licensed nurses, the individual's ISP must accurately reflect the residential service by including the correct procedure code for eligible costs (for example, W6094 for a 3-individual Community Home) and the appropriate nursing modifier. Procedure codes for the ineligible costs of the Residential Habilitation Service will not include the nursing modifiers.

  <u>Residential Habilitation by a Nurse</u>

Provider Type **52**, Community Residential Rehabilitation	Specialty **520** C&Y Licensed Group Home Specialty **456** CRR-Adult Specialty **522** Family Living Homes-6500 Specialty **521** Adult Residential-6400 Specialty **524** Unlicensed

Age Limits & Funding: Consolidated Waivers: 3-120 years; Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Allowable Modifiers	Service Level	Service Description	Service Unit
TD (For habilitation provided by RNs) **TE** (For habilitation provided by LPNs)	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 service.	Day

- **Supplemental Habilitation** (Licensed Residential Habilitation Services only)

When Supplemental Habilitation is used to temporarily supplement the licensed residential habilitation service (that is licensed under 55 Pa.Code Chapters 3800, 5310, 6400, 6500) to meet the short-term unique behavioral or medical needs of an individual, the individual's ISP must reflect the Residential Habilitation Service and the Supplemental Habilitation procedure codes. Short-term, as it is used in the Supplemental Habilitation service definition, is defined as 12 consecutive calendar months or less. For example, this service could be used when an individual is discharged from the hospital with additional needs, and requires a temporary addition of 2 hours of one-to-one staffing each day. Another example where this service could be used would be to supply extra temporary staff to meet an individual's behavioral needs that occur as a result of a residential habilitation home's temporary relocation.

Supplemental Habilitation may be authorized for a maximum of 12 consecutive calendar months to meet an individual's short-term behavioral or medical needs.

This Consolidated Waiver-funded Supplemental Habilitation service must be prior authorized by ODP. Please refer to Informational Packet entitled *ODP Guidelines for Prior Authorizing Supplemental Habilitation Services and Additional Individualized Staffing Services for FY 10-11* for more information regarding the prior authorization process.

The procedure codes and service unit for Supplemental Habilitation follows:

<u>Supplemental Habilitation</u>

Provider Type **52**, Community Residential Rehabilitation

Specialty **520** C&Y Licensed Group Home
Specialty **456** CRR-Adult
Specialty **522** Family Living Homes-6500
Specialty **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	Service Level	Service Description	Service Unit
W7070	Supplemental Habilitation 1:1	The provision of 1:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the unique needs of the individual.	15 Minutes
W7084	Supplemental Habilitation 2:1	The provision of 2:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the unique needs of the individual.	15 Minutes

- **Additional Individualized Staffing** (Licensed Residential Habilitation Services only)

  When Additional Individualized Staffing is used to supplement the licensed residential habilitation service (that is licensed under 55 Pa.Code Chapters 3800, 5310, 6400, 6500) to meet the individual's ***long-term*** behavioral or medical needs as well as other life-changing needs that require Additional Individualized Staffing. Other life-changing needs may include the following situations:

  - Individual retires from day program activities or from competitive employment.
  - Court-ordered supervision.
  - Supervision required as a result of a life-changing circumstance.

  This service differs from the Supplemental Habilitation service in that the individual's need for staffing is long-term and the individual's staffing needs can no longer be met as part of the usual Residential Habilitation staffing pattern. Long-term, as it is used in the Additional Individualized Staffing service definition, is defined as a staffing need for one individual that will be required for more than 12 consecutive calendar months until the individual no longer requires the additional staffing. This is an individualized service that may not be used to adjust a provider's rate.

  This Consolidated Waiver-funded Additional Individualized Staffing service must be prior authorized by ODP. Please refer to Informational Packet entitled *ODP Guidelines for Prior Authorizing Supplemental Habilitation Services and Additional Individualized Staffing Services for FY 10-11* for more information regarding the prior authorization process.
  The procedure codes and service units for Additional Individualized Staffing follows:

  <u>Additional Individualized Staffing</u>

  Provider Type **52**, Community Residential Rehabilitation

  Specialty **520** C&Y Licensed Group Home
  Specialty **456** CRR-Adult
  Specialty **522** Family Living Homes-6500
  Specialty **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	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

- **Other Home and Community Based Services** (unbundling services)

  The Residential Habilitation Service provider may provide other non-habilitation home and community-based services authorized in the individual's ISP that are not a required component of the basic Residential Habilitation Service (for example, Physical therapy). The provision of such services may not duplicate services integral to a Residential Habilitation Service provider's licensure, and must be included on the individual's ISP as a separate service using the other home and community-based service's procedure code and applicable modifiers. The Residential Habilitation Service provider must meet the respective provider qualification criteria to render the discrete service. Please note that the individual retains free choice of provider to render the discrete service.

Bed Reservation Days *(Consolidated & P/FDS Waiver)*

Bed Reservation Days may be utilized for temporary absences in Waiver-funded licensed and unlicensed residential habilitation settings. Temporary absences are defined as absences due to therapeutic or medical leave in which an individual is expected to return to the residential habilitation setting. The bed reservation days allow reimbursement of an unlicensed Residential Habilitation Service provider for temporary absences of individuals enrolled in the Consolidated or P/FDS Waiver, and reimbursement of a licensed Residential Habilitation Service provider for temporary absences of individuals enrolled in the Consolidated Waiver. ODP will provide reimbursement for bed reservation days as per the Residential Habilitation policy, distributed October 22, 2008.

Payment will not be made for a therapeutic or medical leave day if the provider uses the bed for an alternative purpose during a temporary absence. For example, the Department will not pay for therapeutic or medical leave when the provider uses the bed to provide respite services to another individual.

- **Therapeutic Leave**

  A therapeutic leave day is defined as an absence from the residential habilitation service location to visit with a relative or friend, including absence due to vacation when the individual is not accompanied by a staff person from the residential habilitation service location, and is, therefore, not receiving services from the Residential Habilitation Service provider. Based on the definition of a day unit, the first day of absence for therapeutic leave is defined as 12 to 24 hours of continuous absence within a 24 hour period between 12:00 a.m. and 11:59 p.m. when the individual is not accompanied by, or receiving services from, the Residential Habilitation Service provider. If the individual's therapeutic leave begins immediately after the day program, then the absence begins when the day program ends.

- **Medical Leave**

  Medical leave is defined as a temporary absence when an individual has been admitted into a nursing facility, acute care general hospital, rehabilitative hospital, rehabilitation unit of an acute care general hospital, or short term stay in a rehabilitation facility, psychiatric hospital, or psychiatric unit of an acute care general hospital and is expected to return to the residential habilitation service location.

  The first day of absence for medical leave is the date of admission to the facility regardless of the length of the absence. The last day of the medical leave is the day before the date of discharge from the facility. On the date of discharge, the service is considered a Residential Habilitation Service day, not a medical leave day, regardless of the number of hours of service provided on that calendar day.

  Providers of Waiver-funded residential services are expected to be involved in situations when an individual they serve is hospitalized and is expected to return to the home. This involvement can range from attending and maintaining regular appointments with the treating physician to participating in the discharge planning process for the individual. In addition provider agencies may render staff support to an individual in the hospital when there is a compelling reason to do so, such as an indication that the person will be at significant risk absent those supports and the staffing level at the home permits or when no other type of support is available. This determination should be made on a case-by-case basis.

Claims submission of Bed Reservation Days (both licensed and unlicensed Residential Habilitation Service settings)

Temporary absence days will be billed using modifiers as specified below. To receive payment for either therapeutic or medical leave, the Residential Habilitation Service provider must submit claims using the appropriate eligible and ineligible procedure

codes and modifiers to differentiate between Residential Habilitation Service, therapeutic leave, and medical leave

The modifiers and service units for Bed Reservation days follow:

Bed Reservation Days

Provider Type **52**, Community Residential Rehabilitation

Specialty **520** C&Y Licensed Group Home
Specialty **456** CRR-Adult
Specialty **522** Family Living Homes-6500
Specialty **521** Adult Residential-6400
Specialty **524** Unlicensed

Age Limits & Funding: Consolidated Waivers: 3-120 years; Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Allowable Modifiers	Service Level	Service Description	Service Unit
UC	Bed Reservation for Therapeutic Leave	This modifier must be added to the eligible and ineligible service procedure codes on the claim submitted for the Residential Habilitation Service the individual is receiving, when the individual is temporarily absent from the Residential Habilitation Service setting for therapeutic leave.	**Day**
UD	Bed Reservation for Medical Leave	This modifier must be added to the eligible and ineligible service procedure codes on the claim submitted for the Residential Habilitation Service the individual is receiving, when the individual is temporarily absent from the Residential Habilitation Service setting for a stay in a hospital or rehabilitation facility.	**Day**

Permanent Vacancy (*Consolidated Waiver and Base Funding*, 55 Pa.Code Chapters 6400, 5310, 3800 licensed homes only)

A permanent vacancy is defined as one in which the individual is no longer eligible for and is, therefore, dis-enrolled from the Consolidated Waiver because the individual is not expected to return to the residential habilitation site due to one of the following situations:

- The individual dies.
- The individual moves out of the Commonwealth of Pennsylvania.
- The individual is permanently placed in an alternative setting such as an ICF/MR or a nursing home.

Payment for Permanent Vacancies must be prior authorized by ODP. Please refer to ODP Informational Packet 007-09 entitled *Payment through Treasury for Direct Service Providers* for information regarding this process.

The Department will not pay for a permanent vacancy if the provider uses the permanent vacancy for an alternative purpose such as respite, if the provider does not

cooperate with the placement process, or if there is a planned move from a Residential Habilitation service location operated by one provider agency to a Residential Habilitation service location operated by another provider agency.

ODP has the option to recoup any funded permanent vacancies if:

- A licensing action is a result of founded abuse or neglect by the provider agency.
- The provider has a provisional licensing status under certain circumstances (for example, a 3rd or 4th provisional license is issued to the provider agency).
- A provider's license has been revoked and the provider agency files an appeal.
- An incident of founded neglect results in an Act 28 notification to the local District Attorney or Attorney General when applicable to determine if the neglect is a criminal offense in accordance with the Act.
- The provider has any pending Medical Assistance restrictions.

For planned moves, the provider agency of the current Residential Habilitation service location is responsible to initiate the process to fill the vacancy immediately upon notification or recognition of an impending vacancy. For example, an individual who resides in a Residential Habilitation service location operated by Provider A notifies the provider of their intent to move to a Residential Habilitation service location operated by Provider B. Upon notification of the intent to move, the transition process begins, and Provider A is responsible to notify the authorizing AE to begin the vacancy management process. In these situations, the vacancy management process will take place during the transition of the individual from Provider A to Provider B.

ODP will allow movement of individuals to a different site location within the same provider agency when a permanent vacancy exists at one of the provider's service locations that would better meet the needs of an individual. When a permanent vacancy exists, a provider may use the approved 60 calendar day time period to move individuals internally in order to better accommodate the individuals' changing needs. Only the initial 60 calendar day time period will be approved as a permanent vacancy regardless of the number of individuals moved within the provider agency's site locations. The changing need of the individuals who will be moved must be reflected in each individual's ISP. The provider agency must communicate the site location of the final remaining vacancy to the Regional Waiver Capacity within 5 calendar days. The provider agency will designate that it plans to make internal moves on the Provider Vacancy Management Notification Form by checking the appropriate block on the form. In addition, a plan is required to be attached to the Provider Vacancy Management Notification Form with details of the movement. In no event will the movement between a provider agency's site locations alter the approved program capacity at any service location unless requested of and approved by ODP.

The procedure codes and service unit for Permanent Vacancy follow:

Permanent Vacancy

Provider Type **52**, Community Residential Rehabilitation Specialty **520** C & Y Licensed Group Home
Specialty **456** CRR-Adult
Specialty **524** Unlicensed [Community Homes]
Specialty **521** Adult Residential-6400
Age Limits & Funding: Consolidated Waivers: 3 - 120 years old; Base Funded: 0 – 120 years old
Allowable Place of Service: 12-Home

Procedure Code	Service Level	Service Description	Service Unit
W7056	Permanent Vacancy for Residential Services, Eligible Portion	This procedure code is used to bill for the costs of the eligible portion of permanent vacancies in Residential Habilitation service locations, as per ODP's vacancy management policy.	Day
W7030	Permanent Vacancy for Residential Services, Ineligible Portion	This procedure code is used to bill for the costs of the ineligible portion of permanent vacancies in Residential Habilitation service locations, as per ODP's vacancy management policy.	Day

Eligible Settings for Temporary and Permanent Absences

The Residential Habilitation policy applies to:

- Temporary and permanent absences that occur in Consolidated Waiver-funded Residential Habilitation service locations licensed under 55 Pa.Code Chapter 6400, or exempt from licensing under 55 Pa.Code §6400.3(f)(7).
- Temporary absences for Consolidated Waiver participants in Family Living Homes licensed under 55 Pa.Code Chapter 6500 or exempt from licensing under 55 Pa.Code §6500.3(f)(5), children's residential settings licensed under 55 Pa.Code Chapter 3800 and community residential rehabilitation services licensed under 55 Pa.Code Chapter 5310.
- Permanent vacancies for Consolidated Waiver participants in Residential Habilitation service locations licensed under 55 Pa.Code Chapter 3800 or Chapter 5310 only with ODP approval and only retrospectively, if the vacancy is filled with a Waiver participant.

Unlicensed Residential Habilitation Services

These are direct and indirect services provided in provider owned, rented, leased, or operated unlicensed Residential Habilitation settings (for example, unlicensed Community Homes or unlicensed Family Living Homes). The primary family living provider is eligible for substitute care to provide relief, based on the needs of the individual and the primary lifesharer. The costs of substitute care are included in the Family Living provider agency rate.

Unlicensed Residential Habilitation is rendered in provider owned, rented, leased or operated community homes and family living homes:

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

The 30 hours per week per home is a weekly average in a year of the total services of all individuals who reside in the provider owned, rented, leased or operated home.

All waiver-funded homes must be integrated and dispersed in the community in noncontiguous locations and may not be located on campus settings.

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

Unlicensed Residential Habilitation—Community Homes

Provider Type **52**, Community Residential Rehabilitation Specialty **524** Unlicensed
Age Limits & Funding: Consolidated & P/FDS Waivers: 18[7]–120 years old; Base Funding: 18[7]-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	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

[7] The Community Home Service paid through the Consolidated or P/FDS Waiver or through base funds is primarily for adult individuals with mental retardation. However, there may be exceptions as stated in various Pennsylvania laws.

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

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

Unlicensed Residential Habilitation—Family Living Homes

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

Licensed Residential Habilitation Services

These are direct (face-to-face) and indirect services provided in provider owned, rented, leased, or operated licensed residential habilitation settings (for example, licensed Family Living Homes). Licensed Residential Habilitation Services are only available through the Consolidated Waiver and base funds.

Services must meet regulatory requirements of homes licensed under 55 Pa.Code Chapters 3800, 5310, 6400, or 6500. Waiver-funded Licensed Residential Habilitation Services may **not** be provided in Personal Care Homes. Waiver-funded Licensed Residential Habilitation Services may only be provided in Domiciliary Care Homes if the home is licensed by the Department of Public Welfare and certified by the local Area Agency on Aging (see Bulletin 00-00-05, *Domiciliary Care for Persons with Mental Retardation*).

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 Consolidated Waiver or base funds are limited to residential habilitation service settings. Child residential services provided in secure settings, detention centers, mobile programs, outdoor programs, and residential treatment facilities accredited by JCAHO (Joint Commission on Accreditation of Healthcare Organizations) may not be funded through the Consolidated Waiver.

The procedure codes and service units for Child Residential Services follow:

Licensed Residential Habilitation—Child Residential Services

Provider Type **52**, Community Residential Rehabilitation Specialty **520** C & Y Licensed Group Home
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	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-Ten-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a five-to-ten-individual home if the home was established prior to January 1, 1996.	Day
W7019	Five-to-Ten-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a five-to-ten-individual home.	Day

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

CRRS are characterized as transitional residential habilitation programs in community settings for individuals with chronic psychiatric disabilities. This service is full-care CRRS for adults with mental retardation and mental illness. Full-care CRRS for adults 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 § 5310.6, are excluded.

The procedure codes and service units for Community Residential Rehabilitation Services follow:

Licensed Residential Habilitation—Community Residential Rehabilitation Services for the Mentally Ill

Provider Type **52**, Community Residential Rehabilitation Specialty **456** CRR-Adult
Age Limits & Funding: Consolidated Waiver: 18[8] – 120 years old; Base Funding: 18[8] - 120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	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-Ten-	The eligible portion of the community	Day

[8] The Community Residential Rehabilitation Service paid through the Consolidated Waiver or through base funds is primarily for adult individuals with mental retardation. However, there may be exceptions as stated in various Pennsylvania laws.

	Individual Home, Eligible	residential rehabilitation services provided in a five-to-ten-individual home, if the home was established prior to January 1, 1996.	
W7029	Five-to-Ten-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a five-to-ten-individual home.	Day

Family Living Homes (55 Pa.Code Chapter 6500)

Family Living Homes are different than other licensed Residential Habilitation homes as these settings provide for lifesharing arrangements. Individuals live in host family homes and are encouraged to become contributing members of the family unit. Family living arrangements are chosen by individuals and families in conjunction with host families and in accordance with the individual's needs. Licensed Family Living Homes are limited to homes in which one or two individuals with mental retardation reside with a host family. Relatives, Legal Guardians and Legally Responsible Individuals, and their Spouses, (including spouses of the individual) may not be the host family. The individuals with mental retardation may not be family members or relatives of family members of the host family. However, individuals with mental retardation who receive services in the family living home may be related to each other. The primary lifesharer is eligible for substitute care to provide relief, based on the needs of the individual and the primary lifesharer. The costs of substitute care are included in the Family Living provider agency rate.

The procedure codes and service units for Licensed Family Living Homes follow:

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[9] - 120 years old; Base Funding: 18[9] - 120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	**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

[9] The Adult Family Living Service paid through the Consolidated Waiver or through base funds is primarily for adult individuals with mental retardation. However, there may be exceptions as stated in various Pennsylvania laws.

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	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

Community Home Services for Individuals with Mental Retardation (55 Pa.Code Chapter 6400)

A licensed community home is a home licensed under 55 Pa.Code Chapter 6400 where Residential Habilitation Services are provided to individuals with mental retardation. 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 mental retardation…."

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

Licensed Residential Habilitation—Community Homes

Provider Type **52**, Community Residential Rehabilitation Specialty **521** Adult Residential-6400
Age Limits & Funding: Consolidated Waiver: 18[10] - 120 years old; Base Funding: 18[10] - 120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	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	The eligible portion of the licensed	Day

[10] The Community Home Service paid through the Consolidated Waiver or through base funds is primarily for adult individuals with mental retardation. However, there may be exceptions as stated in various Pennsylvania laws.

	Home, Eligible	community home services provided in a two-individual home.	
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-Ten-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a five-to-ten-individual home, if the home was established prior to January 1, 1996.	Day
W6099	Five-to-Ten-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a five-to-ten-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 §6400.271-275.	Day

Companion Services

Companion Services are provided to individuals living in private residences for the limited purposes of providing supervision and necessary care and minimal assistance that is focused solely on the health and safety of the adult individual (18 years of age and older) with mental retardation. This service is not available to people who are residing in Unlicensed or Licensed Residential Habilitation settings. Companion Services are used in lieu of habilitation services to protect the health and welfare of the individual when a habilitative outcome is not appropriate or feasible (that is, when the individual is *not* learning, enhancing, or maintaining a skill). 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 with mental retardation. For example, a companion can be used during overnight hours for an individual who lives on their own but does not have the ability to safely evacuate in the event of an emergency. This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety. Companions may supervise and provide necessary care and minimal assistance with daily living activities, including grooming, health care, household care, meal preparation and planning, and socialization. This service may not be provided at the same time as any other direct service.

Transportation included in the rate for Companion Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP. This means that when Companion Services are provided and transportation is integral to the delivery of that service, transportation funding is included in the rate for that service. In these cases transportation cannot be authorized as a separate service on the ISP or duplicated through the inclusion of a separate transportation service authorized on an individual's ISP to meet the transportation components of these services.

Companion Services paid through an FMS for self-directing Waiver participants do not include transportation as part of the rate paid for the service. For self-directing Waiver participants, discrete Transportation services may be included on the ISP to meet the transportation needs of the Companion Service.

This service may be provided in Pennsylvania, or anywhere in the 50 United States, the District of Columbia, or the American territories during temporary travel. The service may also be provided on an ongoing basis by qualified agency providers located in or individual providers residing in Pennsylvania as well as agency or individual providers based in states contiguous to Pennsylvania.

This service is not available for people residing in agency-owned, rented, leased, or operated (that is, licensed and unlicensed Family Living homes) homes. Companion and Home and Community Habilitation (Unlicensed) Services have a combined maximum limit of 24 hours (96 15-minute units) per participant per calendar day.

The procedure codes, modifiers, and service units for Companion Services follow:

Companion Services

Provider Type **51**, Home & Community Habilitation
Provider Type **54**, Intermediate Service Organization

Specialty **363**, Companion Service
Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent

(The asterisked services below are applicable to Provider type 54 and specialties 540 and 541).
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	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

Provider Type **54**, Intermediate Service Organization Specialty **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

Day Services

ODP requires that individuals are provided with flexibility in the utilization of day services (to include Home and Community Habilitation (Unlicensed) utilized for community-based day services, Licensed Day Services, Prevocational Services, Supported Employment, and Transitional Work Services). This flexibility may include the use of different day service options to meet a individual's needs (for example, Supported Employment three days per calendar week combined with Transitional Work Services two days per calendar week), as well as timely revisions to ISPs to accommodate changes in day service needs. The goal is to provide individuals with unique day service combinations to meet individuals' needs, and help individuals to achieve employment and volunteering outcomes. The flexibility provides a safety net often expressed by families as needed in the event an individual is not successful in maintaining employment.

Agency-based providers of Licensed Day Habilitation or Prevocational Services may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does *not* include transportation to and from the individual's home (including licensed and unlicensed Residential Habilitation settings) and the Day Habilitation service.

The Day Services provider is not responsible for transportation to and from other service offerings and is only responsible for the transportation that is necessary during the delivery of the Day service that the provider is authorized to provide. The following example may help explain the requirement. The individual arrives at the authorized Day service location and the Day service begins. As part of the Day service, the individual requires a ride to and from a community location to accomplish the Day service outcomes identified in the ISP. The Day service provider must ensure the provision of necessary transportation to accomplish the outcomes associated to them as the Day service provider. In most cases the Day service provider will use agency staff and an agency vehicle; however, the team should consider all appropriate options.

If a Day service provider wishes to provide transportation services as a separate service offering, the Day service provider would need to enroll as a provider or vendor of transportation services. In addition, when the provider offers transportation as an

additional service, the provider may consider the option to subcontract with existing transportation entities as long as they verify those entities meet the requirements to render transportation services.

Transportation included in the rate for the Day service may NOT be duplicated through the inclusion of the transportation service on an individual's ISP. This means that when the Day service is provided and transportation is integral to the delivery of that service, transportation funding is included in the rate for that service. In these cases transportation cannot be authorized as a separate service on the ISP or duplicated through the inclusion of a separate transportation service authorized on an individual's ISP to meet the transportation components of the these services.

These services may be provided on an ongoing basis by qualified providers based in Pennsylvania or in states contiguous to Pennsylvania. When provided in contiguous states, the service must be licensed in accordance with that state's comparable licensing regulations.

Licensed Day Services

Licensed Day Habilitation (55 Pa.Code Chapter 2380), Adult Training Facilities and Older Adult Daily Living Centers (6 Pa.Code Chapter 11)

This is a direct service (face-to-face) that must meet the regulatory requirements of either 55 Pa.Code Chapter 2380 (Adult Training Facilities) or 6 Pa.Code Chapter 11 (Older Adult Daily Living Centers). Services consist 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 following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment (both the direct and indirect portions of the service).

Licensed Day Habilitation Services, Prevocational Services, Transitional Work Services, and Home and Community Habilitation (Unlicensed) services may not overlap in terms of day and time.

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

Licensed Day Habilitation—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 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.	
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 Enhanced	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		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses.	

Please note: If an individual requires 1:1 or 2:1 staffing during Licensed Day Habilitation Service, the day service provider is responsible to provide the staffing. Needed day staffing may not be provided by the individual's Residential Habilitation, Home and Community Habilitation (Unlicensed), or other non-day habilitation provider, and these types of services may not be used to supplement the Licensed Day Habilitation Service.

The procedure code and service unit for Older Adult Daily Living Centers follow:

Licensed Day Habilitation—Older Adult Daily Living Centers

Provider Type **51**, Home & Community Habilitation Specialty **410**, Adult Day Care
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	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 older individuals with mental retardation in licensed Older Adult Daily Living Centers.	15 minutes

Prevocational Service (55 Pa.Code Chapter 2390), Vocational Facilities

This is a direct service (face-to-face) that must meet the regulatory requirements of 55 Pa.Code Chapter 2390 (Vocational Facilities). This service is provided to assist individuals in developing skills necessary for placement in a higher level vocational program and ultimately into competitive employment. Individuals receiving prevocational services must have an employment outcome included in their ISP. The service may be provided as:

- *Facility-based employment*. Facility-based employment focuses on the development of competitive worker traits through the use of work as the primary training method.
- *Occupational training*. Occupational training 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.
- *Vocational evaluation*. Vocational evaluation 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.
- *Vocational facility*. A vocational facility is a premise where habilitative employment or employment training is provided to one or more individuals with disabilities.
- *Work activities center*. A work activities center is a program focusing on behavioral and/or therapeutic techniques to enable individuals to attain sufficient vocational, personal, social, independent living skills to progress to a higher level vocational program.

Agency-based providers of Prevocational Services may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does not include transportation to and from the individual's home (including licensed and unlicensed Residential Habilitation settings) and the day service. Transportation included in the rate for Prevocational Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP.

Handicapped employment as defined in 55 Pa.Code Chapter 2390 may not be funded through the Waivers.

This service may not be funded through either Waiver or through base allocation if it is available to individuals through a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or section 602 (16) and (17) of the Individuals with Disabilities Education Act (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 Rehabilitation Act of 1973 as amended and the IDEA.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment (both the direct and indirect portions of the service).

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Home and Community Habilitation (unlicensed) services may not overlap in terms of day and time.

The procedure codes, modifiers, and service units for Prevocational Service follow:

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 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.	
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 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 members are licensed nurses.	

Please note: If an individual requires 1:1 or 2:1 staffing during Prevocational Services, the Prevocational provider is responsible to provide the staffing. Needed day staffing may not be provided by the individual's Residential Habilitation, Home and Community Habilitation (Unlicensed), or other non-prevocational service provider, and these types of services may not be used to supplement the Prevocational Service.

Waiver-Funded Supports Coordination

The following definition and procedure code for Supports Coordination applies only to those Supports Coordination services funded through the Consolidated and P/FDS Waivers.

Supports Coordination is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for waiver participants. Locating services and supports consists of assistance to the participant 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 locating function include all of the following, in addition to the documentation of 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 participants' unique strengths and needs, for planning purposes and ISP development in order to address all areas of needs and the participant's strengths and preferences.
- Coordinate the development of the ISP.
- Assist the participant 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 participant and his or her family in identifying and choosing willing and qualified providers.
- Inform participants about unpaid, informal, generic, and specialized services and supports that are necessary to address the identified needs of the participant and to achieve the outcomes specified in the ISP;
- Provide information to participants on fair hearing rights and assist with fair hearing requests when needed and upon request.
- Assist participants in gaining access to needed services and entitlements, and to exercise civil rights.

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

- Use a person centered planning approach and a team process to develop the participant's ISP to meet the participant'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 participant, to develop the ISP to address all of the participant's needs.

- Periodic review of the ISP with the participant, including update of the ISP at least annually and whenever a participant's needs change.
- Periodic review of the standardized needs assessment through a face-to-face visit with the participant, at least annually or more frequently based on changes in a participant's needs, to ensure the assessment is current.
- Coordinate support planning with providers of service to ensure consistency of services.
- Coordinate with other program areas as necessary to ensure all areas of the participant's needs are addressed.
- Contact with family, friends, and other community members to coordinate the participant's natural support network.
- Facilitate the resolution of barriers to service delivery and civil rights.
- Disseminate information and support to participants and others who are responsible for planning and implementation of services.

Monitoring consists of ongoing contact with the participant and their family, and oversight, to ensure services are implemented as per the participant's plan. Activities included under the monitoring function include all of the following, in addition to the documentation of activities:

- Monitor the health and welfare of participants through regular contacts at the minimum frequency outlined in Appendix D-2-a of the Consolidated or P/FDS Waiver.
- Monitor ISP implementation through monitoring visits with the participant, at the minimum frequency outlined in Appendix D-2-a of the Consolidated or P/FDS Waiver.
- Visit with the participant's family, when applicable, and providers of service for monitoring of health and welfare and support plan implementation.
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of participants.
- Evaluate participant progress.
- Monitor participant and/or family satisfaction with services.
- Arrange for modifications in services and service delivery, as necessary to address the needs of the participant, and modify the ISP accordingly.
- Ensure that services are appropriately documented in HCSIS on the ISP.
- Work with the authorizing entity regarding the authorization of services.
- Communicate the authorization status to ISP team members, as appropriate.
- Validate that service objectives and outcomes are consistent with the participant's needs and desired outcomes.
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and participant rights.
- Participate in activities related to Independent Monitoring for Quality, such as obtaining consent to participate from the participant, preparing survey information, and follow up activities ("closing the loop").

In addition to locating, coordinating, and monitoring, Supports Coordination also includes providing information and assistance in order to help participants decide whether to select participant direction of services, and assistance for participants who opt to direct services. Activities include all of the following, in addition to the documentation of activities:

- Provide participants 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 participant is interested in this model, and ensure continuity of services during transition.
- Assist the participant in designating a surrogate[11], as desired, as outlined in Appendix E-1-f of the Consolidated or P/FDS Waiver.
- Provide support to participants who are directing their services, such as assistance with managing participant-directed services specified in the ISP.

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 mental retardation and qualifies for Medical Assistance.
- Direct Prevention Services, which are used to reduce the probability of the occurrence of mental retardation resulting from social, emotional, intellectual, or biological disorders.
- General information to participants, families, and the public that is not on behalf of a waiver participant;
- Travel expenses of the Supports Coordinator may not be billed as a discrete unit of service.
- Services otherwise available under Medicaid and Early Intervention.
- Services that constitute the administration of foster care programs.

[11] Not everyone can make legally binding decisions for themselves. This would include minor children and some adults who have substantial mental impairment. In these instances, a substitute decision-maker may be identified under State law. Substitute decision-makers have various legal titles, but for the purposes of this bulletin, they will be referred to as "surrogates." "Surrogates" include the following:

- Parents of children under 18 years of age under the common law and 35 P.S. § 10101.
- Legal custodian of a minor as provided in 42 Pa.C.S. § 6357.
- Health care agents and representatives for adults as provided in 20 Pa.C.S. Ch. 54.
- Guardians of various kinds as provided in 20 Pa.C.S. Ch. 55 (as limited by 20 Pa.C.S. § 5521(f)).
- Holders of powers of attorney of various kinds as provided in 20 Pa.C.S. Ch. 56.
- Guardians of persons by operation of law in 50 P.S. §4417(c).

Any of these would be considered "legal representatives" as the Center for Medicaid and Medicare Services uses that phrase. Please see *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria.*

- 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 Supports Coordinator links, arranges, or obtains on behalf of the participant.
- Transportation provided to participants 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).
- Assistance in locating or coordinating burial or other services for a deceased participant.

Supports Coordination services may not duplicate other direct Waiver services. SCOs must be conflict-free entities. However, SCOs who are county based may share a Federal Employment Identification Number (FEIN) with the County Transportation Service.

Waiver-funded Supports Coordination services may only be provided to Consolidated and P/FDS participants.

The procedure code and service unit for Supports Coordination Services follows:

Supports Coordination

Provider Type **21**, Case Manager Specialty **218**, MR 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	Supports Coordination	Locating, coordinating, and monitoring needed services and supports for waiver participants.	15 minutes

Supports Broker Services

This is a direct (face-to-face) and indirect service to individuals with mental retardation in arranging for, developing, and managing the services they are self-directing through either employer authority (that is, hiring/managing workers) or budget authority (that is, determining worker salaries within the established wage ranges, shifting units and associated funds between approved services). Services are provided to assist individuals in identifying immediate and long-term needs, developing community-based

options to meet those needs, and accessing identified supports and services. Services also involve practical skills training and information for individuals and surrogates (that is, employer or managing employer) related to directing and managing services. This service is limited to:

- Assistance in identifying and sustaining a personal support network of family, friends, and associates to meet individual needs.
- Assistance in arranging for and effectively managing generic community resources and informal supports to meet individual needs.
- Assistance at planning meetings to ensure the individual's access to needed quality community resources.
- *In depth* practical skills training for individuals and surrogates related to self-direction and management of qualified SSW. Training is limited to employer responsibilities (for example, hiring, managing, and terminating SSWs; reviewing and approving timesheets; problem solving; conflict resolution).
- Assistance to the individual in managing, monitoring, and reviewing their participant directed services and associated funds.
- Development of back-up plans in the event of emergencies and/or unexpected SSW absences.
- Training to the individual to help them recognize reportable incidents and help them report the incidents to the Supports Coordinator or provider as required.
- Assistance with paperwork related to the individual's employer or managing employer responsibilities as the employer of record or managing employer of SSWs.
- Assistance with budgeting, including review and evaluation of monthly expenditure reports.
- Providing detailed information and training to individuals about: person-centered planning and how it is applied, risks and responsibilities related to self-direction, free choice of willing and qualified providers, individual rights, and use of community (that is, services or organizations available within the individual's community) and natural supports (that is, unpaid assistance to an individual).

This service is limited to individuals who are self-directing their services through employer and/or budget authority. This service is limited to a maximum of 1040 units per individual per fiscal year based on a 52-week year.

Supports brokers must work collaboratively with the individual's Supports Coordinator. The role of the Supports Coordinator continues to involve the primary functions of locating, coordinating, and monitoring of waiver services; while the Supports Broker assists individuals and surrogates with being able to self-direct the individual's services and supports. It is important to understand that each role is vital to the support of the individual and their surrogate. It is also important to understand that Supports Coordinators provide information related to self direction to individuals, families, and surrogates; however, Supports Coordinators do not assist individuals, families, and surrogates with the activities associated with self direction.

Supports Broker Services are different from Supports Coordination and Supports Brokers may not replace the role or perform the functions of a Supports Coordinator. No duplicate payments will be made.

Supports Broker Services are an identified participant-directed service and are available to individuals who:

- Have an identified need for Supports Broker Services.
- Are self directing their services.
- Are enrolled in one of the FMS options (Vendor Fiscal/Employer Agent [VF/EA] and Agency With Choice [AWC]).

Supports Broker Services can be provided to individuals that self direct by hiring qualified individual(s) to be the SSW of the Supports Broker Service or by selecting a qualified and willing provider to render the Supports Broker Services.

Supports Broker Services may not be rendered by providers that offer other mental retardation services or that offer mental retardation administrative services (for example, a Health Care Quality Unit or an Independent Monitoring Program). The only exception to this restriction is the ability for both the VF/EA FMS and AWC FMS to provide or pay for PDS, including Supports Broker Services, and to provide the VF/EA FMS or AWC FMS administrative services to individuals who self direct.

Supports Broker Services may be provided in Pennsylvania, or anywhere in the 50 United States, the District of Columbia, or the American territories during temporary travel. The service may also be provided on an ongoing basis by qualified agency providers located in or individual providers residing in Pennsylvania as well as agency or individual providers based in states contiguous to Pennsylvania.

The procedure code and service unit for Supports Broker Services follows:

<u>Supports Broker Service</u>

Provider Type **51**, Home & Community Habilitation Specialty **510**, Home & Community Habilitation
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
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; 12-Home; 99-Other (Community)

Procedure Code	**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 (hiring/managing workers) or budget authority (determining worker salaries, shifting units and associated funds between approved services and/or small unlicensed providers). Services are provided to assist individuals and surrogates in planning, organizing, and managing	15 minutes

		community resources and supports and workers. This service is limited to a maximum of 1040 units per individual per fiscal year based on a 52-week year.	

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

Employment Services

Supported Employment Services

Supported Employment Services are direct and indirect services that are provided in community employment work sites with co-workers who do not have disabilities for the purposes of finding and supporting individuals with mental retardation in competitive jobs of their choice. Supported Employment Services consist of two components: job finding and job support. Individuals who are receiving Supported Employment Services must receive minimum wage or higher for the hours worked in competitive employment.

Supported Employment Services consist of paid employment for individuals who, because of their disabilities, need intensive support to perform in a work setting. Supported Employment Services include activities needed to sustain paid work by individuals receiving Waiver services, including supervision and training. When Supported Employment Services are provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by the individuals receiving Waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment Services rendered under the Waivers are not available under a program funded by either the Rehabilitation Act of 1973 as amended, or by the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Documentation must be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

Federal Financial Participation through the Waivers may not be claimed for incentive payments, subsidies, or unrelated vocational expenses such as the following:

- Incentive payments made to an employer of individuals receiving services to encourage or subsidize the employer's participation in a supported employment program.
- Payments that are passed through to individuals receiving Supported Employment Services.
- Payments for vocational training that are not directly related to an individual's supported employment program.

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 the Office of Vocational Rehabilitation (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 finding activities are rendered on the behalf of one individual at a time.

Job support consists of training individuals in 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, 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 co-workers that will enable peer support. Job support activities are a direct service to one individual at a time.

Providers of Supported Employment Services may not bill travel time as a distinct, separate service unit when providing either the direct portion (job support) or the indirect portion (job finding) of the service. Travel costs are included as a part of the rate paid to the provider for each rendered unit of service.

Ongoing use of the service is limited to support for individuals that cannot be provided by the employer through regular supervisory channels or on-the-job resources that are available to employees who are non-disabled.

The provision of job finding services must be evaluated at least once every 6 calendar months by the ISP team, to assess 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 ISP team must identify changes to the Supported Employment Service to realize this outcome or other service options to meet the

individual's needs. The ISP must be updated, if necessary, to reflect the team's determination.

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.

The service may be provided on an ongoing basis by qualified providers based in Pennsylvania or in states contiguous to Pennsylvania.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment (both the direct and indirect portions of the service).
The procedure code and service unit for Supported Employment follows:

Supported Employment Services

Provider Type **53**, Employment-Competitive Specialty **530**, Job Finding
Specialty **531**, Job Support
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
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	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

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

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Used with W7235	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

Transitional Work Services

Transitional Work Services consist of supporting individuals in transition 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. Options for Transitional Work Services include:

- *Mobile Work Force*. A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who 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.
- *Work Station in Industry*. 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*. Affirmative Industry is operated as an integrated business, where disabled and non-disabled employees work together to carry out the job functions of the business.
- *Enclave*. An Enclave is a business model where disabled individuals are employed by a business/industry to perform specific job functions while working alongside non-disabled workers.

Agency-based providers of Transitional Work Services may only incorporate transportation costs into their rate when the transportation is necessary for involving individuals in activities that are integral to these services. An example is transportation that originates from a provider site to a community activity or function that is part of the overall program of activities of the provider. This does *not* include transportation to and from the individual's home (including licensed and unlicensed Residential Habilitation settings) and the Transitional Work Service.

The Transitional Work provider is not responsible for transportation to and from other service offerings and is only responsible for the transportation that is necessary during the delivery of the Transitional Work Service that the provider is authorized to provide. The following example may help explain the requirement. The individual arrives at the authorized Transitional Work service location and the Transitional Work Service begins. As part of the Transitional Work Service, the individual requires a ride to and from a community location to accomplish the Transitional Work outcomes identified in the ISP. The Transitional Work provider must ensure the provision of necessary transportation to accomplish the outcomes associated to them as the Transitional Work provider.

If a Transitional Work Services provider wishes to provide transportation services as a separate service offering, the Transitional Work Services provider would need to enroll as a provider or vendor of transportation services. In addition, when the provider offers transportation as an additional service, the provider may consider the option to subcontract with existing transportation entities as long as they verify those entities meet the qualification criteria to render transportation services.

Transportation included in the rate for Transitional Work Services may NOT be duplicated through the inclusion of the transportation service on an individual's ISP. This sentence means that when these services are being provided and transportation is integral to the delivery of that service, transportation funding is included in the rate for

that service. In these cases transportation cannot be authorized as a separate service on the ISP or duplicated through the inclusion of a separate transportation service authorized on an individual's ISP to meet the transportation components of the Transitions Work Services.

This service may not be funded through either Waiver or through base allocation if it is available to individuals under a program funded under section 110 of the Rehabilitation Act of 1973, as amended or section 602 (16) and (17) of IDEA. Documentation must be maintained in the file of each individual receiving these services to satisfy the state assurance that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.

The following services have a combined total limitation of 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year: Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Supported Employment (both the direct and indirect portions of the service).

Licensed Day Habilitation, Prevocational Services, Transitional Work Services, and Home and Community Habilitation (Unlicensed) services may not overlap in terms of day and time.

The service may be provided on an ongoing basis by qualified providers based in Pennsylvania or in states contiguous to Pennsylvania.

The procedure codes and service units for Transitional Work Service follow:

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	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

Please note: If an individual requires 1:1 staffing during Transitional Work Services, the Transitional Work Services provider is responsible to provide the staffing. Needed day staffing may not be provided by the individual's Residential Habilitation, Home and Community Habilitation (Unlicensed), or other non-transitional work service provider,

and these types of services may not be used to supplement the Transitional Work Services.

Nursing Services

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

"Diagnosing and treating human responses to actual or potential health problems through such service 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."

An individual's need for nursing services should be based on the individual's needs assessment results and other appropriate medical professional assessments.

Nursing services are State Medical Assistance Plan services and may only be funded through the waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or private insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Nursing services through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis

The procedure code, modifiers, and service units for Nursing Services follow:

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: 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
T2025	**TD**	**Nursing Service – RN**	This service consists of Nursing services within scope of practice.	15 minutes

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: 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
T2025	**TE**	**Nursing Service – LPN**	This service consists of Nursing services within scope of practice.	15 minutes

Therapy Services

Therapy services include the following:

- Physical therapy provided by a licensed physical therapist based on a prescription for a specific therapy program by a physician. The physical therapist develops a recommended plan of care.
- Occupational therapy by a registered occupational therapist based on a prescription for a specific therapy program by a physician. The occupational therapist develops a recommended plan of care.
- Speech/language therapy provided by an ASHA (American Speech-Language-Hearing Association) certified and state licensed speech-language pathologist upon examination and recommendation by an ASHA certified and state licensed speech-language pathologist or a physician.
- Visual/mobility therapy provided by a trained visual or mobility specialist/instructor based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician.
- Behavior therapy provided by a licensed psychologist or psychiatrist based on an evaluation and recommendation by a licensed psychologist or psychiatrist.

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 individualized outcome. 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 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.

Physical Therapy, Occupational Therapy, Speech and Language Therapy, and the Behavior Therapies are State Medical Assistance Plan services and may only be funded through the waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Therapy services through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by

the Supports Coordinator. This documentation must be updated on at least an annual basis.

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."

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

Physical Therapy

Provider Type **17**, Therapist Specialty **170**, Physical Therapist
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
T2025	**GP**	**Physical Therapy**	Physical Therapy service delivered under an outpatient physical therapy plan of care.	15 minutes

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. (4) Analyzing, selecting and

adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

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

Occupational Therapy

Provider Type **17**, Therapist Specialty **171**, Occupational Therapist
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
T2025	**GO**	**Occupational Therapy**	Occupational Therapy service delivered under an outpatient occupational therapy plan of care.	15 minutes

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.

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

Speech and Language Therapy

Provider Type **17**, Therapist Specialty **173**, Speech/Hearing Therapist
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
T2025	**GN**	**Speech and Language Therapy**	Speech/Language Therapy service provided by an ASHA certified and state licensed speech-language pathologist.	15 minutes

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 an 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 may take the form of individual therapy with the individual and the psychologist or psychiatrist, or in a group setting supervised and directed by the psychologist or psychiatrist.
The procedure code, modifier, and service unit for Individual and Group Behavior Therapy follow:

Behavior Therapy

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

Visual/Mobility 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.

The procedure code and service unit for Visual/Mobility Therapy follow:

Visual/Mobility Therapy

Provider Type **51**, Home & Community Habilitation Specialty **517**, Visual & Mobility Therapist
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
W7246	**Visual/Mobility Therapy**	Visual/Mobility Training for individuals with mental retardation who are blind or have visual impairments.	15 minutes

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 training to individuals, staff, parents and caretakers. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

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

- Collection and evaluation of behavioral data;
- Observation of the participant in various settings for the purpose of developing a behavior support plan;
- Collaboration with the participant, their family, and their 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 participant, based on functional behavioral assessments;
- Conducting training related to the implementation of behavior support plans for the participant, family members, and staff;
- Implementation of activities and strategies identified in the participant's behavior support plan;
- Monitoring implementation of the behavior support plan, and revising as needed;
- Collaboration with the participant, their family, and their 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, the location of other authorized services, 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.

Behavioral Support services may be provided during the same day and time as other services, but may not duplicate other services. For example, Behavioral Support may be provided during the same day and time as Residential Habilitation, but the Behavioral Support provider may not render services that overlap with the responsibilities of the Residential Habilitation provider.
The procedure code and service units for Behavioral Support follow:

Behavioral Support Services

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

Respite Services (Waiver-Funded)

Respite 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 to the individual. 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. Respite Services are limited to individuals residing in private homes (the individual's own home or the home of a relative or friend).

The provision of Respite Services does not prohibit supporting individuals' participation in activities in the community during the period of respite. The provision of 24-hour respite services does not prohibit individuals' participation 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 day unit. Each day unit is defined as a period of time that is more than 16 hours to 24 hours in length.
    - For In-Home Respite, the day unit is calculated from the time the respite worker arrives at the individual's home to begin providing relief to the normal caregiver until the time the respite worker stops providing relief to the normal caregiver. If an individual attends another service while receiving In-Home Respite, 24 Hours, the time the individual is attending the other service is not calculated towards the number of units that the respite provider renders. In summary, if the individual receives In-Home Respite services from the respite provider more than 16 hours within the 24 hour time period, this is considered a day of respite.
    - For Out-of-Home Respite, 24-Hour or Respite Camp, 24-Hour the the day unit is calculated from the time the individual arrives at the respite setting until the individual returns to their normal living arrangement. If an individual attends another service while receiving respite services at a Respite Out-of Home facility and the individual is expected to return to the respite facility after the other service ends, the time the individual is attending the other service is not calculated towards the number of units that the respite provider renders. In summary, if the individual receives Out-of Home Respite services from the respite provider more than 16 hours within the 24 hour time period, this is considered a day of respite.
    - 24-hour respite is limited to 30 day units per individual per fiscal year, except when extended by the ODP Regional Office based on individual needs.
- 15-Minute Respite is provided for periods of 16 hours or less within a 24-hour period, and is billed using a 15-minute unit.
    - 15-minute respite is limited to 480 (15 minute) units per individual per fiscal year, except when extended by the ODP Regional Office based on individual needs.

Federal and State financial participation through the **Waivers** is limited to:

1. Respite Services provided for individuals residing in the individual's unlicensed home or the unlicensed home of relative, friend, or other family member.
2. Respite services that are provided by providers or individuals who meet the qualification requirements outlined in Appendix C of the Consolidated and P/FDS Waivers. This requirement extends to all types of respite, including Respite – Camp.
3. Room and board costs associated with respite care services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence.
4. The following Respite Service limits apply to all Waiver-funded Respite, which includes Respite Camp Services:
    a. Thirty (30) day units of 24-hour respite per individual in a period of one fiscal year except when extended by the ODP Regional Office. This

requirement is applicable to In-Home Respite – 24 Hours; Respite – Unlicensed Out of Home, 24 Hours; Respite – Licensed Out of Home, 24 Hours; and Respite – Camp, 24 Hours.

b. 480 (15 minute) units of 15-minute respite per individual in a period of one fiscal year except when extended by the ODP Regional Office. This requirement is applicable to In-Home Respite – 15 Minutes; Respite – Unlicensed Out of Home, 15 Minutes; Respite – Licensed Out of Home, 15 Minutes; and Respite – Camp, 15 minutes.

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

- Individual's private home or place of residence located in Pennsylvania.
- Licensed or approved foster family home or family living home (55 Pa.Code Chapter 6500) located in Pennsylvania.
- Waiver funded licensed community homes (55 Pa.Code Chapter 6400) 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 site location's approved program capacity for emergency situations only. Written approval to provide respite services beyond the approved program capacity must be obtained from the ODP Regional Waiver Capacity Manager before the provision of respite occurs. Modifier U2 will be used with the respite procedure code both in the ISP and when the provider submits a claim for the service.

  In <u>no</u> circumstance will this emergency approval result in more than 4 individuals receiving services from the Community Home provider in a calendar day, regardless of the site location's licensed capacity.

  This respite policy for Community Homes does not alter or change the Respite in a Larger Setting policy (mentioned on page 11 of this document) that provides an exception process to request respite services be provided in a large non-Waiver-funded setting in which no approved program capacity is established.

- Licensed Child Residential Service Home (55 Pa.Code Chapter 3800).
- Licensed Community Residential Rehabilitation Services for the Mentally Ill Home (55 Pa.Code Chapter 5310)
- Unlicensed home of a provider or individual meeting the qualifications.
- Other community settings such as summer camp where the setting meets applicable state or local codes and the provider of service meets the provider qualifications established by the Department. This includes respite provided in Pennsylvania, or anywhere in the 50 United States, the District of Columbia, or the American territories during temporary travel. It also includes Respite Services provided on an ongoing basis by qualified agency providers located in or

individual providers residing in Pennsylvania as well as agency or individual providers based in states contiguous to Pennsylvania.

This service is not available for individuals residing in agency-owned, rented, leased, or operated homes (for example, licensed and unlicensed Family Living homes).

These services may **not** be provided in personal care boarding homes, nursing homes, hospitals, or ICFs/MR. Respite may be provided in hospitals and nursing homes through base funding under Base-Funded Respite Care.

Respite billed under the following procedure codes can only be funded through Waiver dollars.

For Respite – Licensed Out-of-Home, 24 Hours settings with a Waiver-funded permanent or temporary vacancy, base funds may be used to pay for the respite service when respite is provided to an individual who receives base-funded services in the vacant bed. Base funds may only be used for procedure codes W9591, W9592, W9593, and W9594.

Respite – In-Home, 24 Hours

This service is provided in segments of day units (each day unit comprises a period of time that is more than 16 hours to 24 hours in length). This service is provided in the private homes of individuals with mental retardation. The regular caregiver may be present in the setting in which the respite is provided.

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

Respite—In-Home, 24 Hour Service

Provider Type **51**, Home & Community Habilitation Specialty **512**, Respite Care-Home Based
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
(The asterisked services below are applicable to Provider type 54 and specialties 540 and 541).
Age Limits & Funding: Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 12-Home; 99-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 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.	

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

Respite – In-Home, 15 Minutes

This service is provided in segments of 16 hours or less in a 24-hour period in individuals' private homes. There is no requirement for the regular caregiver to be absent from the setting in which respite is provided. The regular caregiver may be present in the setting in which the respite is provided.

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

Respite, In-Home, 15 Minutes Service

Provider Type **51**, Home & Community Habilitation Specialty **512**, Respite Care-Home Based
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
(The asterisked services below are applicable to Provider type 54 and specialties 540 and 541).
Age Limits & Funding: Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 12-Home; 99-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	The provision of the service at a staff-	15 minutes

		Level 2	to-individual ratio of 1:1.	
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 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 members are licensed nurses.	

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

Respite – Unlicensed Out-of-Home, 24 Hours

This service is provided in segments of day units (each day unit comprises a period of time that is more than 16 hours to 24 hours in length). This service may be provided in the private homes of family or friends with whom the individual does not reside, or in other unlicensed homes or locations acceptable to individuals and families and subject to provider qualification criteria. Room and board costs are excluded from the eligible portion of the Respite Services when the service is provided in a provider owned, leased, rented, or operated setting that is not licensed or accredited by the State. If there are room and board costs for these settings, they may be funded through the ineligible codes listed below.

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

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 Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
(The asterisked services below are applicable to Provider type 54 and specialties 540 and 541).

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
W6060		Basic Staff Support Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided 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
W6061		Staff Support Level 1 Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided 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
W6062*		Staff Support Level 2 Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range 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.	
W6063*		Staff Support Level 2 Enhanced Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range of 1:1 with a staff member who is licensed or degreed.	Day
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
W6064*		Staff Support Level 3 Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range 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 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.	
W6065*		Staff Support Level 3	The ineligible (room and board) cost portion of the unlicensed out-of-home	Day

		Enhanced Ineligible Costs	respite service provided at a staff-to-individual ratio range of 2:1 where both staff members are licensed or degreed.	

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) for the eligible cost portion of the service 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. The U4 modifier is not used with the procedure codes for the ineligible cost portion of the service.	Day

Respite – Unlicensed Out-of-Home, 15 Minutes

This service is provided in segments of 16 hours or less in a 24-hour period. This service is provided in the private homes of family or friends with whom the individual does not reside, or other unlicensed homes or locations acceptable to individuals and families and subject to provider qualification criteria. Room and board costs are excluded from Respite Services when the service is provided in a setting that is not licensed or accredited by the State. If there are room and board costs for these settings, they may be funded through the ineligible codes listed below.

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

Respite—Unlicensed Out-of-Home, 15 Minutes Service

Provider Type **51**, Home & Community Habilitation Specialty **513**, Respite Care-Out of Home
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
(The asterisked services below are applicable to Provider type 54 and specialties 540 and 541).
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
W6066		Basic Staff Support	The ineligible (room and board) cost portion of the unlicensed out-of-home	15 minutes

		Ineligible Costs	respite service provided at a staff-to-individual ratio range of 1:4.	
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
W6067		Staff Support Level 1 Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided 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
W6068*		Staff Support Level 2 Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range 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.	
W6069*		Staff Support Level 2 Enhanced Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range of 1:1 with a staff member who is licensed or degreed.	15 minutes
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
W6070*		Staff Support Level 3 Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range 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 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 members are licensed nurses.	
W6071*		Staff Support Level 3 Enhanced Ineligible Costs	The ineligible (room and board) cost portion of the unlicensed out-of-home respite service provided at a staff-to-individual ratio range of 2:1 where both staff members are licensed or degreed.	15 minutes

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

Allowable Modifiers	Service Level	Service Description	Service Unit
U4*	No benefit	This modifier is to be used with the noted	15 minutes

Only used with W8012 W8013 W8014 W8015	allowance	procedure codes and modifiers (as appropriate) for the eligible cost portion of the service 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. The U4 modifier is not used with the procedure codes for the ineligible cost portion of the service.	

Respite – Licensed Out-of-Home, 24 Hours

This service is provided in segments of day units (each day unit comprises a period of time that is more than 16 hours to 24 hours in length) in licensed residential habilitation homes under 55 Pa.Code Chapter 3800, 5310, 6400 or 6500. These procedure codes will be used when:

- The licensed residential habilitation home only provides respite services at the service location (that is, individuals do not permanently reside in the home).
- The residential habilitation home does not have a funded temporary or permanent vacancy associated with the respite bed at the respite service location.

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 site location's approved program capacity for emergency situations only. Written approval to provide respite services beyond the approved program capacity must be obtained from the ODP Regional Waiver Capacity Manager before the provision of respite occurs. Modifier U2 will be used with the respite procedure code both in the ISP and when the provider submits a claim for the service.

In no circumstance will this emergency approval result in more than 4 individuals receiving services from the Community Home provider in a calendar day, regardless of the site location's licensed capacity.

Respite to each individual who receives respite services is limited to 30 calendar days per calendar year.

This respite policy for Community Homes does not alter or change the Respite in a Larger Setting policy (mentioned on page 11 of this document) that provides an exception process to request respite services be provided in a large non-Waiver-funded setting in which no approved program capacity is established.

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

Respite—Licensed Out-of-home, 24 Hours Service

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 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.	Day

Respite – Licensed Out-of-Home, 24 Hours (to be used when the licensed facility has an available bed that is used for respite) (Waiver and Base funding applies to the following four procedure codes.)

The following procedure codes are to be used when respite is provided in Waiver-funded licensed settings under 55 Pa.Code Chapters 6400, 6500, 5310, and 3800 when there is an available bed that is used for respite because of a funded temporary or permanent vacancy. These procedure codes are associated with the same provider type as the licensed residential service (provider type 52). The rate paid for the respite service will be a combination of both the eligible and ineligible residential habilitation service rates established for that specific residential service location.

A day unit is used to bill for these procedure codes. For respite services, each day unit is defined as a period of time that is more than 16 hours to 24 hours in length.

The procedure code and service unit for Respite in a Child Residential Facility (3810) follows:

Respite—Child Residential Facility Service (with a funded temporary or permanent vacancy)

Provider Type **52**, Community Residential Rehabilitation Specialty **520** C & Y Licensed Group Home
Age Limits & Funding: Consolidated & P/FDS Waivers: 3 - 21 years old; Base Funds: 0 - 21 years old
Allowable Place of Service: 12-Home; 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W9591	**Respite, Child Residential Service, 24 Hours**	Respite provided by the Licensed Child Residential Service under 55 Pa.Code Chapter 3800.	Day

The procedure code and service unit for Respite in a Community Residential Rehabilitation Service for the Mentally Ill Facility (5310) follows:

Respite—Community Residential Rehabilitation Service for the Mentally Ill Service (with a funded temporary or permanent vacancy)

Provider Type **52**, Community Residential Rehabilitation Specialty **456** CRR-Adult
Age Limits & Funding: Consolidated & P/FDS Waivers: 18[12] – 120 years old; Base Funds: 18[12]-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W9592	**Respite, Community Residential Rehabilitation, 24 Hours**	Respite provided by the Licensed Community Residential Rehabilitation under 55 Pa.Code Chapter 5310.	Day

The procedure code and service unit for Respite in Family Living Homes (6500) follows:

Respite—Family Living Home Service (with a funded temporary or permanent vacancy)

Provider Type **52**, Community Residential Rehabilitation Specialty **522** Family Living Homes-6500
Age Limits & Funding: Consolidated & P/FDS Waivers: 3 - 120 years old; Base Funds: 3-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W9593	**Respite, Family Living Homes, 24 Hours**	Respite provided by the Licensed Family Living Home under 55 Pa.Code Chapter 6500.	Day

[12] The respite service in a Community Residential Rehabilitation setting paid through the Consolidated or P/FDS Waiver is primarily for adult individuals with mental retardation. However, there may be exceptions as stated in various Pennsylvania laws.

The procedure code and service unit for Respite in Community Homes for Individuals with Mental Retardation (6400) follows:

Respite—Community Home Service (with a funded temporary or permanent vacancy)

Provider Type **52**, Community Residential Rehabilitation Specialty **521** Adult Residential-6400
Age Limits & Funding: Consolidated & P/FDS Waivers: 18[13] - 120 years old; Base Funds: 18[13]-120 years old
Allowable Place of Service: 12-Home; 99-Other (Community)

Procedure Code	Service Level	Service Description	Service Unit
W9594	**Respite, Community Homes, 24 Hours**	Respite provided by the Licensed Community Home under 55 Pa.Code Chapter 6400.	Day

Respite – Licensed Out-of-Home, 15 minutes

This service is provided in segments of 16 hours or less in a 24-hour period in residential habilitation homes licensed under 55 Pa.Code Chapters 3800, 5310, 6400, or 6500.

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

Respite—Licensed Out-of-Home, 15 Minutes Service

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.	

[13] The respite service in a Community Home paid through the Consolidated or P/FDS Waiver is primarily for adult individuals with mental retardation. However, there may be exceptions as stated in various Pennsylvania laws.

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 staff members who are degreed.	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.	

Respite Camp, 24 hours

Respite Camp, 24 Hour services are provided in segments of day units (each day unit comprises a period of time that is more than 16 hours to 24 hours in length) in overnight camp settings. Overnight camps are community settings that offer overnight group accommodations and organized supervision, socialization, skill-building, or instruction activities. When the Respite Camp service offers additional community activities which include entrance fees, tickets, or other charges to participate in the community activity, those additional activity charges are not included in the rate for this service. These community activity charges may be paid through private funds of the individual or family members or other non-waiver dollars.

For camp settings that are not licensed or accredited by the State, room and board costs are excluded from the rate paid for the eligible portion of the Respite Camp services. If there are room and board costs for these unlicensed or non-accredited settings, the costs may be funded through the ineligible procedure code listed below. Camps that are licensed or accredited include room and board costs as part of the rate for the eligible camp service.

Respite – Camp, 24 Hour services are included in the 30-unit limit per fiscal year for 24-Hour Waiver-funded Respite.
This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania.

The procedure codes and service units for Respite – Camp, 24 hours follow:

Respite Camp, 24 Hours Service

Provider Type **55**, Vendor — Specialty **554**, Respite, Overnight Camp
Provider Type **54**, Intermediate Service Organization — Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
Age Limits & Funding: Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7285*	**Respite – Camp, 24 hours, Eligible**	The eligible portion of the Respite Camp service provided in segments of day units in residential camp settings. Respite in overnight camps is not contingent upon an emergency	Day

		situation.	
W8401*	**Respite – Camp, 24 hours, Ineligible**	The ineligible (room and board) portion of the Respite Camp service provided in segments of day units in residential camp settings that are not licensed or accredited by the State.	Day

Respite Camp, 15 minutes

Respite Camp, 15 minute services are provided in segments of 16 hours or less in a 24-hour period at day camp settings. Day camps are community settings that offer group accommodations and organized supervision, socialization, skill-building, and/or instruction activities. When the Respite Camp service offers additional community activities which include entrance fees, tickets, or other charges to participate in the community activity, those additional activity charges are not included in the rate for this service. These community activity charges may be paid through private funds of the individual or family members or other non-waiver dollars.

For camp settings that are not licensed or accredited by the State, room and board costs are excluded from the rate paid for the eligible portion of the Respite Camp services. If there are room and board costs for these unlicensed or non-accredited settings, the costs may be funded through the ineligible procedure code listed below. For example, if an individual attends a non-licensed camp and is provided lunch as part of the day camp, then the cost of the lunch is not eligible for FFP and may be billed using the ineligible code. Camps that are licensed or accredited include room and board costs as part of the rate for the eligible camp service.

Respite – Camp, 15-minute services are included in the 480-unit limit per fiscal year for 15-minute Waiver-funded Respite.
This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania.

The procedure code and service units for Respite – Camp, 15 minutes follow:

Respite Camp, 15 Minutes Service

Provider Type **55**, Vendor Specialty **555**, Respite, Day Camp
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
Age Limits & Funding: Consolidated & P/FDS Waivers: 3 - 120 years old
Allowable Place of Service: 99-Community

Procedure Code	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 in day camps is not contingent upon an emergency situation.	15 minutes
W8400*	**Respite – Camp, 15**	The ineligible (room and board) portion of the Respite Camp service	15 minutes

	minutes, Ineligible	provided in segments of 16 hours or less in day camp settings that are not licensed or accredited by the State.	

Transportation Services

Transportation Services are direct services offered in order to enable individuals to gain access to Waiver and other community services and resources specified in their approved ISP.

This includes transportation as a discrete service offering that is provided by Adult Training Facilities, Prevocational Service and Transitional Work Service providers who transport individuals to and from the individual's own private home and the provider site. It is **not** transportation that is an integral part of the provision of activities within Habilitation Service settings nor is it transportation associated with Residential Habilitation Services, as transportation in these situations is built into the rate for the habilitation service.

This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania. The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania and may be located anywhere in the 50 United States, the District of Columbia, or the American territories.

Transportation Mile

This transportation service is rendered by providers, family members, and other qualified licensed drivers. Transportation Mile is used to reimburse the qualified licensed driver who transports the individual to and from services and resources specified in the ISP when using non-agency vehicles. For individuals who self direct their services, Transportation Mile may be used to reimburse an individual's surrogate who is the employer or the managing employer to transport the individual to and from services and resources specified in the ISP. Mileage reimbursement to agency providers is limited to situations where transportation costs are not included in the provider's rate for services.

The unit of service is one mile. Mileage will be paid round trip. Mileage that may be reimbursed is calculated as follows:

- Total Mileage required to transport the individual to and from a service or resource specified in the ISP when the individual is physically in the vehicle.
- Mileage required to transport individuals from one service or resource to another service or resource specified in the ISP while the individual is physically in the vehicle.
- Mileage will be reimbursed to the qualified provider for their return trip after the individual was transported to a service or resource and for the trip back to pick up

the individual. The mileage to be reimbursed to the qualified provider (when the individual is not in the vehicle) for return trips will be no greater then the mileage required to transport the individual.

The rate for Transportation Mile will be the reimbursement rate established for Department of Public Welfare employees for business travel. The rate paid for mileage is based on the federal reimbursement rate and could change during the fiscal year.

When Transportation Mile is provided to more than one individual at a time, the total number of units of service that are to be provided are equitably divided among the individuals for whom transportation is provided.

The procedure code and service unit for Transportation Mile follow:

Transportation Mile Service

Provider Type **55**, Vendor — Specialty **267**, Non-Emergency
Provider Type **54**, Intermediate Service Organization — Specialty **540**, ISO – Agency with Choice
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: 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

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 tokens and transit passes may be purchased by the AE, AE contracted payment agents, Financial Management Service Organizations, or providers of service.

Tokens or passes that are purchased for an individual may be provided to the individual on a daily, weekly or monthly basis.

The procedure code and service unit for Public Transportation follow:

Public Transportation Service

Provider Type **55**, Vendor Specialty **267**, Non-Emergency
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
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: 99-Community

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

Transportation Per Diem

This is transportation provided to an individual by provider agencies for non-emergency purposes. The service is designed to provide individuals with access to services and resources specified in their ISP. A day unit is defined as one calendar day.

The procedure code and service unit for Transportation Per Diem follow:

Transportation-Per Diem Service

Provider Type **26**, Transportation Specialty **267**, Non-Emergency
Provider Type **55**, Vendor Specialty **267**, Non-Emergency
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
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: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7273	**Transportation (per diem)**	Non-emergency transportation provided to individuals with mental retardation by	Day

		provider agencies, in order to enable individuals to access services and resources specified in the individual's approved individual support plan. These costs are prorated by the usage for individuals receiving waiver services when vehicles are also used for accessing services and activities for people who are not waiver participants.	

Transportation Trip

Transportation provided to individuals by provider agencies (excluding transportation included in the rate for habilitation services) for which costs are determined on a per trip basis. A trip is either transportation to a service from an individual's home or from the service to the individual's home. Taking an individual to a service and returning the individual to his or her home is considered two trips or two units of service. The zone distance is determined by the Transportation Trip Provider.

The procedure codes and service units for Transportation Trip follow:

Transportation Trip Service

Provider Type **26**, Transportation — Specialty **267**, Non-Emergency
Provider Type **55**, Vendor — Specialty **267**, Non-Emergency
Provider Type **54**, Intermediate Service Organization — Specialty **540**, ISO – Agency with Choice
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: 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7274	Zone 1	A defined geographical area that is the shortest distance from the service site.	Per trip
W7275	Zone 2	A defined geographical area that represents a middle distance from the service site.	Per trip
W7276	Zone 3	A defined geographical area that is the longest distance from the service site.	Per trip

Home Finding Services

Direct services provided to assist individuals to locate and maintain their own home. Services are limited to assistance in financial planning, arranging for or moving utility hook-ups, managing home responsibilities, arranging for home modifications and repairs, assistance in making monthly payments, and assistance in purchasing home security devices, such as beepers and alarms which are necessary to ensure the individual's health and well-being.

Financial support that constitutes a room and board expense is excluded from federal financial participation in the waivers.

The procedure code and service unit for Home Finding follows:

Provider Type **51**, Home & Community Habilitation Specialty **571**, Home Finding
Provider Type **55**, Vendor Specialty **571**, Home Finding
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
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: 12-Home; 99-Community

Procedure Code	Service Level	Service Description	Service Unit
W7277	**Home Finding**	Direct services provided to assist a individual with mental retardation to locate and maintain a home, such as assistance in financial planning, arranging for or moving utility hook-ups, managing home responsibilities, arranging for home modifications and repairs, making monthly payments, and assistance in purchasing home security devices such as beepers which are necessary to ensure the individual's health and well-being.	15 minutes

Home Accessibility Adaptations

Home Accessibility Adaptations consist of certain modifications to the private home of the individual which are necessary due to the individual's disability, to ensure the health, security, and accessibility of the individual, or which enable the individual to function with greater independence in the home. The term 'private home' includes homes owned, rented, or leased by the following and not owned, rented, or leased from a provider agency:

- The individual with mental retardation.
- Parents or relatives with which the individual resides.
- Family living homes that are privately owned, rented or leased by the host family.

This service may only be used to adapt the individual's primary residence and may not be used to adapt homes that are provider owned, rented, or leased.

Home modifications must have utility primarily for the individual with the disability, 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 assessed needs.

Modifications shall 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. Adaptations that add to the total square footage of the home are excluded from this benefit. The only exception to this is adaptations to bathrooms that are necessary to complete the adaptation (for example, necessary to configure a bathroom to accommodate a wheelchair). Durable medical equipment is excluded.

Maximum state and federal funding participation is limited to $20,000 per individual during 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 mental retardation waiver. The 10-year period begins at the first utilization of authorized Home Accessibility Adaptations. The 10-year period incorporates the previous 9 fiscal years and the current fiscal year. For FY 2010/2011, the 10-year period started in FY 2001/2002 (that is started on July 1, 2001). For tracking purposes, the date, nature, and cost of the most recent Home Accessibility Adaptation should be documented in the ISP in the 'Physical Development' field. 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 for this service.

Modifications to a household subject to funding under the Waivers are limited to the following and must be necessary due to the individual's disability:

- Ramps from 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 an individual 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.

- Plexiglas windows 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 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 be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania. The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania and may be located anywhere in the 50 United States, the District of Columbia, or the American territories.

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

Home Accessibility Adaptations Service

Provider Type **55**, Vendor Specialty **543**, Environmental Accessibility Adaptations
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
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: 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 mental retardation. Maximum state participation for home adaptations is limited to $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.	Outcome based

Vehicle Accessibility Adaptations

Vehicle Accessibility Adaptations consist of certain modifications to the vehicle of the individual that is used as the primary means of transportation to meet the individual's needs. These vehicle modifications are necessary due to the individual's disability and to meet an assessed need as documented in the ISP. 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 long-term support to the individual and is not a paid

provider agency of such services. This service may also be used to adapt a privately owned vehicle of a family living host family when the vehicle is not owned by a provider agency. This service is not used to adapt provider owned, leased, or rented vehicles or provider operated vehicles used to provide transportation services to individuals.

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 Waivers cannot be used to purchase vehicles for the individual, 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 vehicle accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation price is required.

Maximum state and federal funding participation is limited to $10,000 per individual during a 5-year period. The 5-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations or when the individual transfers to a different mental retardation waiver. The 5-year period incorporates the previous 4 fiscal years and the current fiscal year. For FY 2010/2011, the 5-year period started in FY 2006/2007 (that is, started on July 1, 2006). For tracking purposes, the date, nature, and cost of the most recent Vehicle Accessibility Adaptation should be documented in the ISP in the 'Physical Development' field.

These adaptations funded through the Waivers 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.

This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania. The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania and may be located anywhere in the 50 United States, the District of Columbia, or the American territories.

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

<u>Vehicle Accessibility Adaptations Service</u>

Provider Type **55**, Vendor	Specialty **543**, Environmental Accessibility Adaptations
Provider Type **54**, Intermediate Service Organization	Specialty **540**, ISO – Agency with Choice
	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: 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 mental retardation. Maximum state participation for vehicle adaptations is limited to $10,000 every 5 years.	Outcome based

Assistive Technology

Assistive Technology is defined as 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 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.

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;
- 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 to the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices.

Please note that repair and maintenance of devices and purchases of extended warranties are limited to those assistive technology devices purchased through the Waivers.

All assistive technology items shall meet the applicable standards of manufacture, design, and installation. Items shall be specific to the individual's assessed needs and not be approved to benefit the public at large, staff, significant others, or family members. Items reimbursed with Waiver funds shall be in addition to any medical supplies provided under the Medicaid state plan and shall exclude those items not of direct medical or remedial benefit to the individual. If the participant receives Behavioral

Therapy or Behavioral Support Services, the assistive technology must be consistent with the individual's behavioral support plan.

This service excludes durable medical equipment, as defined by 55 Pa.Code Chapter 1123 and the Medical Assistance State Plan.

Assistive Technology may only be funded through the Waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private insurance limitations have been exhausted prior to funding Assistive Technology services through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis.

This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania. The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania and may be located anywhere in the 50 United States, the District of Columbia, or the American territories.

The procedure codes and service units for Assistive Technology follow:

Assistive Technology Service

Provider Type **55**, Vendor — Specialty **552**, Adaptive Appliances/Equipment
Provider Type **54**, Intermediate Service Organization — Specialty **540**, ISO – Agency with Choice
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; 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 mental retardation in their activities of daily living.	Outcome based
T2029* (For medical Assistive Technology)	**SE**			

Homemaker/Chore Services

Homemaker services consist of services to enable the individual or family members or friends with whom the individual resides to maintain their private residence. This service

can only be provided when a household member is temporarily absent or unable to manage the home, or when no landlord or agency caretaker staff is responsible to perform the homemaker activities. Homemaker Services must be provided by a qualified homemaker and may include cleaning and laundry, meal preparation, and other general household care.

Chore services consist of services needed to maintain the home in a clean, sanitary, and safe condition. This service can only be provided in the following situations:

- Neither the individual, nor anyone else in the household, is capable of physically performing and financially providing for the function.
- No other relative, caregiver, landlord, community/volunteer agency, or third party payer is physically capable of or responsible for their 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 residence is excluded from federal financial participation.

This service is limited to 40 hours per individual per fiscal year when the individual or family members or friends with whom the individual resides are temporarily unable to physically perform and financially provide for the homemaker/chore functions. A person is considered temporarily unable when the condition or situation that prevents them from physically performing and financially providing for the homemaker/chore functions is expected to improve.

There is no limit when the individual lives independently or with family member(s) or friend(s) who are permanently unable to physically perform and financially provide for the homemaker/chore functions. A person is considered permanently unable to provide the homemaker/chore service when the condition or situation that prevents them from physically 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 physically perform and financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the 'Outcome Summary' section of the ISP.

This service is not available for individuals residing in agency-owned, rented, leased, or operated homes (for example, licensed and unlicensed Family Living Homes and Community Homes).

This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania.

The procedure codes, modifiers, and service units for Homemaker/Chore follow:

Homemaker/Chore Service

Provider Type **43**, Homemaker Agency	Specialty **430**, Homemaker Services
Provider Type **51**, Home & Community Habilitation	Specialty **431**, Homemaker/Chore Services Specialty **430**, Homemaker Services
Provider Type **55**, Vendor	Specialty **431**, Homemaker/Chore Services Specialty **430**, Homemaker Services
Provider Type **54**, Intermediate Service Organization	Specialty **540**, ISO – Agency with Choice 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: 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 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.	Hour
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	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice	15 minutes

with W7283		Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage. When the UA modifier is used with the procedure code, the U4 modifier is used after the UA modifier when submitting a claim.	

Education Support Services

Education Support Services consist of special education and related services as defined in Sections (16) and (17) of IDEA to the extent that they are not available under a program funded by IDEA or available for funding by OVR. Educational 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 assistance necessary for the person to participate in apprenticeship programs.

This service may be provided by qualified providers or vendors based in Pennsylvania or in states contiguous to Pennsylvania.
The procedure code and service units for Education Support Services follow:

Education Support Service

Provider Type **55**, Vendor — Specialty **533**, Educational Service
Provider Type **54**, Intermediate Service Organization — Specialty **540**, ISO – Agency with Choice
Specialty **541,** ISO – Fiscal/Employer Agent
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	Service Level	Service Description	Service Unit
W7284*	**Education Support Services**	Support, in the form of payment, for education courses and training to the extent that they are not available under a program funded by IDEA.	Outcome based

Specialized Supplies

Specialized Supplies consist of incontinence supplies that are not available through the State Plan or private insurance. Specialized Supplies are limited to diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves. This service is limited to $500 per individual per fiscal year. This service is not eligible for individuals who reside in a licensed or unlicensed residential habilitation setting.

Specialized Supplies may only be funded through the waiver or base allocation when the service may not be provided under the State Plan or private insurance because the State Plan or private insurance limitations have been reached, or when the service is not covered under the State Plan or private insurance. The Supports Coordinator is responsible to verify that the State Plan and/or private

insurance limitations have been exhausted prior to funding Specialized Supplies through the Consolidated or P/FDS Waiver. Documentation that the services are not available through the State Plan and/or private insurance must be maintained in the individual's file by the Supports Coordinator. This documentation must be updated on at least an annual basis.

These services may be provided in Pennsylvania, or anywhere in the 50 United States, the District of Columbia, or the American territories. The physical location of the company that sells a good is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania and may be located anywhere in the 50 United States, the District of Columbia, or the American territories.

The procedure code and service unit for Specialized Supplies follows:

Specialized Supplies

Provider Type **55, Vendor** Specialty **553**, Habilitation Supplies
Provider Type **54**, Intermediate Service Organization Specialty **540**, ISO – Agency with Choice
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: 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, underpads, and vinyl or latex gloves. This service is limited to $500 per individual per fiscal year.	Outcome based

Administrative Services

Financial Management Services (FMS) (previously referred to as Intermediary Service Organizations)

Payment to a Waiver-funded FMS that provides FMS services to individuals that choose to self direct some or all of their services must be paid using administrative dollars, not Waiver service dollars. The cost of the needed administrative services is excluded from the individuals' "Waiver service funded amount" and is not included in the P/FDS Waiver service cap.

FMS organizations provide an administrative service that assists Waiver-funded individuals and surrogates in the employment and management of employee-related functions and the management of qualified small unlicensed provider services and vendor services.

Waiver-funded individuals and surrogates who choose to self direct may choose either the AWC FMS or the VF/EA FMS option, but may not choose both options at the same time. For Waiver-funded individuals, there is one statewide VF/EA FMS option that will be used to assist individuals and surrogates who choose to self direct using the VF/EA FMS option. There are identified and qualified AWC FMS providers locally based to render AWC FMS services to individuals that choose to self direct using the AWC FMS option.

Certain identified PDS, when rendered by qualified individuals (that is, SSWs), small unlicensed providers, and vendors, may be paid via the identified statewide VF/EA FMS or locally based AWC FMS. Small unlicensed providers are defined as an individual or agency that renders unlicensed services to a maximum of four (4) individuals statewide. Other providers that render licensed services or that provide unlicensed services to more than four (4) individuals statewide are not eligible to be paid via FMS organizations and providers.

VF/EA FMS (self directing)

Under the VF/EA FMS model, the individual or their designated surrogate is the common law employer by Internal Revenue Service (IRS) standards. The VF/EA FMS is the employer agent and is paid a monthly administrative fee to provide the employer agent functions and other identified administrative services.

The procedure code and service unit for VF/EA FMS for the monthly administrative fee follows:

Vendor Fiscal/Employer Agent FMS

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 mental retardation and/or their surrogates in the direct employment and management of qualified SSWs and management of qualified small unlicensed providers and vendors.	Per month

VF/EA FMS One-Time Vendor Payments (non-self directing)

Individuals who do not self-direct their services may have situations where Vendor services are identified as a need. The needed vendor service can be managed by a VF/EA FMS. The VF/EA FMS can claim an administrative fee per the ODP billing requirements for one time vendor services. This administration fee is $25.00 or 15% per transaction, whichever is less.

The procedure codes, modifier, and service units for Vendor Fiscal/Employer Agent FMS One-Time Vendor Payments follow:

Vendor Fiscal/Employer Agent FMS One-Time Vendor Payments

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; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W0027		**Vendor Fiscal/Employer Agent Financial Management Services One-Time Vendor Payment**	This is an administrative service to pay the administration fee that is charged when the Vendor Fiscal/Employer Agent FMS makes a one-time vendor payment for individuals who are not self-directing their services. The administrative service is billed as something other than a monthly fee which is $25.00 or 15% per transaction, whichever is less.	Outcome Based
W0027	**U2**	**One-Time Vendor Payment for Respite Camp**	This is an administrative service to pay the administration fee that is charged when the Vendor Fiscal/Employer Agent Financial Management Services makes a one-time vendor payment for individuals who are not self-directing their services and who attend Respite Camp. The administrative service is billed as something other than a monthly fee which is $25.00 or 15% per transaction, whichever is less.	Outcome Based

AWC FMS (self directing)

Under the AWC FMS model, the AWC FMS provider is the employer of record by IRS standards. The AWC FMS receives an administrative fee to provide the administrative services necessary for them to function as the employer of record in a joint employer relationship with the individual or their surrogate who is the designated managing employer. The AWC FMS is the employer of record and is paid a monthly administrative fee to provide the employer of record functions and other identified administrative services.

The procedure code and service unit for AWC FMS monthly administrative fee follow:

Agency with Choice FMS

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 mental retardation and/or their surrogates in the employment and management of qualified SSWs and management of qualified small unlicensed providers and vendors..	Per month

AWC FMS One-Time Vendor Payments (non-self directing)

Individuals who do not self-direct their services may have situations where Vendor services are identified as a need. The needed services may be managed by the AWC FMS provider. The AWC FMS can claim an administrative fee per the ODP billing requirements for one time vendor services. This administration fee is $25.00 or 15% per transaction, whichever is less.

The procedure code, modifier, and service units for AWC FMS One-Time Vendor Payments follow:

Agency with Choice FMS One-Time Vendor Payments

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	Allowable Modifiers	Service Level	Service Description	Service Unit
W0026		**Agency With Choice Financial Management**	This is an administrative service and administration fee that is charged when the Agency With Choice FMS makes a one-time vendor payment for	Outcome Based

		Services One-Time Vendor Payment	individuals who are not self-directing their services. The administrative service is billed as something other than a monthly fee which is $25.00 or 15% per transaction, whichever is less.	
W0026	**U2**	**One-Time Vendor Payment for Respite Camp**	This is an administrative service and administration fee that is charged when the Agency With Choice FMS makes a one-time vendor payment for individuals who are not self-directing their services and who attend Respite Camp. The administrative service is billed as something other than a monthly fee which is $25.00 or 15% per transaction, whichever is less.	Outcome Based

Base-Funded Categorical Administrative Expenditures

FMS organizations provide an administrative service that assists base-funded individuals and surrogates in the employment and management of employee related services (that is, SSWs) and the management of qualified small unlicensed provider services and vendor services.

Local VF/EA FMS (self directing)

Under the local VF/EA FMS model, the individual or their designated surrogate is the common law employer by IRS standards. The VF/EA FMS is the employer agent and is paid an administrative fee to provide the employer agent functions and other identified administrative services.

AWC FMS (self directing)

Under the AWC FMS model, the AWC FMS provider is the employer of record by IRS standards. The AWC FMS receives an administrative fee to render the administrative services necessary for them to function as the employer of record in a joint employer relationship with the individual or their surrogate who is the designated managing employer. The AWC FMS is the employer of record and is paid an administrative fee to provide the employer of record functions and other identified administrative services.

The procedure code and service unit for Base-Funded Categorical Administration Expenditures follows:

Local Vendor Fiscal/Employer Agent FMS & Agency With Choice FMS Service

Provider Type **54**, Intermediate Services Organization

Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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
W0025	**Agency With Choice and Local Vendor Fiscal/Employer Agent Financial Management Services—Base Funded individuals**	An indirect service that assists individuals with mental retardation 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

Base-Funded Services

The services included in the remainder of this narrative are designated as Base-Funded, and *are limited to base funding only*. Please refer to 55 Pa.Code Chapter 6350 for more information regarding base-funded services.

Base-Funded Services are provided through base funding from the County Program. The Waivers cannot pay for these base-funded services. The following services are available to all individuals with mental retardation in need of services. Base-funded services are administered through County Programs, based on the needs of individuals and the availability of funding. These services are designed to offer a variety of services to the individual with mental retardation or their family for the purpose of enabling the individual to remain with his or her family in a community setting or to maintain independence in a community setting.

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 4 weeks (28 days) per individual per fiscal year, except when the Department 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:

1. Individual's private home or place of residence located in Pennsylvania.
2. Licensed or approved foster family home located in Pennsylvania.
3. Licensed community (55 Pa.Code Chapter 6400) or family living (55 Pa.Code Chapter 6500) home located in Pennsylvania.
4. Unlicensed home of a provider or family that the County Program has approved.
5. Medical facilities, such as hospitals, nursing homes, or private Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) when there is a documented medical need and County Administrator approves the respite service in a medical facility. Respite services may not be provided in State-operated ICFs/MR.

The following procedure codes are for direct services that are provided in segments of day units to individuals residing in their own home or the home of a relative, friend, or other family.

The procedure codes, modifiers, and service units for Respite Care – 24 Hours (Base-Funded) follow:

Respite Care (Base Funded), 24 Hours Service

Provider Type **51**, Home & Community Habilitation
Provider Type **03**, Extended Care Facility
Provider Type **54**, Intermediate Services Organization

Specialty **513**, Respite Care-Out of Home
Specialty **036**, Respite Care
Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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 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.	
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 participants 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 mental retardation in need of services.

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

Support (Medical Environment) Service

Provider Type **51**, Home & Community Habilitation
Provider Type **54**, Intermediate Services Organization

Specialty **510**, Home & Community Habilitation
Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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)

The following services and codes may be used for Licensed Residential Services that are funded through Base funds due to the size of the home (serving 11 or more individuals):

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 funded through base funding are limited to residential service settings.

The procedure code and service unit for Child Residential Services follows:

Residential Habilitation—Child Residential Services (11+ 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 11 or more individuals).	Day

Community Residential Rehabilitation Services for the Mentally Ill (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 mental retardation 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 Community Residential Rehabilitation Services for the Mentally Ill follows:

Residential Habilitation—Community Residential Rehabilitation Services for the Mentally Ill (11+ 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 11 or more individuals).	Day

Community Home Services for Individuals with Mental Retardation (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 mental retardation. 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 mental retardation…."

The procedure code and service unit for Community Homes for Individuals with Mental Retardation follows:

Residential Habilitation—Community Home Services (11+ 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 11 or more individuals).	Day

Family Aide

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 mental retardation.

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 follow:

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 Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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
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 follows:

Special Diet Preparation Services

Provider Type **55**, Vendor
Provider Type **54**, Intermediate Services Organization

Specialty **519**, FSS/Consumer Payment
Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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
W7315	**Special Diet Preparation**	This service provides individuals with mental retardation 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 Waiver participants 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 Activities follows:

Recreation/Leisure Time Services

Provider Type **55**, Vendor
Provider Type **54**, Intermediate Services Organization

Specialty **519**, FSS/Consumer Payment
Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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 mental retardation 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 Chapter 4300.65(1). This service is available to Waiver participants 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 follow:

Home Rehabilitation Services

Provider Type **55**, Vendor

Specialty **519**, FSS/Consumer Payment
Specialty **543**, Environmental Accessibility Adaptations

Provider Type **54**, Intermediate Services Organization

Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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
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 mental retardation 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 Payment follows:

Family Support Services/Individual Payment

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 — Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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 Family Supports Services.	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 follows:

Base Service Not Otherwise Specified

Provider Type **55**, Vendor — Specialty **519**, FSS/Consumer Payment
Provider Type **54**, Intermediate Services Organization — Specialty **541**, ISO-Fiscal/Employer Agent
Specialty **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

Unanticipated Emergencies

A modifier has been created that will be added to the following services' procedure codes on a provider's claim to indicate an unanticipated emergency. Please refer to Bulletin 00-10-03 entitled *Planning and Managing for Unanticipated Emergencies* for more information.

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

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