Commonwealth of Pennsylvania
Department of Human Services
Office of Developmental Program's

Individual Support Plan (ISP)
Manual for Individuals with an Intellectual Disability

Table of Contents

SECTION 1: ISP PROCESS 4

SECTION 2: ISP PREPARATION 4

SECTION 2.1: ISP INVITATION LETTER 5
SECTION 2.2: INFORMATION GATHERING 6
SECTION 2.3: ASSESSMENT PROCESS 6

SECTION 3: DEVELOPMENT OF THE ISP 9

SECTION 3.1: ANNOTATED ISP (ATTACHMENT #4) 11
SECTION 3.2: QUESTIONS TO HELP FACILITATE THE DEVELOPMENT OF THE ISP (ATTACHMENT #5) 11
SECTION 3.3: OUTCOME DEVELOPMENT 11
SECTION 3.4: OUTCOME ACTIONS 12
SECTION 3.5: IDENTIFICATION OF SERVICES AND SUPPORTS 13
SECTION 3.6: PARTICIPANT DIRECTED SERVICES (PDS) 14
SECTION 3.7: CHOOSING QUALIFIED PROVIDERS FOR FUNDED SERVICES 15
SECTION 3.8: PROVIDER BACK-UP PLANS 15
SECTION 3.9 QUALIFIED PROVIDER ISP ROLES AND RESPONSIBILITIES 16
SECTION 3.10: SC RESPONSIBILITIES REGARDING THE TIMELINE FOR ISPS 16
SECTION 3.11: ISP DEVELOPMENT UNDER 55 PA. CODE CHAPTERS 2380, 2390, 6400 AND 6500: 17

SECTION 4: INDIVIDUAL SUPPORT PLAN SIGNATURE FORM (DP 1032) (ATTACHMENT #3) 18

SECTION 5: ISP APPROVAL AND AUTHORIZATION 18

SECTION 6: ISP REVIEW CHECKLIST, DP 1050 19

SECTION 7: IMPLEMENTATION OF SERVICES 20

SECTION 8: ADDRESSING CHANGES IN NEED THROUGHOUT THE YEAR 21

SECTION 9: UPDATING ISPS 21

SECTION 10: SERVICE UTILIZATION 23

SECTION 11: MONITORING OF SERVICES 24

SECTION 12: WAIVER AND BASE ADMINISTRATIVE SERVICES 26

SECTION 13: WAIVER SERVICES 31

SECTION 13.1: ASSISTIVE TECHNOLOGY 32
SECTION 13.2: BEHAVIORAL SUPPORT 35
SECTION 13.3: COMPANION SERVICES 37
SECTION 13.4: EDUCATION SUPPORT SERVICES 39
SECTION 13.5: EMPLOYMENT SERVICES 41
SECTION 13.6: HOME AND COMMUNITY HABILITATION (UNLICENSED) 50
SECTION 13.7: HOME ACCESSIBILITY ADAPTATIONS 55
SECTION 13.8: HOMEMAKER/CHORE SERVICES 58
SECTION 13.9: LICENSED DAY HABILITATION 61
SECTION 13.10: NURSING SERVICES 64
SECTION 13.11: RESIDENTIAL HABILITATION SERVICES (LICENSED) CONSOLIDATED WAIVER 67

SECTION 13.12: RESIDENTIAL ENHANCED STAFFING (ADD-ONS TO THE RESIDENTIAL HABILITATION SERVICE) 74
SECTION 13.13: RESIDENTIAL HABILITATION SERVICES (UNLICENSED) CONSOLIDATED WAIVER ONLY 78
SECTION 13.14: RESPITE 80
SECTION 13.15: SPECIALIZED SUPPLIES 93
SECTION 13.16: SUPPORTS BROKER SERVICES 94
SECTION 13.17: SUPPORTS COORDINATION 98
SECTION 13.18: THERAPY SERVICES 101
SECTION 13.19: TRANSPORTATION 111
SECTION 13.20: VEHICLE ACCESSIBILITY ADAPTATIONS 114

SECTION 14: WAIVER RELATIVES, LEGAL GUARDIANS AND LEGALLY RESPONSIBLE INDIVIDUALS POLICY RELATED TO SERVICE 116

SECTION 15: WAIVER TRAVEL POLICY RELATED TO SERVICE DEFINITIONS 117

SECTION 16: BASE-FUNDED SERVICES 118

SECTION 17: RESOURCES 126

SECTION 17.1: PRIORITIZATION OF URGENCY OF NEED FOR SERVICES (PUNS) 126
SECTION 17.2: INDEPENDENT MONITORING FOR QUALITY (IM4Q) 127
SECTION 17.3: POSITIVE PRACTICES RESOURCE TEAM (PPRT) 128

SECTION 18: ISP KEY TERMS 129

SECTION 19: GENERAL BILLING TERMS 133

Section 1: ISP Process

The SC should assist the individual[1] and his/her family or surrogate to understand the Individual Support Plan (ISP) process and who participates in it. This includes understanding the concepts of Positive Approaches, Everyday Lives, and Person Centered Planning, the options for services and service delivery and supporting the individual in gaining the tools needed to be effective in leading and meaningfully participating in the development of their ISP.

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

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

Section 2: ISP Preparation

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

The ISP team may consist of:

- The individual.
- The individual's family, guardian, surrogate or advocate.
- The SC.

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

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

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

- The plan team that shall participate in the development of the ISP includes the individual, the program specialist or family living specialist, the direct service worker for the licensed provider and other people the individual chooses to invite. 55 Pa. Code §§ 2380.184(a), 2390.154(a), 6400.184(a), 6500.154(a).

- At least three plan team members must be present for the ISP meeting. 55 Pa. Code §§ 2380.184(b), 2390.154(b), 6400.184(b), 6500.154(b).

- Per 55 Pa. Code §§ 2380.33(b)(4), 2390.33(b)(4), 6400.44(b)(4), 6500.43(d)(4) only, the program specialist is the only plan team member that is required at the plan team meeting. ODP will cite the facility or program for a violation if the program specialist or an assigned proxy does not attend the team meeting.

- The individual receiving services has the choice to attend the meeting. 55 Pa. Code §§ 2380.184(b), 2390.154(b), 6400.184(b), 6500.154(b).

Section 2.1: ISP Invitation letter

The individual determines the date and location of the ISP team meeting; therefore, the SC should make every effort to accommodate the individual in scheduling this meeting. This includes making several attempts to reach out to the individual. If by the third attempt, the individual refuses to provide input on their preference in scheduling the meeting, the SC must proceed in scheduling the meeting in accordance with the timelines set forth in the waiver, 55 Pa. Code Chapter 51 and this manual.

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

✎ *SC documentation requirements for ISP invitation letters:*

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

Section 2.2: Information Gathering

Preparing for the ISP meeting involves information gathering that should begin at least 90 calendar days prior to the end date of the plan. Information gathering for the ISP should include physical development, communication styles, learning styles, educational background, social/emotional information, medical information, personality traits, environmental influences, interactions, preferences, relationships that impact the individual's quality of life, and an evaluation of risk.

Information gathering includes:

- Involvement of people who know the individual best and can offer rich and detailed information about the individual and his/her needs.
- Identification, coordination and collection of new and/or updated information from team members and/or other professionals in the following areas:

    - Formal and informal assessments, including ODP's statewide needs assessment.
    - Employment preference/experiences.
    - Interest in Life sharing.
    - Communication.
    - Personal preferences (interests and hobbies).
    - Evaluation of risk (incident histories).
    - Medical information including current health status.
    - Personality traits.
    - Interactions with others.
    - Relationships that impact the individual's quality of life.
    - Learning styles.
    - Physical development.
    - Living situation.
    - Incident reports.
    - SC monitoring findings.
    - Educational background.
    - Progress toward Outcomes and Social/emotional information.
    - Environmental influences.
    - IM4Q considerations and other external monitoring, if relevant.
    - Financial information.
    - Lifetime Medical History.

Section 2.3: Assessment process

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

Formal assessment types include, but are not limited to: the Vineland, Adaptive Behavior Scale (ABS), Alpern-Boll Developmental Profile (LPRN BOAL), therapy and medical evaluations, Office of Vocational Rehabilitation (OVR) assessments, and Individual Educational Plans (IEPs). Informal assessments include, but are not limited to: a provider's annual assessment,

other school aged assessments, family and friends' observations, observations by direct care professionals, and understanding of the individual and his or her needs.

In order to receive services and to ensure that services provided can meet the needs of an individual to ensure health and welfare, an individual age 16-72 must have a standardized needs assessment prior to enrollment in the waiver. Once an individual is entered into the queue in HCSIS, Statewide Needs Assessment scheduling occurs. After enrollment in either the Person/Family Directed Support (P/FDS) or Consolidated Waiver, all waiver participants must then have a statewide standardized needs assessment completed once every three years. A new standardized needs assessment is required if a major change in the individual's life occurs that has a lasting impact on his or her support needs that is anticipated to last more than six months, and makes his or her standardized assessment inaccurate and no longer current.

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

For more information about utilizing the information from the SIS assessment in the ISP, please visit the ODP Consulting website, listed at the end of this document, for a SIS/ISP Crosswalk. For more information regarding the purpose of the SIS and SIS requirements, please visit the DPW website for the SIS Bulletin and SIS Manual.

✐ *SC documentation requirements for SIS Assessments:*

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

- Home Living
  - Individual Preferences
  - Functional Information
  - Health and Safety
- Community Living
  - Individual Preferences
  - Health and Safety
- Lifelong Learning
  - Individual Preferences
  - Functional Information
- Employment
  - Individual Preferences
  - Functional Information

        - Health and Safety
- Health and Safety
    - Health and Safety
    - Individual Preferences
    - Medical Information
    - Functional Information
- Social Activity
    - Individual Preferences
    - Functional Information
    - Health and Safety
- Protection and Advocacy
    - Individual Preferences
    - Functional Information
- Medical Supports
    - Medical Information
    - Health and Safety
    - Functional Information
    - Behavioral Supports
    - Health and Safety
    - Medical Information

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

ODP will assure that all individuals who are deaf and enrolled or enrolling in the Consolidated Waiver have a Deaf Services Assessment. The Deaf Services Assessment will evaluate expressive and receptive language skills including:

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

The Deaf Services Assessment will also make recommendations concerning:

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

✐ *SC documentation requirements for Deaf Services Assessment:*

- The following sections of the ISP need to be completed per the Enhanced Communication Services HCSIS Job Aid:
    - Individual > Demographics > Demo. Individual > Demographics > Diagnosis (Additional Diagnosis)
    - Plan > Functional Info > Functional Level (Communication)
    - Plan > Functional Info > Other Non-Medical Evaluation

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

✐ SC documentation requirements for other Assessments:

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

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

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

Section 3: Development of the ISP

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

- Abbreviated ISPs may be completed for an individual who is not eligible for Medical Assistance and receives non-waiver services that cost less than $2,000 in a Fiscal Year (FY). When completing an abbreviated ISP, the following minimum screens must be completed:
    - Demographics
    - Individual Preferences.
    - Outcome Summary.
    - Outcome Actions.
    - Services and Supports Directory (Provider, Vendor, and/or ISO).
    - Service Details (only for individuals who have a funded service).

- Although the cost of Base-funded Case Management services will not be included in the $2,000 limit listed in the previous bullet, ODP recommends that individuals, SCs and teams include in the ISP the specific actions the SC will perform in support of the individual's outcomes and priorities.
- ODP allowed abbreviated plans to be completed in the past for individuals receiving Targeted Service Management. To comply with federal requirements, a full ISP must be completed for any new individual who begins to receive Targeted Service Management on or after July 1, 2015. For individuals currently receiving Targeted Service Management, a full ISP must be completed at the next annual meeting. Full ISPs must be completed and approved no later than April 30, 2016.

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

Once an assessed need is identified, the team should discuss whether the need can be met through natural supports (i.e. family, friends, medical professionals, etc.) or if the need requires the support of a paid service. Paid services are appropriate when naturally occurring supports are not available or when a person or entity with special skills or training is necessary to support the assessed need. While all needs must be reviewed, not all needs require a paid service. Discussions include recommended services and supports to address the individual's current assessed needs which lead to services that are based upon those assessed needs and the personal preferences of the individual.

If the individual and the ISP team determine an additional paid service is necessary to address an assessed need, then the specific skill the individual wants to work on is identified and a measurable outcome action is developed to support that skill development. The ISP also identifies who will provide services with what frequency and specifies who holds responsibility for different aspects of plan implementation, any unique training that is required to meet the unique needs of the individual, monitoring and coordination, including those related to health care, risk mitigation, behavioral support, financial support and communications. Any changes to demographic information should be addressed and updated in HCSIS as they occur.

✐ SC documentation requirements for training to meet the unique needs of the individual:

- Training to meet the unique needs of the individual may include training related to the following areas, but this is not an exhaustive list:
  - Communication needs - the SC should document this in the functional section of the ISP under communication.

- Mobility – the SC should document in the physical development section of the ISP.
- Behavior concerns – the SC should document in the health and safety section of the ISP under the behavior plan section.

Section 3.1: Annotated ISP (attachment #4)

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

Section 3.2: Questions to Help Facilitate the development of the ISP (attachment #5)

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

Section 3.3: Outcome Development

Through the ISP process, the ISP team uncovers what is important to the individual and develops Outcome Statements that reflect the individual's priorities. Measurable Outcome Actions are developed based upon an individual's ability to acquire, maintain and improve a skill, including those that increase the individual's safety and well-being.

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

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

Outcome development criteria:

- The team develops Outcome Statements to support the attainment of what is important to the individual within the context of his or her everyday life and Outcome Actions that the individual and/or others perform that will achieve the individual's Outcome Statement.

- Outcomes should build on gathered information which reflects the individual's needs and preferences to meet those needs.
- Outcome Statements represent desired changes and important things that should be maintained or make a difference in the individual's life while meeting their assessed needs.
- Outcomes signify a shared commitment to take action.
- There should be a clear connection between preferences and choices and the actions the ISP team determines are necessary to meet needs associated with the individual's preferences and choices.
- The individual and ISP team should work together to find acceptable Outcome Statements that enable the individual to exercise his or her choices, while at the same time Outcome Actions that meet the individual's needs, minimize risk, and achieve or maintain good health.
- Although every funded service must be linked to an Outcome, not every Outcome requires a funded service. There may be Outcome Statements that are important to the individual but do not relate to, or are not supported by, a funded service.
- Any barriers or concerns that prevent the Outcomes from being tangible and reachable must be addressed during the ISP process.

An Outcome Statement supported by a funded service should relate back to the service definition and the assessed need for the service. For example, an Outcome Action supported by Home & Community Habilitation (HCH) should show how the individual will learn, maintain or achieve a skill. Note: The Outcome Phrase should reflect the Outcome Statement and not be the service name.

Section 3.4: Outcome Actions

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

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

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

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

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

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

✐ *SC documentation requirements for natural supports:*

- If natural supports are not currently available, the SC should document within the outcomes section of the ISP the SCs efforts to explore natural supports. Other non-ODP funding sources include the Pennsylvania Medical Assistance (MA) State plan, Behavioral health, OVR and the Department of Education.

Section 3.5: Identification of Services and Supports

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

- Natural supports and other funding sources should be considered prior to ODP funding.
- The team uses the Outcome Actions to ensure that services reflect the action steps needed to promote the achievement of the Outcome Statement.
- Each funded service must be linked to an assessed need and an Outcome.
- The team should identify the type, duration, frequency and amount of each service needed to achieve the Outcome Actions identified in the ISP.

    - Type of service is documented through the service name on the *Service Details* screen in HCSIS.
    - Duration of services is documented through the start and end dates of the service on the *Service Details* screen in HCSIS. Duration is also documented under the *Outcome Actions* section in the *Frequency and Duration of actions needed* field. Duration means length of time.
    - Frequency of services is documented on the *Outcome Actions* screen in the *Frequency and Duration of the actions needed* field. The frequency of a service is the number of times that the service is rendered (i.e. daily, weekly, monthly or annually depending on the service) based on the needs of the individual.
    - Amount of services is documented through the number of units included on the ISP in the *Service Details* screen in HCSIS.
    - Training to meet the unique needs of the individual which includes, but is not limited to (communication, mobility and behavioral).

✐ *SC documentation requirements for identification of services and supports:*

- The type, duration, frequency, and amount of each service are documented in the service and supports section of the ISP.

Section 3.6: Participant Directed Services (PDS)

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

Who can use Participant Directed Services?

- To be eligible for PDS, the individual **must live** in a private residence.
- Individuals living in licensed and unlicensed agency owned, rented, leased or operated homes **may not** participate in PDS at this time, but must be given choice in their lives.
- Individuals, or their surrogate, who choose to self-direct must select one of the FMS options to assist with PDS.
- The individual's ISP must have a PDS (wage range) and include the authorized needed vendor services that are paid by an FMS organization.
- The individual's ISP must include the designated procedure code for the FMS organization's monthly administrative service per ODP instructions.

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

- The individual is the common-law employer or managing employer.
- The individual has more control over their services and is given the ability to manage them and the Qualified Support Service Workers (SSWs) who provide them.

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

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

- Vendor Fiscal/Employer Agent (VF/EA) FMS option: The individual or their surrogate becomes the "**Common Law Employer**" or the legal employer.
- Agency with Choice (AWC) FMS option: The individual or their surrogate becomes the "**Managing Employer**" however the AWC FMS is the legal employer.

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

What services can an individual and his/her surrogate self-direct?

- Home and Community Habilitation (Unlicensed)
- Supported Employment
- Homemaker/Chore
- Unlicensed Respite
- Specialized Supplies
- Supports Broker
- Companion
- Home and Vehicle Accessibility Adaptations
- Assistive Technology
- Transportation (Mile) and Public Transportation
- Education Support
- Respite Camp – Day and Overnight

Section 3.7: Choosing Qualified Providers for Funded Services

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

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

✎ SC documentation requirements for choice of qualified providers:

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

Section 3.8: Provider Back-up Plans

Providers are obligated to render services according to the approved and authorized ISP. A back-up plan is the strategy developed by a provider to ensure the HCBS the provider is authorized to provide is delivered in the amount, frequency, and duration as referenced in the individual's ISP. These back-up plans are developed with the unique needs and risk factors of the participant in mind and discussed and shared with the individual and team. A provider shall develop and provide detailed information on the back-up plan in accordance with 55 Pa. Code §51.32 when individuals are supported in their own private residence or other settings where staff might not be continuously available. The ISP should include a backup plan to address

contingencies such as emergencies, including the failure of a support worker to appear when scheduled to provide necessary services when the absence of the service presents a risk to the participant's health and welfare. Back-up plans are then discussed and updated if necessary, during the ISP plan year or during the next ISP meeting. SCs should monitor that the individual is receiving the appropriate type, amount, duration, and frequency of services to address the individual's assessed needs and that support desired Outcome Statements as documented in the approved and authorized ISP. If services are not rendered per the ISP due to the individual not being available because they are in hospital/rehabilitation care for an extended period, the provider should notify the SC and AE immediately. Individuals that self-direct their services already complete a DP #1009 emergency back-up designation form. The following represents ODP criteria for all other back-up plans:

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

✐ *SC documentation requirements for back-up plans:*

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

Section 3.9 Qualified Provider ISP Roles and Responsibilities

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

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

Section 3.10: SC responsibilities regarding the timeline for ISPs

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

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

- Coordinating information gathering and assessment activity, which includes Utilizing and incorporating statewide needs assessment information the Annual Review ISP meetings, at least 90 calendar days prior to the end date of the ISP.

- Distributing invitations to team members at least 30 calendar days before the ISP meeting is held.

- Facilitating the ISP meeting with all team members invited at least 60 calendar days prior to the end date of the ISP.

- Submitting the Annual ISP to the AE or county for plan approval and service authorization at least 30 calendar days prior to the end date of the ISP.

.

- Distributing the ISP Signature Form to ISP team members.

- Resubmitting the ISP for approval and authorization within 7 calendar days of the date it was returned to the SCO for revision.

- Distributing approved and authorized ISPs to the individual, family, and team members (identified on pages 4-5) who do not have HCSIS access within 14 calendar days prior to the end date of the ISP.

The ISP timeline is (attachment #2) to this manual, and also located on the ODP consulting website www.odpconsulting.net. ODP will use the timeline as a basis for compliance to ensure that the ISP is completed timely.

Section 3.11: ISP development under 55 Pa. Code Chapters 2380, 2390, 6400 and 6500:

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

Section 4: Individual Support Plan Signature Form (DP 1032) (attachment #3)

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

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

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

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

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

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

Section 5: ISP Approval and Authorization

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

By definition, the Annual Review Update Date is the end date of the current ISP plan year.

The Annual Review Update Date does not change from year to year. Only the year changes, not the month or day. For example: if last year's Annual Review Update Date was 8/9/13, this year's Annual Review Update would be 8/9/14. The only exception is during a Leap Year. Previously, HCSIS required the Annual Review Update Date to be within the fiscal year that the Annual Review ISP is being completed. A HCSIS release in September made the change to allow for the Annual Review Update Date to be entered beyond the fiscal year.

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

The SC should enter the ISP into HCSIS in accordance with ODP policy and Department standards and submit to the AE for approval and authorization at least 30 calendar days prior to the end date of the ISP. If the AE sends the ISP back to the SC for revision, the SC must make the necessary corrections and resubmit the ISP back to the AE within seven (7) days of the date it was returned.

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

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

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

Section 6: ISP Review Checklist, DP 1050

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

List of the services included on the Checklist:

- Licensed and Unlicensed Residential Habilitation
- Licensed 6400 One Person Homes
- Intensive Staffing

    - Licensed (2380 and 2390) Day Program Services with 1:1 or higher staffing ratio
    - Unlicensed Home and Community Habilitation with an average of 16 or more hours or 64 units daily
    - Supplemental Habilitation/Additional Individualized Staffing (SH/AIS)
- Pre-Vocational, and
- Supported Employment – Job Finding

Six-Month Review

As per 55 Pa. Code Chapter 51 ODP's Home and Community Based Services regulations and the approved Consolidated and P/FDS waivers, six-month reviews are required for the following waiver services:

- Licensed and Unlicensed Residential Habilitation
- Licensed 6400 One Person Home
- Prevocational, and
- Supported Employment – Job Finding

Six-month reviews are to be based on the Annual Review Update Date and must be documented using the Biannual ISP.

If there are no changes identified during the six-month review, the Biannual Review ISP must be completed to confirm that no changes were identified. If the six-month review results in the need for a changed service, a Critical Revision ISP should be completed and the service details should be modified. The Critical Revision ISP is then subject to AE review, approval, and authorization. If the six-month review indicates that the person no longer meets the criteria for continuation of the identified service, the team needs to develop an action plan.

Section 7: Implementation of Services

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

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

Section 8: Addressing Changes in Need throughout the Year

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

- **Waiver Individuals**: Individuals enrolled in one of the Waivers must have their assessed needs addressed within the scope and limitation of the applicable Waiver, therefore the ISP services must be updated as necessary to address a change in need.

    - If the change in need impacts the currently authorized services and/or funding, the SC must create a critical revision. The critical revision must be created and submitted for authorization to the AE within seven calendar days of notification of the change.
    - If a change in need does not impact services or funding, the SC must create a general update. The general update must be created and finalized in HCSIS within 7 calendar days of verification of the change in need.
    - If the new service(s) or funding is denied by the AE, the AE must provide the individual their due process rights.
    - When a change in need will cause the individual enrolled in the PFDS Waiver to exceed the PFDS cap, the individual should be considered for enrollment in the Consolidated Waiver. If capacity is not available, a PUNS should be initiated to assess these needs. In the interim, base funds if available may be used to augment the services required by the individual in the PFDS Waiver.
    - If an individual must request an exception to exceed the established limits or service conditions as detailed in the approved Waiver service definitions, a "*Request for Exception to established limits or maximum number of service units*" DP # 1023 must be completed by the SCO and forwarded to the appropriate AE, who will review it and forward it to the appropriate RPM.
    - The AE must approve and authorize or deny the revised ISP, including the attached funding, within 14 calendar days of receiving the revised ISP.

✐ *SC documentation for changes in need throughout the year:*

- If an individual experiences a change in need throughout the year, this change must be reflected in the individual's ISP.

- Upon verification of a change in need, the SC must document the change in a Service Note in HCSIS, update the individual's PUNS if applicable and initiate a critical revision to the ISP.

Section 9: Updating ISPs

ISP Teams should review services at least annually and as needs change throughout the year unless the service requires a 6-month review. ISP decisions made by teams, Bureau of Hearings and Appeals (BHA) or the Secretary of Human Services, are specific to the circumstances or needs of the individual at the time the decision was made and, in most cases, are not considered permanent or lifetime decisions. It is expected that these types of ISP decisions are revisited at least annually at the Annual Review ISP Meeting. If, at any time, the team or AE who is expected to authorize services based on individual needs, determines the

services that were included in the ISP as a result of previously made decisions are not needed, it is expected that the ISP be revised to reflect the current needs.

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

- Plan Creation – A plan creation is used when creating and ISP for the first time in HCSIS (referred to as the initial ISP), when there is not a current ISP in HCSIS or when there is a time-span or gap between two ISPs. The team sets proposed ISP review dates within the 365 calendar day required timeline. The initial ISP is considered a "bridge plan", with a start date that is generally 60 to 90 calendar days after the initial ISP meeting and an end date of the following June 30, the last day of the FY. The initial ISP does not encompass an entire FY due to the timing of the initial ISP meeting. The "bridge plan" is used to align the ISP end date with the FY end date.

- Fiscal Year (FY) Renewal – A fiscal year renewal is used to renew the ISP for the following FY. The start date of the HCSIS ISP coincides with the start of the FY, or July 1. The FY ISP "expires" at the end of the fiscal year, or June 30. ISPs are developed on a FY basis in order to create service authorizations that encompass the full FY. Authorization takes place by service and each service is assigned a start and an end date. The FY ISP can include up to one year of service. The ISP created through a fiscal year renewal will pre-populate with information from the previous ISP. Therefore, care should be taken to ensure that services continue to be accurately reflected. This process of renewing plans on the FY promotes efficiency in provider billing, as well as, the ability to generate reports that accurately reflect all services and payments by FY. Additionally, as major changes to the Waivers typically occur at the beginning of the FY, it allows for easier maintenance of any changes that are made. If an annual review update and the FY renewal planning activities fall within the same month, it is recommended that the annual review update be completed first.

- Critical Revision – A revision to the ISP is used when an individual experiences a change in need which requires a change in current services, addition of services or a change in the amount of funding required to meet the needs of the individual. A critical revision to an ISP must be approved and authorized by the AE. Discussion and agreement amongst the team members should occur before all critical revisions are finalized. If the individual, family member or any other team member disagrees with the content of the ISP, this should be documented on the ISP Signature Form (DP 1032).

- Bi-Annual Review – A bi-annual review is a requirement for Pennhurst Class Action members and individuals receiving a service that requires a six month review (see Section 6: ISP Review Checklist), regardless if there are any updates. A bi-annual review is used for editing or updating an existing ISP that requires a review of the ISP twice a year, or every six (6) months. This option will not allow the SC role to modify the plan start and end dates.

- Quarterly Review – A quarterly review is used to edit or update an existing ISP at least every 3 months when no changes to the existing services and supports are required. The 4th quarterly review date originates from the date of the annual review and therefore,

is the annual review update meeting. This option will not allow the SC role to modify plan start and end dates.

- General Update – The category field in HCSIS used to update content in the ISP that does not impact services or funding.

- Annual Review Update – An annual review update is used to document the results of an annual review ISP meeting.

Section 10: Service Utilization

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

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

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

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

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

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

- Permanent Change in Need – as issue is occurring due to a life event that is happening to an individual, or their family member, that would cause a permanent change of service need.
- Provider not rendering service per the frequency and duration as outlined in the ISP.

These issues will help identify the reasons for over or under utilization and may help inform discussions and decisions.

✐ *SC documentation for Service Utilization:*

- The SC should have conversations about service utilization with the individual, family and ISP team and document those conversations in the individual's service notes and monitoring tools in HCSIS. Documentation should include the reason(s) for the under or over utilization that has occurred. This information should also be discussed and documented during the annual review ISP meeting.

Section 11: Monitoring of Services

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

ODP exercises oversight of the ISPs through its AE Oversight Monitoring Process to ensure that ISPs are implemented as written, including implementation of services and Outcomes, as well as, to ensure that ISPs for Waiver individuals are developed in accordance with the current approved Waivers.

SC monitoring verifies that the individual is receiving the appropriate type, amount, duration, and frequency of services to address the individual's assessed needs and desired Outcome Statements as documented in the approved and authorized ISP. For waiver individuals, SC monitoring must take place at the minimum frequency outlined in the approved waivers. For other individuals, SC monitoring must take place at least annually or at a frequency necessary to ensure the health and welfare of the individual.

For more information on SC monitoring requirements, please see Appendix D-2-a (Service Plan Implementation and Monitoring of the Approved Waivers) in the current approved Consolidated or PFDS Waivers and informational packet #048-11 "Instruction on Request for Deviation in Monitoring Frequency".

Supports Coordination Monitoring Requirements:

Consolidated Waiver

For individuals in the Consolidated Waiver who receive a monthly service, the Supports Coordinator shall conduct a minimum of three (3) face-to-face monitoring visits every three (3) calendar months. Of these visits:

- At least one (1) of the visits must take place at the waiver participant's residence;

- One (1) visit must take place at the waiver participant's day service; and
- One (1) visit may take place at any place agreeable to the waiver participant.

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

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

Deviations in monitoring frequency may not result in monitoring that takes place at a frequency less than four (4) face to-face monitoring visits per calendar year. Deviations in monitoring location may only be approved if the deviation allows for monitoring of service delivery at authorized service locations. Deviations in monitoring frequency and location must be prior approved by ODP. The process to be followed is outlined in Informational Packet 048-11, "Instructions on Request for Deviation in Monitoring Frequency".

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

P/FDS Waiver

For individuals living with a family member, the supports coordinator shall contact the individual at least once every three (3) calendar months and shall conduct a face-to-face monitoring at least once every six (6) calendar months. At least one face-to-face monitoring per calendar year must take place in the individual's home.

For individuals in any other living arrangement, including but not limited to their own home, Personal Care Homes, or Domiciliary Care Homes, the supports coordinator shall conduct a face-to-face monitoring at least once every three calendar months and shall contact the waiver participant at least once every calendar month. At least one of the face-to-face monitoring visits every six calendar months must take place in the individual's home.

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

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

Deviations in monitoring frequency may not result in monitoring that takes place at a frequency less than two contacts per calendar year and one face-to-face visit per calendar year. Deviations in monitoring location may only be approved if the deviation allows for monitoring of service delivery at authorized service locations. Deviations in monitoring frequency and location must be approved by ODP.

For individuals in the PFDS waiver who do NOT receive at least one Waiver service each calendar month, ODP requires the following monitoring frequency by the Supports Coordinator, regardless of the participant's living arrangement:
* Contact at least once every calendar month; and

*A face-to-face monitoring contact at least once every three calendar months. At least two of the face-to-face visits per calendar year must take place in the participant's home.

If a monthly service is not provided as per the conditions outlined in Appendix B-6-a-ii, deviations of monitoring frequency and location are not permitted; deviations of monitoring frequency and location are not permitted for these circumstances.

Section 12: Waiver and Base Administrative Services

VF/EA FMS (Self-directing)

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

Provider Type **54** - Intermediate Services Organization
Specialty **541 -** ISO - Fiscal/Employer Agent
Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 11-Office 99-Community

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

AWC FMS (Self-directing)

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3–120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

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

VF/EA FMS Transition Service

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

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

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

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

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

VF/EA FMS Start-up Service

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

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

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

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

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

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

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

Local VF/EA FMS & AWC FMS Service

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

Provider Type **55** - Vendor
Specialties: **267** - Nonemergency; **543** - Environmental Accessibility Adaptations; **552** - Adaptive Appliances/Equipment; **431** - Homemaker/Chore Services; **430** - Homemaker Services; **533** - Educational Service; **553** - Habilitation Supplies; **519** - FSS/Consumer Payment

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

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

<u>OHCDS One-Time Vendor Payments (Non Self-Directing)</u>

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 through an OHCDS provider when the vendor does not enroll directly with HCSIS to provide the service nor enroll directly with PROMISe™ to submit a claim to be paid for the rendered service. The OHCDS provider can charge an administrative fee for one-time vendor services per the ODP billing requirements. This administration fee is $25.00 or 15% per transaction, whichever is less.

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W0026		**OHCDS, Transportation Services**	This is an administrative service to pay the administration fee that is charged when the OHCDS provides an administrative service directly related to	Outcome Based

			the delivery of a Transportation vendor service (one time vendor) for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is $25.00 or 15% per transaction, whichever is less.	

OHCDS One-Time Respite Camp Vendor Payments

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W0026	**U2**	**One-Time Vendor Payment for Respite Camp**	This is an administrative service to pay the administration fee that is charged when the OHCDS provides an administrative service directly related to the delivery of a Respite Camp vendor service (one time vendor) for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is $25.00 or 15% per transaction, whichever is less.	Outcome Based

OHCDS One-Time Other Vendor Payments

Provider Type **55** - Vendor
Specialties: **543** - Environmental Accessibility Adaptations; **552** - Adaptive Appliances/Equipment; **431** - Homemaker/Chore Services; **430** - Homemaker Services; **533** - Educational Service; **553** - Habilitation Supplies

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

Procedure Code	Service Level	Service Description	Service Unit
W0027	**OHCDS, Other Vendor Services**	This is an administrative service to pay the administration fee that is charged when the OHCDS provides an administrative service directly related to the delivery of a vendor service (one time vendor) other than Transportation or Respite Camp for an	Outcome Based

		individual who is not self-directing their services. The administrative service is billed as a monthly fee which is $25.00 or 15% per transaction, whichever is less.	

Section 13: Waiver Services

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

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

The cost of P/FDS Waiver services provided to any 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.

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.

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

In accordance with 42 CFR §441.301(b)(1)(ii), waiver services may not be furnished to individuals who are inpatients of a hospital, nursing facility or ICF/MR. Waiver services *may* be available to individuals who are residing in residential treatment facilities, correctional facilities on a temporary basis[2], or drug and alcohol facilities while the individual is not in the care of the facility. The Waivers may not pay for the cost of the facility, but can be used to meet the needs of the individual outside of the facility. In these instances, the primary purpose of the Waiver services is reunification of the individual with his or her family, friends, and community, and to ensure the individual's health and welfare. In addition, an individual residing in one of these settings may receive Waiver services to support them while visiting family during weekends or over holidays. Please note that all Waiver enrollment policies apply to these individuals.

Each service definition identified in this section contains:

- A service description.

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

- Suggestions for determining need.
- Documentation requirements.
- Service Limits.

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

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

SC documentation requirements:

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

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

Section 13.1: Assistive Technology

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

- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the individual;
- Selecting, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices;
- Training for the individual, or where appropriate, the individual's family members, guardian, advocate, staff, or authorized representative on how to use and/or care for the assistive technology;
- Extended warranties; and

- Ancillary supplies, software, and equipment necessary for the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices not available through the Waiver that assist individuals with a need identified through the evaluation described below.

Determining the need for services:

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

- Is the assistive technology device necessary to address the needs of the individual?
- Was a recommendation obtained from an independent evaluation of the individual's assistive technology needs?
- Is the organization or professional providing the evaluation credentialed, licensed or certified in an area related to the specific type of technology needed?
- Does the organization or professional providing the evaluation of the individual's assistive technology needs not have a fiduciary relationship with the assistive technology provider?
- Does the device meet the applicable standards of manufacture, design and installation?
- Is the device cost effective?

Service limit:

- All items shall meet the applicable standards of manufacture, design, and installation.
- Items shall be specific to the individual's needs and not be a device or equipment that benefits the public at large, staff, significant others, or family members.
- Although Waiver funds cannot be used to purchase items such as iPads, iPods or personal computers, applications to such items that assist individuals with a need identified through the evaluation described below are eligible for Waiver funding through this service.
- Items reimbursed with Waiver funds shall be in addition to any medical supplies provided under the MA State Plan and shall exclude those items not of direct medical or remedial benefit to the individual.
- If the individual receives Behavioral Therapy or Behavioral Support Services, the assistive technology must be consistent with the individual's behavior support plan.
- Assistive technology may only be funded through the Waiver if there is documentation that the service is medically necessary and not covered through the MA State Plan which includes EPSDT, Medicare and/or private insurance. Assistive Technology must be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached and documentation is secured by the Supports Coordinator.

- Assistive technology has a lifetime limit of $10,000.00 per individual except when the limit is extended by ODP using for #DP1023 "*Request for exception to established service limits or maximum number of service units*". The lifetime limit of $10,000 for a single procedure code (medical/non-medical) or $10,000 for the accumulated total of both procedure codes.
- Durable medical equipment, as defined by 55 Pa. Code Chapter 1123 and the MA State Plan, is excluded. Some examples of durable medical equipment include, but are not limited to: Walkers, wheelchairs, hospital beds and mattresses. The waivers will not cover variations of items considered durable medical equipment that are used primarily for the comfort or convenience of the individual such as specialized strollers.
- 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.
- There must be a recommendation by the team, or a person that is part of the team, that identifies the need for an assistive device evaluation.
- An evaluation to support the need for the assistive device must be documented.
- Assistive technology services include direct support to an individual in the selection, acquisition or use of an assistive technology device.

✎SC documentation requirements:

- The assistive technology device was recommended by an independent evaluation of the individual's assistive technology needs.
- The specific necessary equipment must be defined.
- Verification is documented that the MA state plan which includes EPSDT, Medicare and/or private insurance limitations have been exhausted prior to funding, with annual updates recorded in the ISP, as well as, in service notes in HCSIS or in the individual's hard copy file.
- A summary of the documentation must be included in the *Service Details* page of the ISP.

The procedure codes and service units for Assistive Technology Services:

Assistive Technology Service:
Provider Type **55** - Vendor
Specialty **552 –** Adaptive Appliances/Equipment

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Community

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

Section 13.2: Behavioral Support

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

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

- Collection and evaluation of behavioral data;
- Observation of the individual in various settings for the purpose of developing a behavior support plan;
- Collaboration with the individual, 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 individual, based on functional behavioral assessments;
- Conducting training related to the implementation of behavior support plans for the individual, family members, staff and caretakers;
- Implementation of activities and strategies identified in the individual's behavior support plan;
- Monitoring implementation of the behavior support plan, and revising as needed;
- Collaboration with the individual, 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 or service location, or in local public community environments necessary for the provision of the Behavioral Support Services. Direct services must be provided on a one-on-one basis.

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

Determining the need for services:

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

Service limit:

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

✎SC documentation requirements:

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

The procedure code and service unit for 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	Allowable Modifiers	Service Level	Service Description	Service Unit
W7095		**Behavioral Support**	This service includes functional assessment; the development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, relatives, and caregivers. This is a 1 individual to 1 Behavioral Support direct professional service. The individual's family members, staff, or others involved in the individual's life may be included in Behavior Support activities.	15 minutes

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

Section 13.3: Companion Services

Companion services are provided to individuals living in private homes for the limited purposes of providing supervision and assistance that is focused solely on the health and safety of the adult individual with an intellectual disability. Companion Services are used in lieu of Home and Community Habilitation Services to protect the health and welfare of the individual when a habilitative outcome is not appropriate or feasible (i.e. when the individual is not learning, enhancing, or maintaining a skill).

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 assistance with daily living activities, including grooming, health care, household care, meal preparation and planning, and socialization.

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

Determining the need for services:
The team should utilize Attachment 8, *Comparison of Home and Community Habilitation (Unlicensed) and Companion for ISP Teams*, as a resource in addressing the following:

- Determine that companions are either supervising or providing care and assistance that is focused solely on the health and safety of the individual.
- Companion Services are used when there are no habilitative Outcome Actions for the individual associated with the delivery of the service. The individual is not learning, enhancing, or maintaining a skill.
- The Outcome Actions related to Companion services only relate to assistance to and supervision of the individual to ensure health and welfare.
- Does the individual need supervision during overnight hours?

Service limit:

- Companion services are used to protect the health and safety of the individual when a habilitation Outcome Action is not appropriate or feasible.
- Companion Services are not available for individuals residing in agency-owned, rented/leased, or operated homes. This service may not be provided at the same time as any other direct waiver service (with the exception of Supports Coordination).
- Companion Services and Home and Community Habilitation have a maximum limit of 24 hours (96 15-minute units) per individual per calendar day whether used in combination or alone.
- Companion Services may not be provided at the same time as any of the following: Home and Community Habilitation, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Transitional Work Services.
- This service can be used for asleep hours when only supervision or non-medical or non-habilitative care is needed to protect the safety of the individual. For example, a companion can be used during overnight hours for an individual who lives on their own but does not have the ability to safely evacuate in the event of an emergency.
- When services are provided by agency-based providers, this service also includes transportation services necessary to enable the individual to participate in the Companion Service, in accordance with the individual's ISP.
- This service is not available to individuals when a legally responsible person is required to provide supervision or assistance or when the service is a covered service under the MA State Plan.

✎SC documentation requirements:

- The supervision and/or care the companion will be providing and why it is necessary to ensure the individual's health and safety in the Outcomes section of the ISP.

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

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

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

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

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

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

Provider Type **54** - Intermediate Service 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
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.4: Education Support Services

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

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

Additional Service Definition Clarification:
Teaching American Sign Language or another form of communication to an adult waiver participant (a participant who is 21 years of age or older or a participant under 21 years of age who has graduated from high school) who is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication is covered under Education Support Services. To qualify to teach American Sign Language or another form of communication through this service the provider must have at least Intermediate Plus sign language skills on the Sign Language Proficiency Interview and meet all other qualification criteria for Education Support Services.

Determining the need for services:

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

- Does the participant have an employment Outcome Statement or other Outcome Actions related to skill attainment or development in the ISP related to the Education Support Service need?
- Does the educational support service relate directly to the Outcome selected by the participant?
- Is the participant age 21 or below? If yes, they should have this service provided for them through the Department of Education.
- Did the participant graduate before the age of 21? If yes, OVR should be contacted prior to payment for this service under the Waivers.

Service limits:

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

✎SC Documentation requirements:

- Documentation of verification that services are not available for funding through OVR or available through IDEA for individuals still in school.
- A summary of the documentation must be included in the *Service Details* page of the ISP.

- Documentation to support the continued need for service re-authorization (i.e. to train on a new skill or progress demonstrated on current Outcome Actions to date).

The procedure code and service units for Education Support Services:

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

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

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

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

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

Section 13.5: Employment Services

ODP expects AEs to institute standard practices to promote employment through the ISP. The AE shall have these practices in place for individuals ages 16-25, and for all individuals attending a facility licensed under 55 Pa. Code Chapter 2390 who are interested in obtaining employment in the community. An individual who does not fall into one of these groups should still have access to employment supports, and should discuss it with their SC. AEs shall ensure that individuals are:

- Advised about the availability of employment services.

- Given the opportunity to choose employment services.
- Given the opportunity to meet with employment providers and people who have jobs if they so choose.

The SC should discuss employment and the availability of employment supports and services at every annual review update meeting. The employment supplement should also be done annually or as needs change and used to determine if an Office of Vocational Rehabilitation (OVR) referral is warranted and what type of employment services might be warranted. The SC shall document all discussions regarding employment in a service note in HCSIS. The Functional Level Employment Screen should be completed for any individual age 16-26, any individual with vocational services included in the outcome section of the ISP regardless of their age and setting, and any individual leaving a State Center. The Employment Screen in the ISP should be filled out for all individuals who have employment services (job finding, job support, transitional work).

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

✎ SC documentation requirements for employment:

- The SC shall document all discussions regarding employment in a service note in HCSIS.

Supported Employment

Supported Employment Services are direct and indirect services that are provided in a variety of community employment work sites with co-workers who do not have disabilities for the purposes of finding and supporting individuals in competitive jobs of their choice. Supported Employment Services enable individuals to receive paid employment at minimum wage or higher from the employer. This service is provided to individuals who, because of their disabilities, need additional support to perform in a work setting. Supported Employment Services include activities such as supervision and training needed by the individual in order to obtain and sustain paid work. Payment will be made only for the 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.

Federal Financial Participation through the Waiver 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; or
- Payments for vocational training that are not directly related to an individual's supported employment program.

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

Job finding

Job finding may include interview assistance, employer outreach and orientation, resume preparation, job searching, and preparation for job tasks. Other examples of activities that may be associated with job finding include participation in individual planning for employment; development of job seeking skills; development of customer-specific job skills; job analysis; support to learn job tasks; consultation with 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 support

Job support consists of training the individual receiving the service on job assignments, periodic follow-up and/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.

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

Determining the need for services:

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

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

Service limits:

- When Supported Employment Services are provided alone or in conjunction with Prevocational, Transitional Work or Licensed Day Habilitation services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- The Job support component of supported employment activities are a direct service to one individual at a time.
- The direct portion of Supported Employment may not be provided at the same time as any of the following: Companion Services, Home and Community Habilitation, Licensed Day Habilitation, Prevocational Services and Transitional Work Services.

- This service may not occur in a 55 Pa. Code Chapter 2390 (licensed prevocational) facility or setting.
- Supported Employment Services may not be rendered under the Waiver until it has been verified that the services are not available to the individual under a program funded by either the Rehabilitation Act of 1973 as amended, or IDEA.
- For job support, the individual must receive minimum wage or higher.
- OVR referral and determination must be completed and received.
- The travel time for supported employment services is built into the existing rate for the service, thus cannot be billed as a discrete service.
- Ongoing use of the service is limited to support for individuals that cannot be provided by the employer through regular supervisory channels and/or on-the-job resources that are available to employees who are non-disabled.

✎SC Documentation requirements:

- Before an individual can receive Supported Employment services, the SC must make a referral to OVR. As part of this process, the SC must complete the "OVR-ODP Interagency Referral Form", OVR-172. The SC must keep a copy of the letter from OVR that notifies the individual of his or her eligibility or ineligibility for OVR services in the individual's file. The SC must document the date the OVR-172 was sent to OVR and the effective date of the eligibility letter received from OVR in the individual's ISP. 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 provision of job finding services must have a six month review completed by the SC to assess whether the service is assisting the individual with finding community employment. If the service is not assisting the individual with finding community employment, the ISP team must identify changes to the Supported Employment Service or other service options to meet the individual's needs.
- The SC should complete the SC section of the ISP review checklist and document the results of discussions with team members.

The procedure code and service unit for Supported Employment Services:

Provider Type **53** - Employment-Competitive
Specialties: **530** - Job Finding; **531**-Job Support

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 16-120 years old;
Base Funding: 16-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

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

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

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

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

1st – U4
2nd – U1

Transitional Work Services

Transitional Work Services consist of supporting individuals in transitioning to integrated, competitive employment through work that occurs in a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations. Individuals receiving this service must have an employment outcome included in their ISP. Transitional work service options include mobile work force, work station in industry, affirmative industry, and enclave.

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. A Work Station in Industry involves individual or group training of individuals at an industry site. Training is conducted by a provider

training/job supervisor or by a representative of the industry, and is phased out as the individual(s) demonstrates job expertise and meets established production rates. Affirmative Industry is operated as an integrated business, where disabled and non-disabled employees work together to carry out the job functions of the business. 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. The goal for this service is competitive employment. This service can be delivered in Pennsylvania and in states contiguous to Pennsylvania.

Additional Service Definition Clarification:

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

Determining the need for services:

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

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

Service limits:

- Transitional Work Services may not be rendered under the Waiver until it has been verified that the services are not available to the individual under a program funded by either the Rehabilitation Act of 1973 as amended, or IDEA. Documentation must be maintained in the file of each individual receiving Transitional Work Services to satisfy the state assurance that the service is not otherwise available to the individual under a program funded under the Rehabilitation Act of 1973 as amended or IDEA.
- When Transitional Work Services are provided alone or in conjunction with Prevocational, Licensed Day Habilitation or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year
- Transitional Work Services may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Home and Community Habilitation Services.
- Transitional work service options include: mobile work force, workstation in industry, affirmative industry or enclave.
- The service also includes transportation that is an integral component of the service, for example, transportation to a work site. The Transitional Work provider is not, however, responsible for transportation to and from an individual's home, unless the provider is designated as the transportation provider in the individual's ISP. In this case, the transportation service must be billed as a discrete service.

- Provider is responsible for all transportation integral to the service. For example, transportation to a work activity.

✎SC Documentation requirements:

- Progress needs to be documented such that the trainer is phased out as the individual meets established production goals in work station and affirmative industry.
- Employment screen for those receiving employment services and at least for all individuals from 16 to 26 years of age.

The procedure codes and service units for Transitional Work Services:

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 16-120 years old;
Base Funding: 16-120 years old
Allowable Place of Service: 99-Other (Community)

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

Prevocational Services

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

- Occupational training which is used to teach skills for a specific occupation in the competitive labor market, and includes personal and work adjustment training that is

designed to develop appropriate worker traits and teach the understanding of the expectations of a work environment.
- Work related evaluation which involves the use of planned activities, systematic observation, and testing to accomplish a formal assessment of the individual, including identification of service needs, potential for employment, and identification of employment objectives.

Individuals receiving Prevocational Services must have an outcome for employment included in their ISP. The service must be reviewed at least every 6 months or more frequently as needed to assess the need for the service and progress on the employment outcome.

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

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

Determining the need for services:

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

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

Service limits:

- Prevocational Services may not be funded through the Waiver if they are available to individuals through program funding under Section 110 of the Rehabilitation Act of 1973, as amended, or section 602 (16) and (17) of the IDEA. Documentation must be maintained in the individual's file to satisfy assurances that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 as amended and the IDEA.
- When Prevocational Services are provided alone or in conjunction with Licensed Day Habilitation Services, Transitional Work or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- Prevocational Services may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Home and Community Habilitation and Transitional Work Services.
- The use of enhanced levels of service is based on the individual's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.
- Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the Waiver.

- If an individual requires 1:1 or 2:1 staffing during licensed day habilitation, the licensed day habilitation service provider is responsible to provide the staffing and the plan for the eventual reduction or discontinuance. Needed day staffing may not be provided by the individual's residential, unlicensed habilitation or other non-day habilitation provider and these types of services may not be used to supplement the licensed day habilitation service.
- Prevocational services require a 6-month review completed by the SC using the ISP review checklist.

✎SC documentation requirements:

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

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 16-120 years old;
Base Funding: 16-120 years old
Allowable Place of Service: 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7087		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:15.	15 minutes
W7088		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:15 to 1:7.5.	15 minutes
W7089		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:7.5 to >1:1.	15 minutes
W7090		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7091		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE	Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7092		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7093		Staff Support	The provision of the service at a staff-to-individual ratio of 2:1 where both staff	15 minutes

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

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

1st – TD or TE
2nd - U1

Section 13.6: Home and Community Habilitation (Unlicensed)

This is a direct service (face-to-face) providing 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, fine and gross motor skills, mobility, personal adjustment, relationship development, socialization, and use of community resources. When services are provided by agency-based providers, this service also includes transportation services necessary to enable the individual to participate in the Home and Community Habilitation Service, in accordance with the individual's ISP. Through the provision of this service individuals will acquire, maintain, or improve skills necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life.

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

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

- Support that enables the individual to access and use community resources such as instruction in using transportation, translation and communication assistance related to a habilitative outcome, and services to assist the individual in shopping and other necessary activities of community life.
- 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.

- 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.
- Support that enables an individual to visit with friends and family in the community.
- Support that enables an individual to participate in public and private boards, advisory groups, and commissions.
- Support that enables the individual to exercise rights as a citizen, such as assistance in exercising civic responsibilities.
- Support provided during overnight hours when the individual needs the habilitation service to protect their health and welfare. The staff providing the Home and Community Habilitation Service must be awake.

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

Additional Service Definition Clarification:

Home and Community Habilitation services shall not be rendered in a building or a room owned, rented or leased by providers with the purpose of providing services solely to individuals with a disability. If a provider is rendering Home and Community Habilitation to four (4) or more individuals with a disability in a building or room, the provider may be subject to licensing requirements under 55 Pa. Code 2380 regarding Adult Training Facilities. Providers may contact the Bureau of Human Services Licensing at 1-866-503-3926, if they have questions regarding the licensure requirements.

Individuals may meet in such a building or room to be transported or transferred to another location where Home and Community Habilitation services will be provided. When individuals meet for transportation purposes, Home and Community Habilitation cannot be billed while the individuals are waiting or gathering.

When an individual residing in a licensed Residential Habilitation setting elects to receive Home and Community Habilitation services as an alternative to a licensed Day Habilitation or Prevocational Service, the Home and Community Habilitation service must occur in the community. Home and Community Habilitation cannot be provided in a licensed setting or camp. If it is determined that an individual needs to receive additional day services in a licensed Residential Habilitation setting, residential enhanced staff through Supplemental Habilitation or Additional Individualized Staff should be explored.

Teaching American Sign Language or another form of communication to an adult waiver participant (a participant who is 21 years of age or older or is under the age of 21 and has graduated from high school) who is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication is covered under Home and Community Habilitation Services. The person who will be teaching the waiver participant must be fluent in the communication mode to be taught and meet all other Home and Community Habilitation qualification criteria in order to qualify to teach American Sign Language or another form of communication through this service.

Determining the need for services:

The team should utilize Attachment 8, *Comparison of Home and Community Habilitation (Unlicensed) and Companion for ISP Teams*, as a resource in addressing the following:

- Is the result of this service for the participant to learn, acquire, maintain and/or improve a skill?
- What are the specific skills the individual needs to acquire maintain or improve?
- Are Outcome Actions for habilitation measurable?
- How many units of service are needed and how many units of service can this individual tolerate in a day/week to acquire the skill?
- If the measurable Outcome Actions only relate to supervision or minimal assistance, then companion is the appropriate service.
- If the individual only needs supervision during overnight hours, the appropriate service is Companion Services.

Service Limits:

- Supplemental habilitation staff available through the licensed residential habilitation service may not be used to provide the separate and discreet service of unlicensed home and community habilitation an individual may be authorized to receive.
- This service is provided in the individual's home or other unlicensed residential or community setting.
- Staff providing enhanced habilitation must meet the following: licensed nurse or a professional with at least a 4-year degree.
- The use of enhanced levels of service is based on the individual's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.
- Home and Community Habilitation may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Licensed Day Habilitation, Prevocational Services and Transitional Work Services. Home and Community Habilitation and Companion Services have a maximum limit of 24 hours (96 15-minute units) per individual per calendar day whether used in combination or alone.
- 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.
- As indicated above for individuals residing in residential settings, Home and Community Habilitation Services may be used as an alternative either part-time or full-time for a Licensed Day Habilitation Service or a Prevocational Service. When this occurs the Home and Community Habilitation units are included in the combined unit limit for services that may not exceed 40 hours (160 15-minute units) per individual, per calendar week based on a 52 week year (Transitional Work Services, Supported Employment Services, Licensed Day Habilitation Services and Prevocational Services).
- Home and Community Habilitation Services cannot be provided in a licensed setting or camp as it is provided in an individual's private home or other community setting.

✎SC Documentation requirements:

- If community habilitation is being requested at an average of 16 or more hours daily, the SC should complete their required section of the ISP review checklist.

- If unlicensed home and community habilitation is being utilized for someone living in a residential habilitation setting, as a non-traditional day service, the SC should document the Outcome Actions of the unlicensed home and community habilitation being provided and monitor that those Outcome Actions are being worked on according to the ISP.

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

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7057		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7058		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7059		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7060*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7061*		Staff Support Level 3 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.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

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

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

1st – TD or TE
2nd - U1

OR

1st – TD or TE
2nd – U4

OR

1st – U4
2nd – U1

Section 13.7: Home Accessibility Adaptations

Home accessibility adaptations consist of certain modifications to the private home of the individual (including homes owned or leased by parents/relatives with whom the individual resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the individual's disability, to ensure the health, security of, and accessibility for the individual, or which enable the individual to function with greater independence in the home. This service may only be used to adapt the individual's primary residence.

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. 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. Adaptations that add to the total square footage of the home are excluded from this benefit. The only exception to this is adaptations to existing bathrooms that are necessary to complete the adaptation (e.g., necessary to configure a bathroom to accommodate a wheelchair).

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

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

- Ramps for street, sidewalk or house.
- Vertical lifts.
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a "track" in the ceiling for moving an individual with a disability from one location to another.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors, and security systems in their room, home or other surroundings.
- Outside railing from street to home.
- Widened doorways, landings, and hallways.
- An additional doorway needed to ensure the safe egress of the individual during emergencies, when approved by the ODP Regional Office.
- Swing clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- 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 not be furnished to adapt homes that are owned, rented, or leased by a Provider Agency.

This service must be delivered in Pennsylvania.

Determining the need for services:

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

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

Service limits:

- Maximum state and federal funding participation is limited to $20,000 per individual during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new $20,000 limit can be applied when the individual moves to a new home. In situations of joint custody (as determined by an official court order) or other situations where an individual divides their time between official residences, the adaptations must be allowable services and must be completed within the overall monetary limit of $20,000 for this service.
- Building a new room is excluded.
- Home accessibility adaptations are limited to individuals residing in private homes (including homes owned or leased by parents/relatives with whom the individual resides and family living homes that are privately owned, rented, or leased by the host family).
- 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 an intellectual disability, parents or relatives with which the individual resides or family living homes that are privately owned, rented or leased by the host family.
- Home modifications must have utility primarily for the individual with the disability.
- Home modifications would not be expected for a family member without a disability and are not part of room and board cost.
- The modification must be allowable as per the list in the service definition.
- Home modifications consist of installation, repair, maintenance and extended warranties for the modifications and when necessary to comply with rental/lease agreements or return of the property to its original condition.

- Adaptations that add to the total square footage of the home are excluded from this benefit. The only exceptions are those adaptations to bathrooms that are necessary to accommodate a wheelchair.
- Durable medical equipment, as defined by 55 Pa. Code Chapter 1123 and the MA State Plan, is excluded. Some examples of durable medical equipment include, but are not limited to: Walkers, wheelchairs, hospital beds and mattresses. The waivers will not cover variations of items considered durable medical equipment that are used primarily for the comfort or convenience of the individual such as specialized strollers.
- Modifications or improvements to the home that are of general utility are excluded.
- Modifications must increase accessibility and must not be restrictive.
- Modifications not of direct benefit to the individual are excluded.

✎SC documentation requirements:

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

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

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

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

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

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

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

Section 13.8: Homemaker/Chore Services

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

Determining the need for services:

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

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

This service can only be provided in the following situations:

- Neither the participant, nor anyone else in the household, is capable of performing and financially providing for the function; and
- No other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision.
- This service must be delivered in Pennsylvania in the participant's private home.

Service limits:

- This service is limited to 40 hours per individual per fiscal year when the individual or family member(s) or friend(s) with whom the individual resides is temporarily unable to perform and financially provide for the homemaker/chore functions.
- A person is considered temporarily unable when the condition or situation that prevents them from 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 perform and financially provide for the homemaker/chore functions.
- Services are not available to people residing in agency owned, rented, leased or operated homes.
- Services do not include maintenance in the form of upkeep and improvements to the individual's residence.

This service can only be provided in the following situations:

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

✎SC documentation requirements:

- Homemaker/Chore services: The ISP team must determine, and the SC will document in the *Outcome Summary Section* of the ISP, whether a person is temporarily or permanently unable to perform or financially provide for the homemaker functions.
- A person is considered permanently unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform and financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the ISP.
- Homemaker services: The SC will document what the homemaker will be doing and continue to monitor that the tasks are occurring.
- Chore services: The SC will document what the chore service provider will be doing and continue to monitor that the tasks are occurring.
- For rental properties, the SC should examine the lease agreement and document any findings of that examination.
- A person is considered permanently unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions is not expected to improve. The ISP team is responsible to determine whether a person is temporarily or permanently unable to perform and financially provide for the homemaker/chore functions. The ISP team's determination should be documented in the ISP.

This service must be delivered in Pennsylvania in the individual's private home. Refer to the Provider Specification section below for criteria on provider requirements.

This service is not available to individuals residing in agency-owned, rented, leased, or operated homes.

The procedure code and service unit for Homemaker/Chore Services:
Provider Type **43** - Homemaker Agency
Specialty **430** - Homemaker Services

Provider Type **51 -** Home & Community Habilitation
Specialties: **431** - Homemaker/Chore Services; **430 -** Homemaker Services

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7283*	**UA**	**Homemaker / Chore (Temporary)**	Indirect services including household cleaning and maintenance and homemaker activities. This service may only be provided when the individual, or 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 with W7283	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial Management Service when no benefit allowance is paid to the support service worker as part of the wage.	15 minutes

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

1st – UA
2nd – U4

Section 13.9: Licensed Day Habilitation

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

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

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

Determining the need for Services:

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

- Does this individual need to have supervision, training and support during the day to learn a skill or participate in an activity?
- For individuals requiring 1:1 or 2:1 staffing, the Licensed Day Habilitation service provider is responsible to provide the staffing and the plan for the eventual reduction or discontinuance of enhanced staffing. The continued need for enhanced staffing should be reviewing in accordance with the time frame set forth in the ISP and annually as part of the ISP process.
- Individual needs are related to the Licensed Day Habilitation general skill areas listed above and are most appropriately addressed through day habilitation services rather than a prevocational or vocational service.

Service Limits:

- When Licensed Day Habilitation services are provided alone or in conjunction with Prevocational, Transitional Work or Supported Employment services, the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- Licensed Day Habilitation may not be provided at the same time as any of the following: Companion Services, the direct portion of Supported Employment, Home and Community Habilitation, Prevocational Services and Transitional Work Services.
- The use of enhanced levels of service is based on the individual's assessed need, not the service worker's personal qualifications. The fact that the service worker possesses a degree is not justification to use the enhanced level of service.
- Licensed Day Habilitation services must be provided in a licensed setting. However, this does not preclude the Licensed Day Habilitation provider from taking the individuals into the community to provide the service.

- The Licensed Day Habilitation provider is responsible to provide 1:1 or 2:1 staffing or 1:1 or 2:1 enhanced staffing as authorized in the ISP. Needed staffing may not be provided by the individual's residential habilitation staff, Home and Community Habilitation (Unlicensed) provider, or other non-day habilitation providers, and may not be used to supplement the Licensed Day Habilitation Service.

✎SC documentation requirements:

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7072		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7073		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7074		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7075		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7076		Staff Support Level 3 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.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – TD or TE
2nd - U1

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

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

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

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

Section 13.10: Nursing Services

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

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

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

- Implementation of the home program can be done by the individual and those people that support him or her.
- Skills that can reasonably be done by a lay person can be provided by direct support professionals with appropriate training and monitoring by a licensed nurse.
- All individuals, families and staff share in the responsibility for maintaining the individual's health and welfare.
- Home programs require periodic treatment and monitoring by a licensed nurse to assure that the skills are maintained and to monitor the individual's clinical condition.

Determining the need for services:

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

- Does this individual have an unstable airway that without immediate intervention could cause respiratory arrest (stop breathing)?
- Does this individual need clinical treatment that either requires the presence of a nurse or that can be taught to a lay person and monitored by a nurse?
- Does this individual have someone supporting him or her that can be taught treatment techniques and maintain equipment and service in a home program?
- The changing of new tracheostomy and gastrostomy tubes requires treatment by a health care practitioner (physician, physician's assistant, certified nurse practitioner) and not a nurse.
- Care can be safely and effectively administered in the home setting and life-supporting equipment can be managed.
- 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 produce a positive result for the individual.

Service limit:

- The service must be provided by a licensed RN or LPN.

- Home Biphasic Intermittent Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP) do not require nursing presence.
- Nursing Services may only be funded through the Waiver if there is documentation that the service is medically necessary and not covered through the Medical Assistance (MA) State Plan which includes Early Periodic Screening and Diagnostic Testing (EPSDT), Medicare and/or private insurance. Nursing Services must be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached and documentation is secured by the Supports Coordinator.
- Children aging out of EPSDT (reaching their 21st birthday) and receiving home health services will be assessed for their current service needs through the Waivers. They will not automatically receive nursing services through ODP.
- Children aging out of the school system (IDEA) and receiving nursing services must be re-evaluated for service needs.
- For children under 21 years of age receiving ESPDT services, ODP nursing services cannot be used to supplement EPSDT nursing services as those services meet the child's need by definition.

✎SC documentation requirements:

- That an evaluation indicating the need for nursing services, specifying the need for services by a licensed registered nurse (RN) or a licensed practical nurse (LPN), has been completed.
- The supports to be provided by each nursing professional must be determined to arrive at the appropriate units of service.
- An emergency action and transportation plan consistent with the patient's condition is present prior to the beginning of service.
- Document how nursing services support the individual's Outcome Statement in the Outcome Actions.
- Document evidence that the individual is no longer eligible for health care benefits for this condition (evidence may include a termination of coverage letter, explanation of benefits, etc.).

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

Nursing Services--RN

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

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

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

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

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

1st – TD
2nd - U1

Nursing Services--LPN

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 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
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code and modifier above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – TE
2nd - U1

Section 13.11: Residential Habilitation Services (Licensed) Consolidated Waiver

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

The Residential Habilitation provider is not responsible for transportation services for which another provider is responsible.

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

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

Additional Service Definition Clarification:
Residential Habilitation Service providers, the individual and ISP team can consider the following to best meet the 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.

Determining the need for the service:

- This service is authorized as a day unit. A day is defined as a period of a minimum of 12 hours of non-continuous care rendered by a residential habilitation provider within a 24-hour period beginning at 12:00 a.m. and ending at 11:59 p.m. The exception to this rule, effective July 1, 2015, occurs when an individual is admitted to a hospital or nursing

facility. When this occurs the residential habilitation provider may not bill for the day the individual is admitted regardless of how many hours of care the residential habilitation provider has rendered during the 24-hour period. When an individual is discharged from a hospital or nursing facility the residential habilitation provider may bill for the discharge day of service regardless of how many hours of care the residential habilitation provider has rendered during the 24-hour period.

Service limits:

- Prior to Residential Habilitation Services being authorized, the SC and ISP team and AE must utilize the ODP Residential Habilitation Service criteria.
- Licensed residential habilitation is only available for individuals who are receiving Consolidated Waiver.
- The following services may not be authorized for individuals who receive Residential Habilitation Services: Companion, Transportation, Homemaker/Chore, Supports Broker, Specialized Supplies and Home and Vehicle Accessibility Adaptations. The only exception is that Home and Vehicle Accessibility Adaptations may be authorized for individuals residing in licensed and unlicensed family living homes when the home or vehicle being adapted and utilized by the individual is not owned, rented or leased by the family living provider agency.
- The licensed residential provider is not responsible for transportation to community activities for which another provider is responsible.
- Licensed residential habilitation may not include other home and community services, for example, physical therapy or nursing. These other services must be included separately on the individual's ISP.

✎SC documentation requirements:

- SCs should review and check off the sections in the ISP checklist that pertain to the residential habilitation service criteria and one person home setting size guidelines if applicable.
- Residential Habilitation Services must be reviewed at least every 6 months or more frequently using the ODP Residential Habilitation Service criteria to determine whether there is a continued need for the service by completing the ISP review checklist.
- SCs are required to document planned therapeutic and medical leave days in the ISP through an Outcome action related to the residential service in the Frequency and duration of the actions needed field. The information on the service details page of the ISP should reflect the total number of residential habilitation days, including therapeutic and medical leave. The SC should update the ISP through a general update as a result of planned or unplanned therapeutic and/or medical leave, and indicate any changes resulting from the leave.

Child Residential Services

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7010		One-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a one-individual home.	Day
W7011		One-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a one-individual home.	Day
W7012		Two-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a two-individual home.	Day
W7013		Two-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a two-individual home.	Day
W7014		Three-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a three-individual home.	Day
W7015		Three-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a three-individual home.	Day
W7016		Four-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a four-individual home.	Day
W7017		Four-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a four-individual home.	Day
W7018		Five-to-Eight-Individual Home, Eligible	The eligible portion of the child Residential Habilitation Services provided in a five-to-eight-individual home.	Day
W7019		Five-to-Eight-Individual Home, Ineligible	The ineligible portion of the child Residential Habilitation Services provided in a five-to-eight-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that	

			the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Community Residential Rehabilitation Services for the Mentally Ill

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 individuals with chronic psychiatric disabilities. This service is full-care CRRS for adults with intellectual disability and mental illness. Full-care CRRS for adults is a program that provides living accommodations for individuals who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. Host homes, as defined in section 5310.6 are excluded.

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7020		One-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a one-individual home.	Day
W7021		One-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a one-individual home.	Day
W7022		Two-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a two-individual home.	Day
W7023		Two-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a two-individual home.	Day
W7024		Three-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a three-individual home.	Day
W7025		Three-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a three-individual home.	Day
W7026		Four-Individual	The eligible portion of the community	Day

		Home, Eligible	residential rehabilitation services provided in a four-individual home.	
W7027		Four-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a four-individual home.	Day
W7028		Five-to-Eight-Individual Home, Eligible	The eligible portion of the community residential rehabilitation services provided in a five-to-Eight individual home.	Day
W7029		Five-to-Eight-Individual Home, Ineligible	The ineligible portion of the community residential rehabilitation services provided in a five-to-Eight-individual home.	Day
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Family Living Homes

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
		Adult Family Living		
W7291		One-Individual	The eligible portion of the licensed family	Day

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

Licensed Residential Habilitation—Family Living Homes (Child)

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

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

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

			being created in HCSIS for the service with the U1 modifier.	

Community Home Services for Individuals with an Intellectual Disability

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W6090		One-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a one-individual home.	Day
W6091		One-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a one-individual home.	Day
W6092		Two-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a two-individual home.	Day
W6093		Two-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a two-individual home.	Day
W6094		Three-Individual Home, Eligible	The eligible portion of the licensed community home services provided in a three-individual home.	Day
W6095		Three-Individual Home, Ineligible	The ineligible portion of the licensed community home services provided in a three-individual home.	Day
W6096		Four-Individual	The eligible portion of the licensed	Day

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

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

1st – UA
2nd - U1

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

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

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

Determining the need for Services:

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

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

Service Limits:

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

✎SC documentation requirements

- All requests for prior authorization of waiver-funded SH or AIS, are completed by using the ISP review Checklist.
- SH is used to temporarily meet the ***short-term*** unique *behavioral* or *medical* needs of an individual who resides in a Consolidated Waiver-Funded licensed residential habilitation setting.
- SH may be authorized for a maximum of 12 consecutive calendar months.
- The individual's ISP must include both a Consolidated Waiver-Funded licensed residential habilitation procedure code and SH procedure code.
- Permanent or long-term needs should be met through the use of the AIS component which meets the unique ***long-term*** additional individualized staffing needs of an individual who resides in a Consolidated Waiver-Funded licensed residential habilitation setting and the individual's staffing needs can no longer be met as part of the regular and routine licensed residential habilitation staffing pattern.
- The individual's ISP must include both the Consolidated Waiver-Funded licensed Residential habilitation service and the AIS procedure codes.
- Prior authorization requests for SH or AIS waiver funded services should be made in a timely manner. ODP will only approve SH or AIS services retroactively for a period no longer than 30 calendar days from the date the ODP regional office receives the request. After receiving an e-mail notification from the provider that there is a need for SH or AIS services, the SC will convene the ISP Team to discuss the need for the SH or AIS services and document the meeting in a service note.
- All other service provided by the residential provider must be included on the ISP as a separate service and billed discretely. The provider must be qualified to deliver each discrete service.

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

Provider Type **52 –** Community Residential Rehabilitation

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

Age Limits & Funding:
Consolidated Waiver - Age is based on the applicable residential habilitation service
Base Funding - Age is based on the applicable residential habilitation service
Allowable Place of Service: 12-Home; 99-Other (Community)

Allowable Modifiers	**Service Level**	**Service Description**	**Service Unit**
TD (For habilitation provided by RNs) **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 residential habilitation service.	Day
U1		Enhanced Communication Service – The provision of habilitation by nursing staff who are proficient in Sign Language due to the medical and communication needs of the individual. To bill this service, the modifier can be used in concert with both the procedure code for the eligible portion of the residential habilitation service and the modifier for habilitation by nursing staff. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – TD or TE
2nd - U1

<u>Supplemental Habilitation (Licensed Residential Habilitation Services only).</u>

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

The procedure codes and service unit for Supplemental Habilitation:

Provider Type **52** – Community Residential Rehabilitation
Specialties: **520** - Child Residential Services – 3800; **456 -** CRR-Adult; **522 -** Family Living Homes-6500; **521 -** Adult Residential-6400

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

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

Additional Individualized Staffing (Licensed Residential Habilitation Services only).

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

The procedure codes and service units for Additional Individualized Staffing:

Provider Type **52** - Community Residential Rehabilitation
Specialties: **520** - Child Residential Services – 3800; **456 -** CRR-Adult; **522 -** Family Living Homes-6500; **521 -** Adult Residential-6400

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7085		Additional Individualized Staffing 1:1	The provision of 1:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the unique long-term needs of the individual.	15 Minutes
W7086		Additional Individualized Staffing 2:1	The provision of 2:1 staffing for habilitation to supplement the basic Residential Habilitation Service to meet the unique long-term needs of the individual.	15 Minutes

	U1		Enhanced Communication Service –This modifier can be utilized with all of the Waiver Procedure Codes in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

Section 13.13: Residential Habilitation Services (Unlicensed) Consolidated Waiver only

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

- 55 Pa. Code §6400.3(f)(7) (for Community Homes), excludes community homes that serve three or fewer individuals with an intellectual disability 18 years of age or older who need a yearly average of 30 hours or less of direct staff contact per week per home; or

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

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

The team must address the following additional questions:

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

Service limits:

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

✎SC documentation requirements:

- Document information on the ISP review checklist.
- SCs are required to document planned therapeutic and medical leave days in the ISP through an Outcome action related to the residential service in the Frequency and duration of the actions needed field. The information on the service details page of the

ISP should reflect the total number of residential habilitation days, including therapeutic and medical leave. The SC should update the ISP through a general update as a result of planned or unplanned therapeutic and/or medical leave, and indicate any changes resulting from the leave.

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

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

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

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

			being created in HCSIS for the service with the U1 modifier.	

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

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

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

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

Section 13.14: Respite

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

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

Individuals can receive two categories of Respite Services: 24-hour respite and 15-minute respite. 24-hour respite is provided for periods of more than 16 hours, and is billed using a daily

unit. 15-minute respite is provided for periods of 16 hours or less, and is billed using a 15-minute unit. Please see the following section for limitations on these services.

Room and board costs may only be included when the Respite Service is provided in a facility that is approved (licensed or accredited) by the state. Room and board costs may be included solely for Respite in a licensed residential setting or Respite in camp settings that are licensed or accredited.

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

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

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

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

Respite Services are limited to:

- Individuals residing in a private home. The only exception is for an emergency circumstance approved by ODP for individuals who receive Residential Habilitation Services.
- 30 units (days) of 24-hour Respite Services per individual in a period of one fiscal year except when extended by ODP using the standard ODP exception process.
- 480 (15 minute) units of temporary Respite Services per individual in a period of one fiscal year except when extended by ODP using the DP #1023 *Request for exception to established service limits or maximum number of service units*.

Determining the need for services:

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

- What are the specific supports the individual needs during respite?
- Has the availability of informal/natural supports been discussed and utilized?

- Is this service necessary due to the caregiver's absence or need for relief?
- Is the level of services provided directly related to the intensity of the physical, behavioral or personal care needs of the individual served and the availability of natural supports?

Service limits:

- The number of units on an ISP may not go over the service unit limitations indicated in the service definitions without ODP prior approval.
- Respite may be provided in hospitals and nursing homes only with base funding under Base Funded Respite Care.
- Waiver-funded licensed 6400 community homes may provide respite in a vacant bed within the established approved program capacity without ODP approval. On a case-by-case basis, ODP may approve the provision of respite services above a service location's approved program capacity and the provision of respite to a waiver participant in a non-waiver funded licensed residential setting for emergency situations only. Written emergency approval to provide respite services must be obtained from the ODP regional Waiver Capacity Manager (WCM) before the provision of respite occurs using DP # 1037 *Request for provision of emergency respite services.*
- If respite in a non-waiver funded licensed residential setting is being considered for a waiver participant, DP#1023 *Request for exception to established service limits or maximum number of service units* must be completed. If approval has already been granted by ODP (via the DP 1037 form for emergency respite, the DP 1023 form need not be completed in its entirety. The AE should note that approval was previously granted and attach that documentation (a copy of the completed DP 1037 form).
- Respite services should not be used to provide scheduled and on-going services to the individual (this would be either companion or habilitation service).
- Respite services are not to provide recreational or social opportunities to the individual.
- Costs associated with room and board are ineligible for waiver funding in settings that are not licensed or accredited and must be paid with state base/waiver ineligible funds.

✎SC documentation requirements:

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

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

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7247		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7248		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7250*		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7251*		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7252*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7253*		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 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.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

Allowable Modifiers	Service Level	Service Description	Service Unit
U4* Only used	**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	Day

with W7250 W7251 W7252 W7253		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.	
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – TD or TE
2nd - U1

OR

1st – TD or TE
2nd – U4

OR

1st – U4
2nd – U1

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

1st – TD or TE
2nd – U4
3rd – U1

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

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7255		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	15 minutes

W7256		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W7258*		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	15 minutes
W7264*		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7265*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7266*		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where 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.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

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

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

1st – TD or TE
2nd - U1

OR

1st – TD or TE
2nd – U4

OR

1st – U4
2nd – U1

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

1st – TD or TE
2nd – U4
3rd – U1

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

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W8000		Basic Staff Support	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of 1:4.	Day
W8001		Staff Support Level 1	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W8002*		Staff Support Level 2	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1.	Day
W8003*		Staff Support Level 2 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE		The provision of the service at a staff-to-	

			individual ratio of 1:1 with a staff member who is a licensed nurse.	
W8004*		Staff Support Level 3	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1.	Day
W8005*		Staff Support Level 3 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1 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.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

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

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

1st – TD or TE
2nd - U1

OR

1st – TD or TE
2nd – U4

OR

1st – U4
2nd – U1

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

1st – TD or TE
2nd – U4
3rd – U1

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

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W8010		Basic Staff Support	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of 1:4.	15 minutes
W8011		Staff Support Level 1	The provision of the eligible cost portion of the service at a staff-to-individual ratio range of <1:4 to >1:1.	15 minutes
W8012*		Staff Support Level 2	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1.	15 minutes
W8013*		Staff Support Level 2 Enhanced	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W8014*		Staff Support Level 3	The provision of the eligible cost portion of the service at a staff-to-individual ratio of 2:1.	15 minutes
W8015*		Staff Support Level 3	The provision of the eligible cost portion of the service at a staff-to-individual ratio	15 minutes

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

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

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

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

1st – TD or TE
2nd - U1

OR

1st – TD or TE
2nd – U4

OR

1st – U4
2nd – U1

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

1st – TD or TE

2nd – U4
3rd – U1

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7259		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day
W7260		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7262		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7263		Staff Support Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	Day
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7299		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1.	Day
W7300		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 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
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract	

			being created in HCSIS for the service with the U1 modifier.	

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

1st – TD or TE
2nd - U1

OR

1st – TD or TE
2nd – U2

OR

1st – U2
2nd – U1

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

1st – TD or TE
2nd – U2
3rd – U1

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

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

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

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

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

1st – TD or TE
2nd - U1

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

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

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

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

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

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

			the U1 modifier.	

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

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

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

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

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

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

Section 13.15: Specialized Supplies

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

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

Service limits:

- This service is not available to individuals who reside in licensed or unlicensed residential habilitation settings.
- Specialized Supplies consist of incontinence supplies that are medically necessary and are not a covered service through the MA State Plan which includes EPSDT, Medicare or private insurance. Specialized Supplies will be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached.

The procedure code and service unit for Specialized Supplies:

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

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

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

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

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

Section 13.16: Supports Broker Services

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

This service is limited to the following list of activities:

- Explaining and providing support in completing employer-or managing employer related paperwork.

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

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

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

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

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

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

Determining the need for services:

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

- The individual, and/or surrogate, is self-directing the individual's services.
- The purpose of the supports broker service is to assist the individual and provide training and support, not to actually perform the activities.
- Determine what assistance or support is needed for the individual to perform the managing employer functions and define the timeframe and activities to be provided.
- Documentation to support the continued need for service as necessary for service re-authorization (i.e. to train on a new skill or progress demonstrated to date on current Outcome Actions).
- Supports Brokers should assist individuals with the functions and activities utilized to manage or, co-manage their SSWs.

Service Limit:

- This service is limited to a maximum of 1040 (15-minute) units per individual per fiscal year based on a 52-week year. This service is limited to individuals who are self-directing their services through an AWC or VF/EA FMS.

✎SC documentation requirements:

- That the individual is self-directing services and that each role the supports broker will perform is vital to the support of the individual in self-directing those services.
- The specific activities that the supports broker will be completing to support the outcome of the service.
- The SC shall enter applicable information in the employment screen in HCSIS for those receiving employment services and at least for all individuals from 16 to 26 years of age.

The procedure code and service unit for Supports Broker Services:

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

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	**Allowable Modifiers**	**Service Level**	**Service Description**	**Service Unit**
W7096*		**Supports Broker Services**	Direct and indirect services to individuals who are self-directing their services through either employer authority or budget authority. This service is limited to a maximum of 1,040 units or 260 hours per individual per fiscal year based on a 52-week year.	15 minutes
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

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

Section 13.17: Supports Coordination

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

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

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

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

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

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

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

The following activities are excluded from Supports Coordination as a billable Waiver service:
- Outreach that occurs before an individual is enrolled in the Waiver;

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

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

Service Limits:

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

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

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

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

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

Section 13.18: Therapy Services

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

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

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

Service limits:

- Therapy Services may only be funded through the Waiver if there is documentation that the service is medically necessary and not covered through the MA State Plan which includes EPSDT, Medicare and/or private insurance. Therapy Services must be provided under the MA State Plan including EPSDT, Medicare and/or private insurance plans until the plan limitations have been reached and documentation is secured by the SC in the outcomes section, concerns related to the outcome.
- Children aging out of EPSDT (reaching their 21st birthday) or the school system (IDEA) and receiving therapy services must be re-evaluated by a physician, physician's assistant or certified nurse practitioner to determine his or her need for therapy services. They will not automatically receive therapy services through ODP.
- For children under 21 years of age receiving EPSDT services, ODP-funded therapy services cannot be used to supplement EPSDT therapy services as those services meet the child's need by definition.

<u>Behavior Therapy</u>

The treatment, by psychological means, of the problem of an emotional nature in which a licensed psychologist or psychiatrist deliberately establishes a professional relationship with a participant, in an attempt to alleviate or ameliorate the emotional distress disturbances, reverse

or change maladaptive patterns of behavioral challenges, and promote positive personality growth and development. Such therapy must take place at the psychologist or psychiatrist's office and may take the form of either individual therapy with the participant and the psychologist or psychiatrist, or group therapy with the participant and other individuals receiving therapy that is supervised and directed by the psychologist or psychiatrist.

Determining the need for services:

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

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

Service limits:

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

✎SC documentation requirements:

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

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 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	15 minutes

			improved social interaction.	
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – HE
2nd - U1

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

1st – HE
2nd – HQ
3rd – U1

Occupational Therapy

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

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

Determining the need for services:

This service is designed to do the following:

- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring fine motor function.

- Enhance skills that can be incorporated into everyday life for improvement in the independence and performance of ADLs or for prevention of the complications of motor disorders.

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

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

Service limits:

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

✎SC documentation requirements:

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

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 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
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – GO
2nd - U1

<u>Physical Therapy</u>

The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows: "…means the evaluation and treatment of any person by the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions, and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

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

Determining the need for services:

Physical therapy is a service designed to do the following:

- Help the individual to acquire, maintain and improve skills.
- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring gross motor function.

- Enhance skills that can be taught and incorporated into everyday life to improve performance and independence in Activities of Daily Living (ADLs) or to prevent the complications of motor disorders.

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

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

Service limit:

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

✎SC documentation requirements:

- Functional limitation in gross or fine motor skills.
- Evaluation of need for Physical Therapy.
- Ability to benefit from Physical Therapy.
- How Physical Therapy supports Outcome Statements (e.g. to increase range of motion or teach to do stand pivot transfer either independently or with an assist).
- Physical Therapy must be ordered by a health care practitioner under the scope of their practice. This includes physicians (MDs or Dos), physician's assistants (PAs) or certified registered nurse practitioners (CRNPs).

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 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
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – GP
2nd - U1

Speech and Language Therapy

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

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

Additional Service Definition Clarification:

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

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

Determining the need for services:

This service is designed to do the following:

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

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

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

Service limit:

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

✎SC documentation requirements:

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

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

Provider Type **17** - Therapist

Specialty **173**, Speech/Hearing Therapist

Age Limits & Funding:
Consolidated & P/FDS Waivers: 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
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the Consolidated Waiver only. It signifies that the individual has been assessed as needing this service by staff proficient in Sign Language. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.	

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

1st – GN
2nd - U1

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.

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

This service must be provided by a trained visual or mobility specialist/instructor based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician. There are no location requirements for this service. Successful Visual/Mobility Therapy services require implementation and repetition of the learned skills outside of the therapy sessions.

Determining the need for services:

This service is designed to do the following:

- Develop skills needed to move as safely and independently as possible in home, school, work and community environments.

- Enhance skills that can be incorporated into everyday life to improve the performance and independence in ADLs or to prevent the complications of motor disorders.

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

- Is this individual blind or does he or she have a visual impairment that impacts on his or her ability to navigate their environment?
- Is there a formal or informal assessment by a visual/mobility therapist that establishes a need for visual and mobility therapy?

✎SC documentation requirements:

- Blindness or visual impairment.
- Denial from blind and visual services.
- Difficulty getting around in the environment related to the visual problems.
- Evaluation from a visual/mobility therapist that specifies:
    - Ability to benefit from Visual/Mobility Therapy (V&MT).
    - Need for V&MT to help the individual navigate their environment.
    - Outcome actions related to navigating in his/her environment.

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

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

Section 13.19: Transportation

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

Service limits:

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

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

Public Transportation

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

The procedure code and service unit for Public Transportation Services:

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

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

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

Age Limits & Funding:
Consolidated & P/FDS Waivers: 3 - 120 years old;
Base Funding: 0 – 120 years old

Allowable Place of Service: 99-Community

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

Transportation Mile

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

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

The procedure code and service unit for Transportation Mile Services:

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

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

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

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

Procedure Code	Service Level	Service Description	Service Unit
W7271*	**Transportation Mile**	Transportation by providers, family members, surrogates who are the employer or managing employer, and other qualified licensed drivers for using vehicles to transport the individual to and from services specified in the individual's approved	Per mile

		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.	

Transportation Trip

This service is transportation provided to individuals for which costs are determined on a per trip basis. Trip distances are defined by ODP through the use of zones. Zones are defined as follows: Zone 1 – greater than 0 and up to 20 miles; Zone 2 – greater than 20 and up to 40 miles; and Zone 3 – greater than 40 and up to 60 miles.

Determining the need for the service:

- Providers that transport more than 6 individuals are required to have an aide on the vehicle. The 6 individuals riding on the vehicle can be supported by different funding streams. This requirement is based solely on the amount of individuals in the vehicle. If a provider transports 6 or fewer individuals, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the individuals, the provider's ability to ensure the health and welfare of individuals and be consistent with ODP requirements for safe transportation. Providers that bill the transportation trip service and use an aide will be required to bill using a U2 modifier. The U2 modifier will not be present in the ISP, as it is use for billing purposes only.

Service Limits:

- The mileage that determines a trip zone is calculated by determining the distance from each specific individual's private home, from the service to the individual's private home, or from one waiver service to another waiver service. The amount of miles calculated to arrive at a particular zone is calculated by taking the most direct route from the individual's home to the service. Each transportation provider must have the data to support each individual's trip: (start point is the individual's home for pick up and address of drop off will determine the number of miles and which zone). The mileage that determines the zone for each person does not take into account the total miles a person may be on a vehicle going to pick other individuals up, only the miles from each individual's home to their service location as indicated above. Taking an individual to a service and returning the individual to his/her home is considered two trips or two units of service. (Note: Individuals within different zones may ride the same vehicle).

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

The procedure codes and service units for Transportation Trip Services:

Provider Type **26** - Transportation
Specialty **267**, Non-Emergency

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

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

Section 13.20: Vehicle Accessibility Adaptations

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

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

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

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

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

Determining the need for services:

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

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

Service limits:

- Only modifications listed in the service definition may be funded through the Waivers.
- Maximum state and federal funding participation is limited to $10,000 per individual during a 5-year period. The 5-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations.

✎SC documentation requirements:

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

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

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

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

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

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

Procedure Code	Service Level	Service Description	Service Unit

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

Section 14: Waiver Relatives, Legal Guardians and Legally Responsible Individuals Policy Related to Service

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

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

Services that relatives or legal guardians can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment, and Transportation (Mile). Relatives or legal guardians who are not the individual's primary caregiver may also provide Supports Broker services if the conditions above are met. Relatives or legal guardians, who function as the employer or managing employer through an FMS, may not provide Supports Broker services to the individual who they are employer or managing employer for. Relatives or legal guardians who are not the individual's primary caregiver may also provide **waiver-funded** Respite Services when the conditions listed above are met. The primary caregiver is the person who normally provides care to the individual. Relatives/legal guardians may also provide **base-funded** respite services only when the relative/legal guardian does not live in the same household as the individual, and when the conditions above are met.

Payments to relatives and legal guardians who provide the services outlined above are made through a Financial Management Services (FMS) Organization, or a provider agency. Please note that if a relative or legal guardian is employed by a provider agency, an AWC/FMS Organization or a common law employer they may not be paid through the Waivers to provide services other than those stated above. Payments are based upon services rendered that are documented on timesheets submitted by the relative/legal guardian to the FMS or agency, which is consistent with the participant's authorized services on his or her ISP. The relative or legal guardian who provides services must document service delivery per Department standards and ODP policy requirements.

Legally responsible individuals may be paid to provide services funded through the Waivers on a service-by-service basis. A legally responsible individual is a person who has legal obligation under the provisions of law to care for another person, including parents of minors (natural or adoptive), spouses, and legally-assigned relative caregivers of minor children. These individuals may be paid to provide Waiver services when the following conditions are met:

- The service is considered extraordinary care, which means it is not part of the supports the legally responsible individual is ordinarily obligated to provide.
- The service would otherwise need to be provided by a qualified provider of services funded under the Waiver.
- The service is provided by a legally responsible individual who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved Waivers.
- Services that legally responsible individuals can provide are limited to the following: Home and Community Habilitation (Unlicensed), Supported Employment, Transportation (Mile) and Supports Broker Services. Legally responsible individuals, who function as the employer or managing employer through an FMS, may not provide supports broker services to the individual who they are employer or managing employer for.

Section 15: Waiver Travel Policy Related To Service Definitions

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

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

These services may be provided anywhere during temporary travel.

During the temporary travel period, qualified agency and individual providers that render these services must be located in Pennsylvania or in states that are contiguous to Pennsylvania. Provider agency staff or contracted personnel must be residents of Pennsylvania or residents of states contiguous to Pennsylvania. For services that are participant directed, the qualified SSW or qualified individual that renders the service while traveling must be a resident of Pennsylvania or residents of states that are contiguous to Pennsylvania. The physical location of the public transportation company that sells public transportation services is not required to be located in Pennsylvania or in a state contiguous to Pennsylvania, however, the provider of the public transportation service that holds the signed MA agreement with ODP must be physically located in PA or states contiguous to PA.

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

- The provision of home and community-based services during travel is limited to no more than 30 calendar days per fiscal year.
- The travel plans are reviewed and discussed as part of an ISP team meeting, and the team identifies safeguards to protect the individual's health and welfare during travel.
- The roles and responsibilities of the individual receiving services and the staff person(s) for home and community-based services are the same during travel as at home.
- The waiver will not fund the travel costs of either the individual or the agency or individual provider travel costs:

    - The individual is responsible to fund their own travel costs through private or non-system funds.
    - Travel costs for agency and individual provider staff or contracted personnel, may be funded through private funds of family members of the individual receiving services or non-intellectual disability-system funds generated through fundraising efforts or other means.
    - For services that are Participant Directed, the qualified SSW or individual's travel costs, may be paid for by the individual out of their own personal funds.
    - If the individual decides to pay for the travel costs, there must be documented team consensus that this was the voluntary and willful decision of the individual.

- An individual cannot exceed the authorized units for a service while on temporary travel.
- All service and program requirements, such as provider qualification criteria and documentation of services, apply during the period of travel.
- The location for temporary travel is not limited to Pa. Temporary travel can occur anywhere as long as the individual's health and welfare can be met during the temporary travel.

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

Section 16: Base-Funded Services

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

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

Respite Care, 24 hours (Base-Funded)

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

Individuals can receive Respite Care 24-hour for a period of more than 16 hours to 24 hours. Base-Funded Respite Care is limited to a **total** of 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:

- Individual's private home or place of residence located in Pennsylvania.
- Licensed or approved foster family home located in Pennsylvania.
- Licensed community (55 Pa.Code Chapter 6400) or family living (55 Pa.Code Chapter 6500) home located in Pennsylvania.
- Unlicensed home of a provider or family that the County Program has approved.
- Medical facilities, such as hospitals, nursing homes, or private Intermediate Care Facilities for the Mentally Retarded (ICFs/ID) 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/ID.

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

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

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

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

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

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7287		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4.	Day

W7288		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1.	Day
W7290		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1.	Day
W7099		Staff Support Level 2 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 intellectual disability in need of services.

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

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

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

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

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

Licensed Residential Services (Base-Funded)

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

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

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

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

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

Community Residential Rehabilitation Services for the Mentally 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 intellectual disability and mental illness. Full-care CRRS for adults is a program that provides living accommodations for people who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. Host homes are excluded.

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

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

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

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

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

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

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

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

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

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

Family Aide Services

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

This service is limited to a recommended maximum of four sessions per month (one session is equal to a period of time less than 24 hours), but may be adjusted by the County Program based on individual needs.

The procedure codes, modifiers, and service units for Family Aide Services:

Provider Type **51** - Home & Community Habilitation
Specialty **519**, FSS/Consumer Payment

Provider Type **51** - Home & Community Habilitation
Specialty **362**, Attendant Care/Personal Support Service

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

Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 11 – Office; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description	Service Unit
W7310		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6.	15 minutes
W7311		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5.	15 minutes
W7312		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1.	15 minutes
W7314		Staff Support Level 3	The provision of the service at a staff-to-individual ratio range of 1:1.	15 minutes
W7324		Staff Support Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is a licensed nurse.	
W7325		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1.	15 minutes
W7326		Staff Support Level 4 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are degreed.	15 minutes
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 where both staff members are licensed nurses.	

Special Diet Preparation

This service provides individuals with assistance in the planning or preparation of meals when needed due to a significant modification to a routine diet.

The procedure code and service unit for Special Diet Preparation Services:

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

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

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

Procedure Code	Service Level	Service Description	Service Unit
W7315	**Special Diet Preparation**	This service provides individuals with an intellectual disability with assistance in the planning or preparation of meals when needed due to a significant modification to a routine diet.	Outcome based

Recreation/Leisure Time Activities

This service is provided to enable individuals to participate in regular community activities that are recreational or leisure in nature. Participation in activities with non-related people, within the community, is encouraged. Entrance and membership fees may be included in the cost of recreation/leisure time activities. This service is available to 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 Activity Services:

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

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

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

Procedure Code	Service Level	Service Description	Service Unit
W7316	**Recreation/ Leisure Time Activities**	This service is provided to enable individuals with an intellectual disability to participate in regular community activities that are recreational or leisure in nature.	Outcome based

Home Rehabilitation

The Home Rehabilitation service provides for minor renovations to an individual's or family's home where the individual lives to enable the continued care and support of the individual in the home. A renovation is defined for reimbursement purposes as minor if the cost is $10,000 or less, as per 55 Pa Code 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 Services:

Provider Type **55** - Vendor
Specialties: **519** - FSS/Consumer Payment; **543** - Environmental Accessibility Adaptations

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

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

Procedure Code	Service Level	Service Description	Service Unit
W7317	**Home Rehabilitation**	This service provides for minor renovations to an individual's or family's home to enable the continued care and support of the individual with an intellectual disability in the home.	Outcome based

Family Support Services (FSS)/Individual Payment

FSS/Individual Payment provides an indirect service to assist individuals in the employment and management of providers of the non-waiver service of their choice.

The procedure code and service unit for FSS/Individual Payments:

Provider Type **51** - Home & Community Habilitation
Specialty **519**, FSS/Consumer Payment

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

Provider Type **54** - Intermediate Services Organization

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

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

Procedure Code	Service Level	Service Description	Service Unit
W7320	**FSS/Individual Payment**	This is an indirect service to allow cash and/or voucher payments to individuals and families for FSS	Dollar

Base Service not Otherwise Specified

This service is provided through base funds and is designed to meet the unique needs of the individual receiving services and/or their family. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

The procedure code and service unit for Base Service not Otherwise Specified:

Provider Type **55** - Vendor
Specialty **519**, FSS/Consumer Payment

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

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

Procedure Code	Service Level	Service Description	Service Unit
W7219	**Base Service Not Otherwise Specified**	This service is provided through base funds and is designed to meet the unique needs of the individual receiving services and/or their family.	Outcome-based

Section 17: Resources

Section 17.1: Prioritization of Urgency of Need for Services (PUNS)

PUNS is the current process for categorizing an individual's urgency of need for services. PUNS focuses on the existing services and supports received by the individual, the categories of services requested, and the urgency of need for requested services. This information is used by AEs, SCOs, and ODP to prioritize waiting lists. The following are the PUNS categories of need:

- Emergency Need – Indicated a need for services within the next six months.

- Critical Need – Indicates a need for services greater than six months but less than two years in the future.
- Planning Need – Indicates a need for services greater than two years but less than five years in the future.

The PUNS should be reviewed at every ISP meeting and updated as necessary based on changes in the individual's needs. The team determines if the individual will have any anticipated unmet needs in the next five years and also identifies any natural supports that might help address these unmet needs. Individuals enrolled in the Consolidated Waiver are entitled to have assessed needs addressed through the use of non-Wavier services and supports and through the Waiver within the allowable service limits identified in the Waiver. If an individual has unaddressed needs, the SC must complete or update the PUNS to reflect current needs of the individual as per the current ODP bulletin *Prioritization of Urgency of Need for Services (PUNS) Manual*, or any approved revisions. The PUNS must be completed and/or updated with the individual or family at every annual review update meeting. It is recommended that anyone in the emergency status in PUNS should have a full ISP, not an abbreviated ISP.

✐*SC service note documentation requirements for PUNS:*

- Date of meeting/conversation when form was completed.
- Date mailed to the individual/family.
- If it is recommended that a form not be completed due to no anticipated supports need within 5 years.
- The request for completion over phone.
- If individual/family refuses to sign and reason for refusal.

Section 17.2: Independent Monitoring for Quality (IM4Q)

IM4Q is the method that Pennsylvania has adopted to independently review the quality of services individuals receive statewide in the intellectual disabilities services system. Focusing on the individual's satisfaction and outcomes, IM4Q is one of the few statewide programs of this kind in the country, pioneering community participation in the quality improvement process. Community participation is promoted by having individuals with disabilities, family, and interested citizens as part of each IM4Q survey team. Such participation also helps to ensure the independence of the IM4Q survey process since team members are not affiliated with any services that the individual receives.

Independent monitoring is one of a number of monitoring components with the intellectual disabilities services system. IM4Q also helps to:

- Provide a more comprehensive view of quality by engaging individuals with disabilities, families and citizens as stakeholders in the lives of people in their community.
- Strengthen the advocacy base for individuals with disabilities in the community.
- Reinforce to the community what human services professionals already know about the individual or raise issues that the community would want to know.
- Offer an additional safeguard for the health and well-being of individuals receiving services.

When an individual receiving services participates in an IM4Q interview, the individual may elect whether or not to share the information divulged with the appropriate AE or SCO. If the individual chooses not to share the information, the survey data is entered into HCSIS for its aggregate value only. If the individual chooses to share the information with the AE, then the IM4Q program forwards any considerations or issues to the AE, which then forwards the report to the SCO. Actions to address considerations are developed with the individual and his or her team. SCOs and provider agencies are involved to the extent necessary to address service and outcome-related issues and concerns. Considerations are linked to the ISP process when there is a change in services stemming from the IM4Q consideration, or when the individual or family wants the ISP team to be involved in decisions related to a consideration.

✐ SC service note documentation requirements for IM4Q:

- Considerations are now stored in HCSIS and responded to directly through the HCSIS module. SC Activities that are related to the IM4Q considerations should be documented by the SC in a service note in HCSIS. Not all considerations need to be included in the ISP.

Section 17.3: Positive Practices Resource Team (PPRT)

In July 2006 the Pennsylvania Department of Human Services initiated a partnership with the Office of Developmental Programs (ODP) and the Office of Mental Health and Substance Abuse Services (OMHSAS) for the development of the Positive Practices Resource Allocation Process (PPRT).

Purpose of PPRT:

- Provide a fresh perspective by an outside and independent team.
- Promotes, encourages, and supports efforts that result in improved service capacity.
- Assist the Provider or family to continue to support the person in their community environment resulting in diversion to a State Center or State Hospital.

Criteria for Referral to PPRT: A person with a developmental/intellectual disability (i.e., determined to be eligible for ID services by the MH/ID County Office) who is demonstrating escalating behavioral challenges and who the support team determines may be at risk for needing enhanced levels of support.

More information on the PPRT process including the PPRT Brochure can be found at: http://www.dpw.state.pa.us/communitypartners/informationforadvocatesandstakeholders/positivepracticesresourceteampprt/index.htm

Section 18: ISP Key Terms

Abbreviated Individual Support Plan (ISP) – A shortened ISP that may be used for and individual who is not eligible for Medical Assistance and receives non-waiver services that cost less than $2,000 in a Fiscal Year (FY).

Administrative Entity (AE) – A county/joinder or non-governmental entity that performs waiver operational and administrative functions delegated by the Department, under the Department's approved Consolidated and P/FDS Waivers and Administrative Entity Operating Agreement.

Agency with Choice (AWC) – A type of Financial Management Services (FMS) Provider acting as the Common-Law-Employer which provides an administrative service that supports a Individual or Individual's Surrogate acting as the Managing Employer in the management of the Individual's Support Service Worker (SSW) and supports and services authorized in the Individual's Individual Support Plan (ISP).

Amount (of service) – The total volume of funded services (measured in units) that are authorized in the ISP and rendered to the individual.

Annotated ISP – An ISP template that contains ODP's expectations of required documentation and recommended best practices for each section of the ISP. The Annotated ISP is located in Learning Management System (LMS).

Annual Review ISP Meeting – The team meeting that is held annually to review and update necessary information in the individual's ISP.

Annual Review Update Date - The Annual Review Update Date is the end date of the current plan ISP. The team and the AE must ensure that an Annual Review ISP is completed, approved, and services authorized by the Annual Review Update Date.

Assessed Need – Needs of individuals identified through the Statewide Needs Assessment or other valid assessments and identified as a required need by the individual's team responsible for developing the ISP.

Assessments – Instruments and documents used by the ISP team to identify an individual's needs for Home and Community Based Services (HCBS).

Based Funding Services _- A state funded HCBS

Bridge Plan – A term used to describe an individual's initial ISP, which has a timeline shorter than the Fiscal Year to accommodate varying timelines for initial annual review meetings.

Bureau of Hearings and Appeals (BHA) – The Departmental entity charged with conducting administrative hearings and timely adjudication of appeals which are filed in accordance with state and federal regulations.

Center for Medicare and Medicaid Services (CMS) – The agency in the federal Department of Health and Human Services that is responsible for federal administration of the Medicaid, Medicare and State Children's Health Insurance programs

Common-Law Employer – The person under the VF/EA FMS option who is responsible for some employer-related responsibilities.

Consent to Share ISP – This is a field on the ISP in HCSIS that identifies that the individual and his or her family, guardian, surrogate or advocate provide consent to share the ISP with qualified providers online in HCSIS after it is approved and services authorized.

Consolidated Waiver - A Federally-approved 1915(c) waiver program designed to help individuals with intellectual disabilities age 3 and older to live more independently in their homes and communities

Draft Plan – An ISP in HCSIS that can be edited or used for adding, deleting or revising information in that ISP.

Duration (of services) – The length of time that a service will be provided.

Fiscal Year – The period of time extending from July 1 of one calendar year through June 30 of the next calendar year.

Financial Management Services (FMS) – A type of Provider (either AWC or VF/EA) that provides administrative support to an individual who self-directs all or some of their services. A FMS Provider processes payments for delivered services and performs some financial functions on behalf of the individual. A FMS Provider may also process payments on behalf of an individual who is not self-directing but who requires a one-time Vendor payment.

Frequency (of services) – How often a service will be rendered to an individual.

Home and Community Services Information System (HCSIS) – The secure Internet information system serving the DPW state program offices that oversee Medicaid Waivers.

Independent Monitoring for Quality (IM4Q) – A survey and interview instrument focusing on the quality of services and supports for individuals with intellectual disabilities which provides a source of data to support ODP initiative.

Individual Monitoring Tool – The regularly scheduled and ongoing monitoring of an individual's ISP to ensure that ISPs are implemented as written, including that services are provided as indicated in the ISP.

Individual Support Plan (ISP) – An individual's summary of their planned services (as well as preferences, outcomes, health, safety and medical information), indentified as a result of review by the individual, family and plan team members.

Intermediate Care Facility for persons with an Intellectual Disability (ICF/ID) – A state-operated or non-state operated facility, licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for persons with intellectual disability), providing a level of care specially designed to meet the needs of individuals who have intellectual disability, who require specialized health and rehabilitative services.

Invitation to ISP – The letter sent by the SC which invites members of the individual's plan team to the plan meeting.

ISP Review Checklist (DP 1050) – Required form that is used to serve as a tool in the review of the completed ISP for identified services. The ISP Review Checklist can be used by SCO management, AEs, and ODP reviewers.

ISP Signature Form (DP 1035) – Required form that is used to document attendance and review of required waiver compliance elements at the time of the annual review meeting and during team meetings that result in critical revisions to ISPs.

Legal Guardian – A person not affiliated with a provider agency who has legal standing to make decisions on behalf of a minor or adult (for example, a guardian who has been appointed by the court).

Legally Responsible Individual – A person who has a legal obligation under the provisions of the law to care for another person, including parents of minors (natural and adoptive), spouses and legally-assigned relative caregivers of minor children.

LMS – Learning Management System – Contains a variety of information about HCSIS including instructional web-based courses and job aids.

Natural Supports – Unpaid assistance to an individual, such as friends, family, neighbors, businesses, schools, civic organizations and employers, as well as other non-Waiver funding streams, such as the Pennsylvania Medical Assistance State Plan, Behavioral Health, OVR and the Department of Education.

Non-statutory – Deviations of the minimum monitoring frequency that involve monitoring at a frequency less than the Waiver(s) specify.

Outcome Actions – The team's plan to achieve what the individual considers important to him or her, including natural supports and paid services.

Outcome Statements – Levels of achievement and personal preferences the individual chooses to acquire maintain or improve.

Participant Directed Services (PDS) – The list of identified services in the service definitions and approved Waivers that are available to self-direct.

Pending Revision - The Pending Revision screen is used to review ISPs that have been disapproved and require revision. An ISP will appear on this screen only if it has been disapproved, which means the ISP has the status of pending revision. The screen contains a hyperlink to comments entered by the ISP Approval role and explains why the ISP was not approved. The SC reviews the comments and converts the ISP back to a draft status so the appropriate changes can be made to the plan. A plan will not appear on this screen if it is in draft status, approved status, or pending approval status.

Person/Family Directed Support (P/FDS) Waiver - A Federally-approved 1915(c) waiver program designed to help individuals with intellectual disabilities age 3 and older to live more independently in their homes and communities.

P/FDS Cap – The per individual limitation for Waiver services funded through P/FDS Waiver during a state FY, excluding costs for supports coordination services and other administrative cost of administrative services.

Pennsylvania Guide to Participant Directed Services – A guide developed to help people understand what PDS means and what PDS services they can self-direct. It is located on the odpconsulting.net website under *ODP Topic Information*.

Prioritization of Urgency of Needs for Services (PUNS) – PUNS is the current process for categorizing an individual's need for services. PUNS focuses on the existing services and supports received by the individual, the prioritization of urgency of need for requested services and the categories of services needed. This information is used by AEs, County Programs and ODP to prioritize waiting lists and for budgeting. The following are the PUNS categories of need:

- Emergency Need – Indicates a need for services within the next six months.
- Critical Need – Indicates a need for services greater than six months but less than two years in the future.
- Planning Need – Indicates a need for services greater than two years but less than five years in the future.

Qualified provider – A provider who meets applicable qualification criteria and agrees to provide services to an individual as stated in their ISP. Waiver providers must meet qualification criteria included in the approved Consolidated and PFDS Waivers.

Relative – Any of the following who have not been assigned as legal guardian for the individual with an intellectual disability: a parent of an adult, a stepparent of an adult, grandparent, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, adult child or stepchild of an individual with an intellectual disability and adult grandchild of an individual with an intellectual disability.

Self-Directed Services – This means the individual or their surrogate (representative) manages and directs the supports and services in the individual's ISP. In order to self-direct, they must become either a Common Law Employer or Managing Employer, use one of the FMS options, and must live in their own private residence or the residence of family.

Services and Supports Directory (SSD) – An online database of all the qualified service providers registered in HCSIS that is accessible to individuals and families during the registration process to locate qualified providers within a geographic area. The directory is intended to expand individuals' ability to make informed choices. This is the section of HCSIS where SC's choose qualified service providers and attach them to the ISP.

Statutory – The monitoring frequency as specified in the Waivers.

Supports Coordinators (SC) – A SCO employee whose primary functions are to locate, coordinate and monitor services provided to an individual.

Supports Coordination Organization (SCO) – A provider qualified to deliver the services of locating, coordinating and monitoring services provided to an individual.

Section 19: General Billing Terms

15 Minute Unit of Service*:* The 15 minute unit of service will be comprised of 15 minutes of continuous or non-continuous service within the same calendar day. The full 15 minutes of service does not need to be provided consecutively, but must be rendered within the same calendar day in order for a 15 minute unit of service to be billed.

Day Unit of Service: The day service unit is defined in each actual service definition to which it relates. A provider must meet the requirements of the definition contained in the narrative in order to submit a claim for the rendered unit of service.

Eligible and Ineligible Procedure Codes*:* There are two types of procedure codes that are used for Residential Habilitation services: eligible and ineligible. Eligible procedure codes are used to claim the portion of the cost for the service that is eligible for federal financial participation (for example, staffing). Ineligible procedure codes are used to claim the portion of the costs for the service that are not eligible for federal financial participation such as room and board for a waiver individual or base funding for a non-waiver individual.

For Waiver-funded Residential Habilitation a SC will use both the eligible and ineligible procedure codes, when applicable, when developing the ISP.

For base-funded Residential Habilitation services for 8 or less individuals, the SC will only use the ineligible procedure code with an individualized rate when developing the ISP. For base-funded Residential Habilitation service for 9 or more individuals, the SC will use only the 9 or more procedure code when developing the ISP.

Enhanced Levels of Service*:* Many home and community-based services have enhanced levels of staffing ratios for 1:1 and 2:1 staffing where the service worker must have a license or a degree to render the service. Staff providing enhanced habilitation must meet the following: Licensed Nurse (LN) or a professional with at least a 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 for staff that has a license or degree as indicated by the SIS or County Program assessment process, not the service worker's personal qualifications.

Nursing Modifiers are used with the enhanced levels of service procedure codes to indicate when the home and community habilitation service is rendered by a nurse. The modifiers are for information purposes only and do not affect the rate of the home and community-based service. Modifier TD will be used to indicate that a Registered Nurse (RN) renders the service. Modifier TE will be used to indicate that a Licensed Practical Nurse (LPN) renders the service.

Hour Unit of Service: The hour unit of service will be comprised of 60 minutes of continuous or non-continuous service within the same calendar day. This means the full 60 minutes of service does not need to be provided consecutively, but must be rendered within the same calendar day in order for a unit of service to be billed.

Organized Health Care Delivery System (OHCDS): An arrangement in which a provider that renders at least one direct MA waiver service also chooses to offer a different vendor HCBS by subcontracting with a vendor to facilitate the delivery of vendor goods or services to a participant.

Outcome-Based Unit*:* A service unit that is outcome based is tied to the actual cost of a purchased good.

Per Mile Unit of Service*:* Each unit of service equals one mile.

Per Trip Unit: A trip is either transportation to a service from an individual's home or from the service location to the individual's home. The Transportation Trip provider agency decides the geographical area that equals the per trip service unit.

Provider Types, Specialties, and Place of Service*:* Each service definition includes a list of provider types and specialties that are permitted to render the service or submit a claim for the service. Each service definition includes the allowable places of service where a willing and qualified provider may choose to render the service.

Units of Service*:* Each procedure code has been assigned a service unit that is used for rate development and billing. Each service unit equals the amount of time that a provider must render the service in order to submit a claim to be paid for the service.

Use of Modifiers*:* Some services have unique circumstances that require modifiers to be used that identify individual services and account for differences in service delivery regulations or methods specific to different service settings. The modifiers may be used to inform the PROMISe™ system of critical information needed for claims processing.

The following is a list of modifiers that are used in combination with specific procedure codes and listed in the Service Details page of the ISP in HCSIS. When a provider submits a claim for these services, the procedure code and modifier combination in PROMISe™ must match exactly with the procedure code and modifier combination in HCSIS.

- **TD**--Services rendered by a RN.
- **TE**--Services rendered by a LPN.
- **GP**--Services rendered by a Physical Therapist.
- **GO**--Services rendered by an Occupational Therapist.
- **GN**--Services rendered by a Speech and Language Therapist.
- **SE**--Assistive Technology.
- **UA**--Semi-Independent Living (Licensed Chapter 6400 homes only).
- **UA**--Nontraditional day program for an individual who resides in a residential habilitation setting. Used with Home and Community Habilitation (Unlicensed) procedure code W7060 only.
- **U1 –** Enhanced Communication Service. Services rendered by staff proficient in Sign Language for individuals enrolled in the Consolidated Waiver who have been assessed as needing this service. ODP must approve the modifier prior to a contract being created in HCSIS for the service with the U1 modifier.
- **U2**--One-time vendor payment for Respite-Camp paid by an OHCDS.
- **U2**--Emergency Respite rendered in a Waiver-funded licensed Chapter 6400 home in which ODP permitted the provision of respite services beyond the approved program capacity of the home.
- **U2** –Used with transportation trip codes W7274, W7275 and W7276 to indicate the required use of an aide if the provider is transporting more than 6 individuals.

- **U4**--Individual-Directed Services provided that do not include a benefit allowance for the SSWs. This modifier is only used by AWC/FMS providers.

- **ET:** ODP has created the ET modifier to be used with certain procedure codes only when a provider submits a claim to PROMISe™ for an unanticipated emergency. This modifier is not captured in the Service Details page of an ISP.

ODP must approve the use of the ET modifier with a service procedure code in advance.

When a provider submits a claim for the approved emergency service, the "ET" modifier will be used immediately after any other modifier combination. For example, if Home and Community Habilitation (Unlicensed) is approved to meet the emergency need of the individual, and the individual requires a licensed nurse to provide the habilitative service, then the correct way to list the procedure code and modifier sequence when submitting a claim for the service would be W7061 TE ET.

The modifier and service units for Unanticipated Emergencies follow:

Allowable Modifiers	Service Level	Service Description	Service Unit
ET	**Unanticipated Emergency**	Emergency Funding to meet the unanticipated emergency service needs of an individual.	Service unit will be the one that is used with the needed service

The following are the specific services with which the **ET** modifier may be used:

- Home & Community Habilitation (Unlicensed)
- Unlicensed Residential Habilitation
  - *Community Homes (unlicensed)*
  - *Family Living Homes (unlicensed)*
- Licensed Residential Habilitation
  - *Supplemental Habilitation*
  - *Child Residential Services (licensed under 55 Pa. Code Chapter 3800)*
  - *Community Residential Rehabilitation (licensed under 55 Pa. Code Chapter 5310)*
  - *Family Living Homes (licensed under 55 Pa. Code Chapter 6500)*
  - *Community Homes (licensed under 55 Pa. Code Chapter 6400)*
- Companion Services
- Licensed Day Services (licensed under 55 Pa. Code Chapter 2380 or 6 Pa. Code Chapter 11)
- Therapy Services
- Nursing Services
- Behavior Support
- Transportation Service
- Home Accessibility Adaptations
- Vehicle Accessibility Adaptations
- Assistive Technology
- Homemaker/Chore Services (temporary service only)

- Specialized Supplies
- Respite Care, 24 Hours (Base-Funded)
- Support (Medical Environment)
- Base-Funded Licensed Residential Services
    - *Child Residential Services (licensed under 55 Pa. Code Chapter 3800)*
    - *Community Residential Rehabilitation (licensed under 55 Pa. Code Chapter 5310)*
    - *Community Homes (licensed under 55 Pa. Code Chapter 6400)*
- Family Aide
- Special Diet Preparation
- Home Rehabilitation
- Base Service Not Otherwise Specified