Commonwealth of Pennsylvania
Department of Human Services
Office of Developmental Programs

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

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Section 1: ISP Process

The ISP process, led by the Supports Coordinator (SC), is the most critical activity to help people envision a good life and to develop strategies to achieve the life they want. It is a process to help people explore the experiences, opportunities, and resources available to them through family, friends, and the community. It is also the process to identify which services can enhance those resources and opportunities.

The SC should assist the individual and family to understand and participate in the ISP process. This includes thinking about relationships that are important to the individual; activities that are enjoyable and important to the individual; what kinds of growth experiences the individual would like to explore; what kind of job the individual would like; whether there are any health or safety risks that must be planned for; what the immediate needs are, as well as the needs the individual or family anticipates for the future, and what types of services would assist the individual and family in achieving the quality of life they hope to have.

To create an ISP that is relevant and leads to the life people want to live, the process should be conducted in plain language and in a manner that is accessible to the individual and family. It is important to be sensitive to the lived experience of the individual and family including cultural considerations. If an alternate means of communication is used or if their primary language is not English, the ISP process should utilize the individual's primary means of communication or someone who can interpret on their behalf.

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

Philosophies and concepts including "what is important to people?" in *Everyday Lives: Values in Action*, person-centered approaches, the principles of Positive Approaches, and the LifeCourse Framework are the foundation for completing a plan with the individual and family.

Everyday Lives: Values in Action lists the following as being important to people with disabilities: having personal control and choice in their lives and the same freedom as all citizens; stability; health and safety; being a full participating member of their community; responsibility; being listened to, understood and having their input valued; the experience of success, employment and making a meaningful contribution; respect for their individuality; maintaining relationships and partnership; quality in services; and advocacy.

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.

Positive Approaches, like person-centered principles, recognizes the preferences of the individual and the importance of personal empowerment, and when there are issues of problematic behavior, makes efforts to learn the root cause of the behavior. The root cause can be intrusions on the individual's autonomy and personal control, events or activities that cause stress or anxiety, or the presence of trauma or a mental health diagnosis. Trauma informed care is consistent with the principles of Positive Approaches.

The LifeCourse Framework helps families to have a vision for a good, everyday life across the lifespan. This leads to having a better understanding of the individual's dreams and preferences, identifying the kinds of life experiences and opportunities that will lead the person towards those outcomes for their vision of an everyday life, ensuring access to resources available in the person's life, and what services and supports would help the individual live the life they want and one which includes all facets of community life.

To assist in the planning process, the SC is responsible for ensuring that the individual and family have all the necessary information and support they need to make certain that the individual directs the process to the maximum extent possible and desired. Introducing the LifeCourse Framework can help the individual and family prepare for the ISP process and maximize their aspirations for an Everyday Life.

Section 2: ISP Preparation

In preparation for the ISP meeting, the SC encourages meaningful participation of the individual in all aspects that would impact the individual's life, including the development of and any changes to their ISP. 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 part of and involved in the development of the ISP. It is important to include people who know the individual best as the individual may want the person(s) to assist them with offering detailed information about their preferences, strengths, and needs.

The ISP team may consist of:

- The individual.
- The individual's family, legal guardian, surrogate, or advocate.
- The SC.
- Providers of service, specifically direct care staff.
- The common law employer or managing employer if the individual has chosen to self-direct.
- Any other persons designated by the individual.

When determining who the persons designated by the individual are, the SC must also ask the individual if they would like to have that person(s) contacted for any other reason besides updating the ISP, such as, but not limited to:

- Who should be called if an incident occurs?
    - Should this person(s) be called for all incidents or specific ones (see Incident Management Bulletin 00-21-02)?
        - Do you want the person(s) called each time an incident occurs, or do you want to be asked first before they are called?
    - Can that person(s) also be provided information about the incident (such as a summary report)?

- Is it okay if they are sent information in writing (written report)?

- Who should be called for emergency circumstances?

When the individual is choosing people to be part of the ISP process, the SC must document these persons in the ISP. Since relationships fluctuate and change, the SC must tell the individual of their right to change the members of the ISP team at any time (for example, during a monitoring visit or by phone call). The SC must also talk to the individual at least annually prior to their ISP meeting about who the individual would like to designate to be involved during the ISP annual update meeting. If any changes are made, the SC should update the ISP as soon as possible.

When it is time to set up the ISP meeting date, the SC is responsible for reaching out to the individual to determine if they have preferences about the date and location of the meeting. After the discussion takes place, the SC is responsible for accommodating the individual's preferences to the extent possible.

Annual ISP meetings should be conducted in person with the individual and the individual's ISP team, whenever possible. In-person meetings offer the benefit of having the ISP team present in the room to dedicate their full attention to the individual and ISP planning activities. In addition, in-person meetings offer attendees the opportunity to communicate clearly and observe body language and other nonverbal cues from the individual and others on the ISP team. The Supports Coordinator, at a minimum, must be physically present with the individual during the annual ISP planning meeting. It is best practice to have as many of the other ISP team members physically present. If some ISP team members are not able to attend the annual ISP meeting in person, the individual must be given the choice to hold the meeting or to reschedule the meeting for a date/time when the entire team can be physically present.

If the individual refuses or has not provided input on their preference in scheduling the meeting, the SC should proceed in scheduling the meeting in accordance with the timelines set forth in Section 3.11 of this manual.

Section 2.1: ISP Invitation Letter

Once the ISP meeting details are confirmed, the SC develops the ISP meeting invitation letter and sends it to the individual, their family, team members and any other persons designated by the individual who may contribute valuable information during the planning process. The invitation must be sent 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:

- An electronic record or copy of the invitation letter(s) that was sent to each ISP team member must be maintained in the individual's file at the SCO. The documentation maintained must identify the recipients of the correspondence and the date on which it was sent.

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 ISP.

Information gathering for the ISP should include physical development, communication abilities and needs, learning styles, strengths and functional abilities, educational background, employment and vocational/employment goals, social/emotional information, medical and clinic needs, personality traits, environmental influences, community participation, interactions, preferences, outcomes, relationships that impact the individual's quality of life, and an evaluation of risk in all areas of life.

Section 2.3: Supports Intensity Scale-Adult® and PA Supplement Assessment Process

ODP utilizes a multifaceted assessment process to drive initial and ongoing ISP development, capture person-centered information, and 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 valuable tools.

The Supports Intensity Scale-Adult® (SIS-A) and PA Supplement are the primary statewide standardized needs assessments tools used by ODP. The SIS-A and PA Supplement are administered by an independent contractor, and the results are made available in the form of the SIS-A Summary Report located in SISOnline.

SCOs, AEs and Providers have access to the most current SIS report in HCSIS. The SC is responsible for distributing the SIS-A Summary Report to individuals and families as well as other team members who do not have access to SISOnline or HCSIS.

The SIS-A is designed to measure the relative intensity of support needs of people aged 16-84; however, ODP has received approval by AAIDD to use the tool for individuals aged 14 and above.

To receive services and to ensure that services provided can meet the needs of an individual to ensure health and welfare, individuals 14 years of age and older must have a standardized needs assessment completed within 45 business days of a Targeted Support Management provider's acceptance of the referral or prior to enrollment in an ID/A waiver.

SIS-A and the PA Supplement are to be completed once every five years. A new needs assessment is required if a major change in the individual's life occurs that has a lasting impact on their service or support needs that is anticipated to last more than six months and makes their assessment inaccurate and no longer current.

SC documentation requirements for SIS assessments:

- SCs must document the most recent date the SIS-A and PA Supplement were administered in the Non-Medical Evaluation section of the ISP.
- SCs must use the ISP Signature Page Form to indicate that the SIS-A and PA Supplement were reviewed during the individual's ISP meeting.

- Assessment results should be summarized within the ISP. 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. Please refer to the Annotated ISP for guidance on which sections of the ISP would be appropriate to capture the results from the finalized SIS-A Summary Report.

Section 2.4: Other Formal and Informal Assessments

An assessment of need is required for individuals under the age of 14 for whom the SIS-A and PA Supplement were not designed to be utilized. For these individuals gathering information related to educational, social, emotional, and medical events from the individual's network of family, friends, educators, supporters, and medical providers should be considered as well as possible changes in an individual's living situation, any incidents reported, and possible monitoring findings.

Other formal assessment tools for population groups include but are not limited to the Vineland Adaptive Behavior Scale (ABS), Alpern-Boll Developmental Profile (LPRN BOLL), 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 support professionals, and understanding of the individual's strengths, skills, abilities, and preferences.

Utilizing informal and formal assessments and planning tools (ie. LifeCourse framework and tools) assist with identifying both their immediate and long-term vision for a good life, community resources, experiences, opportunities and specialized services and supports necessary to promote growth and development to achieve desired outcomes.

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. An important tool used to help identify health risks and destabilization early is the Health Risk Screening Tool (HRST) which is required for all waiver individuals receiving Residential Habilitation, Life Sharing, or Supported Living services. It assigns scores (1-6) to health and behavior related rating items that help indicate an associated degree of health risk. Once the screening is completed for an individual, it produces suggested action steps to inform supporters on how to respond to identified risks.

The strategies identified to both mitigate and deal with risks reflect the underlying person-centered principles of the process and are structured in a manner that reflects and supports individual preferences and goals. Each ISP contains detailed information on supports and strategies designed to mitigate risk to the individual, including a back-up plan specific to the individual. The provider develops a back-up plan that outlines how the provider will provide the authorized service(s). The back-up plan must then be shared with the SC, the individual and the team. These back-up plans are developed with the unique needs and risk factors of the individual in mind and are incorporated into the ISP by the SC to ensure that the entire team is aware of the strategies necessary to reduce and, when needed, address risks. For more information, please go to Section 3.9 regarding Provider Back-up Plans.

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.

Section 2.5: Supporting D/deaf[1] Individuals

There are many things to consider when supporting D/deaf individuals. To best support Deaf individuals, ODP requires that all Supports Coordinators complete a two-part training if they currently serve or will serve someone who is Deaf. That training is found on the ODP website. There are also many other helpful trainings and resources on the ODP website. New trainings and resources are added regularly.

In addition to training, ODP has a Deaf Services Coordinator available to provide supports and resources. The Deaf Services Coordinator can be reached by sending an email to RA-ODPDeafServices@pa.gov.

From 2014 to 2021, ODP provided Deaf individuals in the Consolidated Waiver with communication assessments and reassessments. These are otherwise known as Communication Assessment Reports (CAR) and Communication Reassessment Reports (CRR). This was due to a settlement agreement called the Harry M. settlement. The settlement ended in July 2021; however, ODP is still completing reassessments that were previously recommended. No new class members will be identified. Please reference the Supports Coordinators' Guide to the Harry M. Communication Assessment and Reassessment for further information.

Starting July 30, 2021, when a D/deaf individual is enrolled in the Consolidated, Community Living, or P/FDS waiver, the "Harry M. Litigation" checkbox should be checked in the demographics screen in HCSIS. Within 30 days of the individual being enrolled in an applicable waiver, the SC should contact the Deaf Services Coordinator for a consultation. The consultation will allow the Deaf Services Coordinator to recommend specific trainings and resources, and an assessment if applicable.

Please refer to ODP Announcement 21-055: Changes to Deaf Services and the Harry M. Class, as well as the revised Supports Coordinators' Guide to the Communication Assessment and Reassessment, which can be found as an attachment to the announcement here.

[1] The term "D/deaf" captures both Deaf individuals who are members of the Deaf Community and Deaf Culture and deaf individuals who have a hearing loss.

Section 3: Development of the ISP

The ISP is developed by the individual and their ISP team and is facilitated by the SC and the individual in accordance with the ISP Bulletin. The SC must provide information and any assistance that is needed to make sure the individual leads the ISP meeting to the extent possible and if they choose.

All ISP team members play vital roles in the ISP meeting by fully participating to share knowledge, perspective, and insight as the SC creates and updates the ISP based on that information as well as the results of the assessments. Each ISP team member ensures that information provided is current and is presented professionally and with sensitivity. The information collected should present a complete and comprehensive picture of the individual, including possible changes in the individual's living situation or health status, incident reports documented in HCSIS, monitoring findings or other changes that will impact the individual's health and welfare, services and supports or ability to have an everyday life. Service and support options must be promoted and fully explored with every individual.

Once the individual's preferences for how they want to live their life and their needs are assessed, the LifeCourse Integrated Supports Star can assist the ISP team to identify what resources and opportunities in the individual's life can support their preferences and needs and what type of paid services can enhance or supplement those resources. While all needs must be reviewed, not all needs require a paid service.

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

For services that do not assist the individual in achieving or maintaining a specific skill or a valued experience but are needed to ensure the individual's health, safety, and welfare, such as Companion services, the ISP team needs to develop a measurable Outcome Action that supports home and community life in a meaningful way.

In addition, the ISP must be written in plain language and in a manner that is accessible to the individual.

Anyone who has been found eligible for services within the scope of this manual must have an ISP completed and entered into HCSIS.

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

- 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.
- A full ISP is required to be completed for all individuals who receive Targeted Support Management (TSM).

Section 3.1: Annotated ISP (Attachment #4)

The Annotated ISP is attached to this bulletin and located in the Learning Management System (LMS) in addition to MyODP. It is a valuable tool for SCs to use when creating 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: LifeCourse Framework and Tools to Guide the Development of the ISP (Attachment #5)

The LifeCourse Framework was created to help individuals and families of all abilities and all ages develop a vision for a good life. Individuals should be encouraged to think about what they need to know and do, how to identify or develop supports, and how to discover what it takes to live the lives they want to live. Individuals and families may focus on their current situation and stage of life but may also find it helpful to look ahead to think about life experiences that will help move them toward an inclusive, productive life in the future.

It is best practice for SCs to encourage individuals and families to utilize the LifeCourse Framework while developing the ISP. This can include identifying integrated supports, identifying outcomes across life domains and the life span, and acknowledging the vital role of the family. This can also include using any of the LifeCourse tools such as the Integrated Supports Star and/or Trajectory which can be helpful in developing a vision for a good, everyday life as well as resources to draw upon to reach it. The ISP team needs to discuss whether additional support is needed to assist with achieving the individual's vision for a good life for inclusion in the ISP.

The LifeCourse Framework was created by Missouri Family-to-Family under the leadership of the University of Missouri at Kansas City Institute on Human Development, Missouri's University Center on Excellence in Developmental Disabilities. As a participating state in the National Community of Practice for Supporting Families throughout the Lifespan, Pennsylvania's ODP embraces the LifeCourse Framework to guide conversations and planning with the people we support.

The LifeCourse resources can be downloaded using the following link: http://www.lifecoursetools.com/lifecourse-library/foundational-tools/, and the LifeCourse tools can be found on Attachment #5 in addition to the LifeCourse website. Particularly noteworthy for professionals is the resource entitled *"Charting the LifeCourse: Experiences and Questions Booklet"* which can be accessed at: https://www.myodp.org/pluginfile.php/130165/mod_resource/content/1/LC-EXPERIENCES-BOOKLET-updated-9-2016.pdf. The questions in this guide represent the diverse experiences of the families and self-advocates who developed these materials and concepts. Individuals and

families, professionals and community members need tools that will help them along the way in achieving meaningful and self-determined everyday lives. This booklet is intended to be a helpful tool for the journey.

For individuals with disabilities or special healthcare needs and their families, *Charting the LifeCourse: Experiences and Questions* is helpful in: 1) exploring questions and life experiences at all ages and areas of life so they can create and plan a vision for a good life now and in the future; and 2) guiding conversations with family, friends and/or professionals in their support network about life goals and outcomes or what they need to be successful and self-determined now and in the future.

For professionals who serve individuals with disabilities, this guidebook helps to 1) build upon their own understanding of the needs of the people they support; and 2) start conversations about what people need to be successful and self-determined throughout their lives, and to help them think about how their choices, decisions and experiences now can help shape the future.

For the broader community, the LifeCourse guide can be used by anyone who wants to learn more about what people with disabilities and their families experience and think about as they strive to live full and meaningful lives now and in the future. By considering the questions in the guide, community members may find ways to be more inclusive and accepting of all citizens in everyday community life.

Section 3.3: Competitive Integrated Employment

The Employment First Act of 2018 states that competitive integrated employment is “the first consideration and preferred outcome” for working-age Pennsylvanians with a disability. Competitive integrated employment is part-time or full-time work where the individual is paid minimum wage or higher, works in an integrated setting, and is presented, as appropriate, with opportunities for similar benefits and advancement like other employees without a disability in similar positions.

SCs must provide individuals and their family with information on competitive integrated employment during the planning process and upon request. If an individual requests to receive Community Participation Support or Small Group Employment, the SC must document in the Employment/Volunteer Information section of the ISP that competitive integrated employment was discussed as a priority, before other services were considered. In addition, SCs should discuss the use and the possibility of adding the Benefits Counseling service to the plan.

Additional information on competitive integrated employment and employment services can be found in Section 14.9.

Section 3.4: Outcome Development

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

The ISP team develops measurable Outcome Actions based upon the individual's ability to acquire, maintain, or improve skills, including those that increase the individual's safety and well-being. It is important to remember that the goal is to assist individuals with cultivating a favorable life, not just developing a written plan. It is about people having better lives, not just better plans.

Outcome Statements represent what is important to the individual, what the individual needs, what the individual wants to maintain or change in their 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 their health and welfare. It is important to remember that we need to assist the person to create a Vision for a Good Life. The future is not something we enter; it is something we create. Creating the future requires us to make choices and decisions that begin with a dream.
Outcome development criteria:

- There should be a clear connection between the individual's preferences and choices and the actions the ISP team determines are necessary to meet needs associated with the individual's preferences and choices.
- The individual and ISP team should work together to find acceptable Outcome Statements that enable the individual to exercise their choices, while at the same time Outcome Actions that meet the individual's needs, minimize risk, and achieve or maintain health and safety.
- Outcome Actions should be unique to the individual's needs and not a direct reflection of a paid service.
- 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. Resources and opportunities available to the individual through their family and community connections can result in achieving the outcome.
- There may also be situations where more than one funded service, or a combination of funded services and unpaid supports, are linked to the same Outcome.
- 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 In-Home and Community Support should show how the individual will acquire, maintain, or improve a skill.

Section 3.5: 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 resources and opportunities available to the person through their family and community connections. When identifying services and supports, the team considers all available resource opportunities, including friends, family, faith-based

organizations and activities, neighbors, local businesses, schools, civic organizations, and employers.

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

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

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

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

Section 3.6: Identification of Services and Supports

A completed ISP should provide a means of achieving Outcome Statements important to the individual by integrating unpaid supports (such as community resources and opportunities in the person's life) with funded services. The ISP must address all assessed needs that affect the individual's health and welfare.

- Integrated community supports and other funding sources should be considered prior to ODP funding.
- The team uses the Outcome Actions to ensure that services and community supports 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. Each service does not need a separate 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, quarterly, or annually depending on the service) based on the needs of the individual.

- Amount of services is documented through the number of units included on the ISP in the *Service Details* screen in HCSIS.
- Training to meet the needs of the individual which includes but is not limited to the following areas: communication, mobility and behavioral.

SC documentation requirements for identification of services and supports:

- The type, duration, frequency, and amount of each service, including Supports Coordination, are documented in the Services and Supports Section of the ISP.
- If resources and experiences through the family and community are not available at the time the ISP meeting is held, the SC should document the efforts he or she has made to explore these within the Outcomes Section of the ISP.
- Other non-ODP funding sources, including but not limited to the Pennsylvania Medical Assistance (MA) State Plan, Behavioral Health, Early Periodic Screening and Diagnostic Testing (EPSDT), OVR and the Department of Education, should also be documented in the Outcomes Section of the ISP.

Section 3.7: Participant-Directed Services (PDS)

Participant-directed services, also known as self-direction, provides the individual and their surrogates with a high level of choice and control over their services and supports. In ODP's self-direction models, the individual or surrogate directs the provision of waiver services provided by Support Service Professionals (SSPs). The two options to self-direct using ODP's waiver funding are Vendor Fiscal/Employer Agent (VF/EA) financial management services (FMS) and Agency with Choice (AWC) FMS.

AEs, SCOs, ODP, the VF/EA Financial Management Services (FMS) and the AWC FMS share the responsibility of sharing ODP developed or approved information such as individual guides to self-direction, ODP policy bulletins on participant direction, the ODP established wage ranges, and, for VF/EA individuals, the comprehensive enrollment packet provided by the VF/EA FMS organization.

The AE shall make information on FMS and participant direction available to Waiver applicants at Waiver enrollment. SCOs are responsible for ensuring that SCs inform and fully discuss with individuals prior to the initial ISP meeting and at least annually thereafter of the right to choose among and between services and providers to support individuals' needs. SCs must provide individuals with the ODP developed or approved information such as consumer guides to self-direction, ODP policy bulletins on participant direction, the ODP established wage ranges, and the ODP approved statewide VF/EA enrollment packet. SCs provide the individual with a basic overview of the participant-directed options, and the differences and responsibilities associated with each option. SCs provide contact information for the statewide VF/EA on contract with ODP as well as the ODP designated AWC in their AE. The SC is required to share the above information during the planning process, annual ISP meetings, and upon request. SCs also provide individuals with support and assistance to make the decision to exercise participant direction authority and refer individuals to other resources (i.e., FMS, supports brokers) as necessary. If a decision is made to self-direct some or all needed services, the individual and his or her team will then select either the AWC or VF/EA FMS option. Documentation of the choice is documented by the SC on the ISP Signature Form (DP 1032). In addition to providing information and assistance to support an individual with decisions on the option to self-direct,

the SC also supports the individual with designating a surrogate and transition activities when needed.

Who can use PDS?

To be eligible for PDS, the individual **must live** in a private home. Individuals living in agency owned, rented, leased, or operated homes **may not** participate in PDS (this includes a private home where residential habilitation waiver services are occurring). However, there is an exception for the Supports Broker service, which may be provided for individuals who receive Residential Habilitation, Life Sharing or Supported Living services **only** if the individual has a plan to self-direct services through a participant-directed services model in a private home.

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

- The individual is able to expand the amount of choice and control they have over who provides their services and supports, and the way those services are provided.
- The individual is able to select and hire their own Support Service Professional (SSP).
- The individual is able to train their SSPs to provide services in a way that meets their needs.
- The individual is able to create the SSP's schedule.
- The individual is able to supervise their SSPs.
- The individual is able to dismiss a SSP from employment.

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

VF/EA Option: The VF/EA FMS model is provided through a statewide entity on contract with ODP. In the VF/EA model, the individual or their surrogate is the "Employer of Record", most often referred to as the Common Law Employer. Through this model, the individual or their surrogate has responsibility to fulfill functions such as but not limited to:

- Recruiting and hiring qualified SSPs;
- Orienting and training SSPs;
- Determining SSP schedules;
- Determining SSP responsibilities;
- Managing daily activities of SSPs; and
- Dismissing SSPs when appropriate.

Under the VF/EA model, the FMS is responsible for functions such as but not limited to:

- Functioning as the employer agent on behalf of the individual/surrogate.
- Withholding, filing, and paying Federal employment taxes, State income taxes and workers compensation on behalf of the individual/surrogate.
- Paying SSPs and vendors for services rendered as per the individual's authorized ISP.
- Verifying that SSPs meet statewide qualification criteria for the service(s) they provide.
- Conducting criminal background checks and child abuse checks, if applicable, on prospective employees.
- Providing employers with informational materials for enrollment of the employer and the SSPs into the VF/EA FMS model.

AWC FMS Option: The AWC FMS model is available through locally based AWC FMS providers. In the AWC model, the AWC FMS provider is the "Employer of Record" of qualified support service professionals. Through this model, the individual or their surrogate functions as the Managing Employer and works with the AWC FMS to fulfill responsibilities, such as but not limited to:

- Recruiting and referring qualified SSPs to the FMS for hire;
- Participating in training of SSPs;
- Determining SSP responsibilities; and
- Managing the daily activities of SSPs.

In the AWC model, the FMS is responsible for functions such as but not limited to:

- Hiring qualified SSPs referred by individuals/surrogates;
- Processing employment documents;
- Verifying that qualified SSPs meet the qualification standards outlined in Appendix C-3 of the waivers;
- Obtaining criminal background checks and child abuse checks, if applicable, on prospective employees;
- Invoicing PROMISe for services authorized and rendered;
- Preparing and disbursing payroll checks;
- Providing workers compensation for SSPs;
- Providing a variety of supports to individuals/surrogates, to include employer skills training and development of a worker registry; and
- Conducting SSP or Managing Employer training as needed or requested.

The VF/EA or AWC FMS "**administrative service**" available to an individual is an indirect service, which must meet contractual conditions. This service assists individuals and surrogates in the employment and management of support service professionals and vendors. For individuals receiving waiver services, when something is an "**administrative service**" it is not like other waiver services. The individual does not have a choice of organizations that provide the administrative service. However, the individual may select the type of FMS model he/she wants to use. The fee associated with FMS is not included in the ISP "services" budget.

Note: For individuals who are self-directing, the Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) provider and the Agency with Choices Financial Management Services (AWC FMS) provider are required to provide the administrative service and pay for all identified participant-directed and vendor services authorized. An Organized Health Care Delivery System (OHCDS) provider may not be authorized for any reason if the individual's ISP is authorized for one of the two FMS options.

Which services can an individual self-direct?

- Assistive Technology
- Companion
- Homemaker
- Chore
- In-Home and Community Support

- Participant-Directed Goods and Services
- Respite
- Supported Employment
- Supports Broker Services
- Education Support Services
- Specialized Supplies
- Home Accessibility Adaptations
- Vehicle Accessibility Adaptations
- Fees and Registration Costs for Family/Caregiver Training and Support
- Public Transportation and Transportation Mile

SC documentation requirements for participant-directed services:

- Individuals who choose to self-direct must select one of the two FMS options to assist with PDS. Individuals can choose only one PDS service delivery option at a time, and they can switch to the other option if they choose. Individuals can have a mix of traditional provider services and PDS services.
- The individual's ISP must have at least one participant-directed service. This includes participant-directed services with an hourly wage and/or participant-directed vendor services. Participant Goods and Services can be the only PDS service on a Person's ISP.
- The individual's ISP must include the designated procedure code for the FMS organization's monthly administrative service per ODP instructions.
- Individuals who use a PDS service delivery option are not eligible for vendor services through an OHCDS as their PDS service delivery option can be used for the vendor service.

Section 3.8: Choosing Qualified Providers

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

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

SC documentation requirements for choice of qualified providers:

- The ISP Signature Form should document that the individual was offered choice of qualified providers, including SCO.

Section 3.9: Provider Back-up Plans

Providers are obligated to render services in accordance with the approved and authorized ISP. A back-up plan is the strategy developed by a provider, common law employer or managing employer to ensure the services that are authorized are delivered in the amount, frequency, scope and duration as written in the individual's service plan. These back-up plans are developed with the unique needs and risk factors of the individual in mind and are discussed and shared with the individual, their family and team members. The back-up plan should address contingencies such as emergencies, including the failure of a direct support professional to appear when scheduled, or when the absence of the service presents a risk to the individual's health and welfare. In addition to these criteria, back up plans for remote supports utilized in any setting should ensure that the remote supports meet all applicable state and local laws, regulations and policies. These back-up plans are incorporated into the service plan by the SC to ensure that the entire team is aware of the strategies necessary to reduce and, when needed, address risks. Back-up plans are reviewed at the annual service plan meeting and revised as needed throughout the year. 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. The following represents ODP criteria for all other back-up plans:

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

SC documentation requirements for back-up plans:

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

Section 3.10: Qualified Provider ISP Roles and Responsibilities

For licensed services, the ISP will be the first source of review to determine compliance with planning and assessment standards. Qualified providers of service must participate in the assessment and planning process, including ISP team meetings, and provide necessary information to the SC for incorporation into the ISP. Qualified providers will maintain documentation that is given to the SC so that the information is documented in the ISP. Qualified providers are not required to develop their own separate ISP if the individual has a SC; however, the provider is responsible to develop an implementation plan as specified in 6100.221(g). The implementation plan must be consistent with the ISP and must include a

detailed description of the specific activities that can be rendered to assist the individual with achieving their broader desired outcomes in the ISP.

Qualified providers are responsible for completing assessments and evaluations related to the individual. The provider is also responsible for completing and maintaining claims documentation such as documenting service and 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.

Another important role for all qualified providers is to ensure that the incident management process is followed (see Bulletin 00-21-02). All qualified providers, including SCOs, must ensure that any person(s) designated by the individual, who are listed in the ISP (see Section 2), are notified about the incident management activities, as applicable. In addition, all qualified providers are responsible for informing the individual that local law enforcement may be contacted. If the individual expresses interest in this, assistance must be given to the individual to notify or speak with local law enforcement, regardless of the nature of the incident.

Please note, providers must take immediate action to protect the health, safety, and well-being of the individual following the initial knowledge or notice of an incident, alleged incident, or suspected incident. When a provider becomes aware of an incident that is outside the scope of its responsibility, the provider must ensure prompt action is taken to protect the individual and immediately contact the individual's SC to report the incident.

Section 3.11: Responsibilities Regarding the Timeline for Annual ISPs

The Annual ISP timeline (Attachment #2 of the ISP Manual) assists all team members, as well as AEs, with identifying ISP roles and the activities associated with the ISP process. AEs, SCOs and providers are responsible for all or part of the development and/or approval and authorization of ISPs. SCs are responsible for 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 at least 90 calendar days prior to the end date of the ISP.
- Distributing invitations to ISP team members at least 30 calendar days before the ISP meeting is held.
- Facilitating the ISP meeting with all team members invited at least 60 calendar days prior to the end date of the ISP.
- Submitting the Annual ISP to the AE or county for plan approval and service authorization at least 30 calendar days prior to the end date of the ISP.
- Distributing the completed ISP Signature Form to ISP team members.

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

- Distributing approved and authorized ISPs to the individual, family, and other ISP team members (identified on page 6) who do not have HCSIS access within 14 calendar days prior to the end date of the ISP.

Section 3.12: ISP Development Under 55 Pa. Code Chapters 2380, 2390, 6100, 6400 and 6500

- In most cases, the individual will have an SC that creates the ISP in HCSIS before the individual receives services in a setting that is licensed under 55 Pa. Code Chapter 2380, 2390, 6400 or 6500. This is reviewed in Chapter 6100.

- An ISP must be completed, but not entered in HCSIS, for any individual who receives services in a setting licensed under 55 Pa. Code Chapter 2380, 2390, 6400, or 6500, and who does not have an SC. The program specialist as specified in Chapters 2380, 2390, 6400 and 6500 will complete the annotated ISP in Microsoft Word. The program specialist must develop the initial ISP within 90 calendar days after admission to the facility or program.

- ISPs will be monitored during ODP's licensing inspection.

- If an individual lives in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) and receives services in a facility licensed under 55 Pa. Code Chapters 2380 or 2390, the ICF/ID is responsible for developing the ISP.

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

The SC is responsible to review the information on the ISP signature form with the individual. This includes reading and thoroughly explaining each question to the individual prior to indicating the appropriate answers on the check boxes 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 (electronic signatures are acceptable). Electronic signatures must conform to all applicable statutes and regulations relating to electronic signatures, including but not limited to the Electronic Transaction Act (73 P. S. § § 2260.101—2260.5101)). Signing the signature form not only validates attendance but also agreement with all information discussed at the meeting including the review and completion of page 2 of the signature form.

If the individual or any other ISP team member is unable to attend the meeting, the SC should make attempts to reschedule the meeting. After these attempts, a team member may still be unable to attend the ISP meeting, in which case the absence must be documented on the ISP signature form. There may also be rare instances when the individual was not able to be present; the results of the meeting must be shared with the individual. The SC should document this review by having the individual sign the ISP signature form noting the date the review was held.

If the individual was in attendance, but chooses not to sign the ISP signature form, the SC must indicate this on the ISP signature form. If the individual is under the age of 18 and/or has a legal guardian, the individual does not have to sign the form, but should be given the option. The individual's parent or legal guardian is required to sign.

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

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

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

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. To assist the ISP team, HCSIS generates an alert for the SC based on the date entered into the Annual Review Update Date field. This alert is intended to inform the SC that an update to the current ISP is due within 45 days.

By definition in Section 20 of this manual, the Annual Review Update Date is the end date of the current ISP plan year.

The Annual Review Update Date does not change from year to year. Only the year changes, not the month or day. For example: if last year's Annual Review Update Date was 8/9/22, this year's Annual Review Update would be 8/9/23. The only exception is during a Leap Year.

SCs should enter the Annual Review Update Date as well as the Annual Review Meeting Date into HCSIS when completing Annual Review plans. Correct completion of these fields will ensure that reporting mechanisms in HCSIS related to the ISP data are accurate. If the team wishes for the Annual Review Update Date to be updated to align with other requirements, there should be a team agreement. 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 regulation and submit to the AE for approval and authorization at least 30 calendar days prior to the end date of the ISP. If the AE sends the ISP back to the SC for revision, the SC must make the necessary corrections and resubmit the ISP to the AE within seven days of the date it was returned.

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

1. Required prior authorization or ODP approval of a variance to service limits was completed.
2. All Assessed Needs, as identified through the Statewide Needs Assessment instrument, other assessments as appropriate and the planning process, are included in the ISP.
3. 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 and preferences.
4. Services are identified to support assessed needs related to Outcome Statements.
5. The ISP reflects the full range of a waiver individual's needs and therefore must include all Medicaid and non-Medicaid services, including informal, family and community supports and supports paid by other service systems to address those needs.
6. 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.
7. 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 5.1: Auto Approval and Authorization of Services

To provide some efficiencies in the plan approval process, all services will go through an auto approval process and AEs have the option to manage this process using the AE Dashboard.

ODP has developed business rules in HCSIS that all ISP's are subject to. If an ISP meets the criteria of any one of these rules, the ISP will not auto approve and will appear on the AE Plan Dashboard for manual review by the AE.

The following table identifies the Plan Category and waiver(s) subject to the "Rules" listed under the "Rule Name" column. When a rule is met, the plan will go to the AE Plan Dashboard and the AE will be required to manually review and approve it. When a rule is not met, the plan will auto approve. Any plan category/waiver combination not listed below will go to manual approval. Any plan category/waiver combination with a blank space in the table will not be subject to the rules in the "Rule Name" column and will be auto approved.

Supports Coordinators will be able to override the auto plan approval by clicking the override automatic approval checkbox which is the last checkbox on the Submit Draft Plan Screen. When the field is checked for a plan, the plan will require manual approval by the County AE. This checkbox only appears for plans/programs eligible to receive auto approval.

NOTE: If the draft is a Critical Revision without any changes to the services, the Plan will automatically approve, even if the manual approval checkbox is selected.

Plan category/waiver combinations not represented in the table below are not eligible for automatic approval and will require manual review/approval by the AE (e.g., an individual enrolled in the Base Program with any plan revision type or enrolled in Consolidated Waiver whose plan is undergoing a Critical Revision).

A 'Yes' in the Plan Category/Waiver column means if the individual is enrolled in that waiver and the plan is of that plan revision type, the plan will be evaluated for auto approval against that rule. For example, for the Service Addition Rule, if a new service is submitted by the SC for addition to the plan, the plan/service will require manual review by the AE for the service addition to be approved. Another example would include if a Consolidated Waiver FY Renewal is submitted that includes a service that was not on the previous plan (and does not satisfy an Old to New Service Definition Mapping), the FY Renewal will be flagged for manual approval by the County on the Plan Dashboard.

		Requires AE Manual Review Plan Category								
		FY Renewal			Annual Review Update			Critical Revision		
Rule Name	Rule Description	Consld.	CLW	P/FDS	Consld.	CLW	P/FDS	Consld.	P/FDS	CLW
Service Addition Rule	A service is added to the current plan that was not on the previous plan and it does not satisfy an Old to New Service Definition Mapping.	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Service Removal Rule	A service is removed from the current plan that was on the previous plan.	Yes	Yes	Yes	Yes	Yes	Yes			
Unit Increase Rule	The service units have increased by more than 0% as compared to the previous plan.	Yes			Yes					
Unit Decrease Rule	The service units have decreased by more than 0% as compared to the previous plan.	Yes			Yes					
Base Services Rule	Services mapped to only Base funding streams exist on the current plan and service information has changed.	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Prior Plan Pending Rule	Future FY plan being submitted when there is a non-approved Critical Revision of the current FY plan.	Yes	Yes	Yes						
Prior Plan 365 Days	Plan effective begin date is more than 365 days in the past.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Missing Annual Review Rule	The Annual Review Update date has passed and no Annual Review Update was performed in the current FY.	Yes	Yes	Yes					Yes	Yes
Waiver/Program Transfer Rule	The Waiver/Program of the individual has changed since the last approved plan.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

		Requires AE Manual Review Plan Category								
		FY Renewal			Annual Review Update			Critical Revision		
Rule Name	Rule Description	Consld.	CLW	P/FDS	Consld.	CLW	P/FDS	Consld.	P/FDS	CLW
	The new waiver begin date must be after the last plan approval date.									
Service Combination Rule	Certain combination(s) of services exist concurrently on the plan and service information has changed.	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Multiple Funding Stream Rule	Services are mapped to more than one funding stream and an authorization decision has not yet been made.	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Requested for Manual Approval Rule	SC selected Request for Manual Approval checkbox on Draft Plan screen.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Misaligned Needs-Based Service Rule	A Needs-Based service exists on an individual's Plan which does not align with the individual's Needs Group.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
System Exception Rule*	Plan meets the error condition(s) of an existing Plan Approval or Service Authorization screen validation.	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes

Section 6: Variance Form and Process

The process to request a variance to certain waiver service requirements can be found in Bulletin 00-18-06: *Variance Form and Process: Requesting a Variance in the Consolidated, Community Living and Person/Family Directed Support Waivers*.

Any variance request must be made by using the DP 1086 form. The DP 1086 must be used in the preparation, completion, and review of ISPs for individuals enrolled in the Consolidated, P/FDS or Community Living waiver when a variance request is made. The DP 1086 must be completed prior to the requested services being authorized on an ISP. When there is an emergency circumstance, and approval is required by ODP, the AE must contact the ODP Regional Office assigned to their area.

The SCO will complete the DP 1086 and forward it to the appropriate AE.

For variances requiring AE determination, the AE will review the variance request and authorize the service on the ISP if supported by their review. The AE will provide a copy of the DP 1086 with the determination section completed to the SCO and provider (if appropriate).

For variances requiring ODP determination, the AE will submit the DP 1086 and their recommendation to the ODP Regional Office assigned to their area. The ODP Regional Office will provide a copy of the DP 1086 along with ODP's determination to the AE. The AE is responsible for providing this information to the SCO and provider (if appropriate).

The need for the enhanced levels of service below must be reviewed every 6 months at a minimum and the DP 1086 form must be completed based upon that review. The 6-month timeframe will begin on the date that enhanced levels of service are authorized. The ISP team can review the need for enhanced levels of service and complete a DP 1086 form more frequently than 6 months the first year, if needed, to align the review cycle with the Annual Review ISP.

Example: The Annual Review ISP is October 3rd. The ISP team identified the need for enhanced levels of service and the enhanced levels of services were authorized on January 10th. The ISP team must review the need for the enhanced levels of service in July and complete the DP 1086 form. The ISP team would then review the need for the enhanced levels of service at the Annual Review ISP in October and complete the DP 1086 form again. The next 6-month review would be due in April and then again with the Annual Review ISP in October.

Community Participation Support

- Level 3 Enhanced – Provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is certified, has a bachelor's degree or is a licensed nurse.
- Level 4 – Provision of the service at a staff-to-individual ratio of 2:1.
- Level 4 Enhanced – Provision of the service at a staff-to-individual ratio of 2:1 with one staff member who is certified, has a bachelor's degree or is a nurse and one staff member with at least a high school diploma.

In-Home and Community Supports

- Level 3 – The provision of the service at a staff-to-individual ratio of 2:1.

- Level 3 Enhanced – The provision of the service at a staff-to-individual ratio of 2:1 with one staff member who is certified, has a bachelor's degree or is a nurse and one staff member with at least a high school diploma. Level 3 Enhanced services by a nurse are only available to individuals age 21 and older.

Section 7: Restrictive Procedures

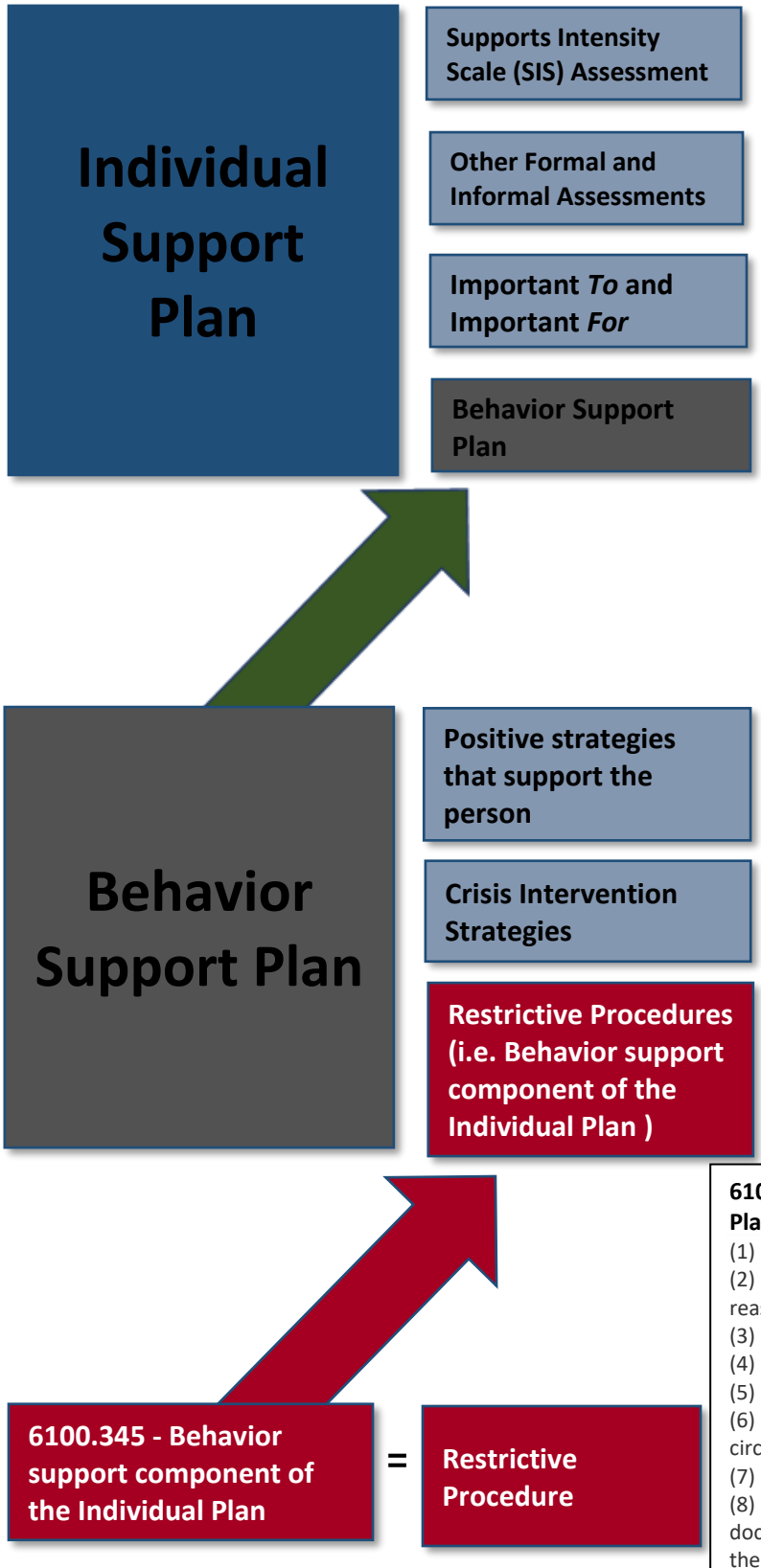
The behavior support component of the Individual Plan has been previously referred to as a restrictive procedure plan or a restrictive component of a Behavior Support Plan. As required by 55 Pa. Code §§ 2380.155, 2390.175, 6100.345, 6400.195 and 6500.165, when a restrictive procedure may be used for a person, the behavior support component of the Individual Plan must include the following:

- The specific behavior to be addressed.
- An assessment of the behavior, including the suspected reason for the behavior.
- The outcome desired.
- A target date to achieve the outcome.
- Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing, and treating physical and behavioral health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.
- Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
- The amount of time the restrictive procedure may be applied.
- The name of the staff person responsible for monitoring and documenting progress with the behavior support component of the Individual Plan.

This information can be summarized in the Individual Support Plan (ISP). The detailed information has been, and will continue to be, included in the Behavior Support Plan. Behavior Support Plans capture applicable behavior planning strategies designed to support the individual. Guidelines related to the provision of the Behavioral Support Service, crisis intervention strategies and any restrictive procedures approved by the Human Rights Team should all be included in the Behavior Support Plan.

Prior to use of a restrictive procedure, including the modification of an individual's rights, the information regarding the necessity and justification for the use of the restrictive procedure must be discussed with the ISP team for inclusion in the behavior support component of the Individual Plan. If a restrictive procedure will be used or if an individual's rights will be modified, the behavior support component of the Individual Plan shall be developed by a professional who has a recognized degree, certification or license relating to behavior support, and shall be reviewed and approved by the Human Rights Team (HRT).

Additional information regarding the behavior support component of the Individual Plan, including informed consent, is contained in Bulletin 00-21-01: Guidance for Human Rights Teams and Human Rights Committees, and its attachments.



A summary of the Behavior Support Plan shall be added to the ISP to include:

- Current need for the Behavior Support service.
- Formal or informal needs assessment that establishes the need for Behavior Support.
- Summary of the findings of the Functional Behavioral Assessment.
- Specific activities that the Behavior Support professional will be completing to support the outcome of the Behavior Support service.
- Training expectations for staff supporting the participant.
- Documentation related to direct and indirect activities:
  - Specific Crisis Intervention strategies to address dangerous or at-risk behaviors.
  - Summary of the information required in §6100.345 for any applicable restrictive procedures approved by the Human Rights Team, including a summary of the fading plan.
- If restrictive procedures are being used the SC must check the "Restrictive Procedure" box in Behavioral Support Plan screen.

Behavior Support Plan

The purpose of the Behavior Support Plan is to provide a comprehensive behavior management tool that captures all applicable behavior planning strategies designed to support the person. Behavior support guidelines, crisis intervention strategies, and relevant restrictive procedures (behavior support component of the individual plan), should all be included as components of the Behavior Support Plan. *Note: The majority of Behavior Support Plans will not contain restrictive procedures because they are only to be used after all other interventions have been exhausted.*

6100.345 - Behavior support component of the Individual Plan will include the following:

(1) The specific behavior to be addressed.
(2) An assessment of the behavior, including the suspected reason for the behavior.
(3) The outcome desired.
(4) A target date to achieve the outcome.
(5) Methods for facilitating positive behaviors
(6) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(7) The amount of time the restrictive procedure may be applied.
(8) The name of the staff person responsible for monitoring and documenting progress with the behavior support component of the individual plan.

Section 8: Implementation of Services

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

Authorized services must also be implemented as written per the current approved ISP, including the type, amount, frequency, and duration listed in the Outcome Actions section of the ISP. Those responsible for service implementation are accountable for the delivery of services as indicated in the ISP and are responsible for documentation to support the provision of services as per 55. Pa. Code, Chapter 6100 (relating to services for individuals with an intellectual disability or autism).

The SC is responsible for verifying that service delivery occurred as written in the ISP. SCs are required to document service delivery in a HCSIS Individual Monitoring Tool. If during monitoring, the SC discovers that services are not being delivered as per the ISP, then the SC is to meet with the team to determine the barrier to service delivery. The SC will facilitate a team discussion to overcome the barrier. If the team cannot reach a resolution to the barrier, the SCO should elevate to the County Program/AE.

Section 9: Addressing Changes in Need Throughout the Year for Individuals Enrolled in a Waiver

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

- If the change in need impacts the currently authorized services and/or funding, the SC must create a critical revision. The critical revision must be created and submitted for authorization to the AE within seven calendar days of notification of the change.

- If a change in need does not impact services or funding, the SC must create a general update. The general update must be created and finalized in HCSIS within seven calendar days of verification of the change in need.

- If the new service(s) or funding is denied by the AE, the AE must provide the individual their due process rights.

- When an individual's service needs change which will cause the individual's Waiver cap to be exceeded, the individual should be considered for enrollment in the next available waiver that will be more suitable to meet the assessed needs. In the interim, base funds or community resources if available may be used to augment the services required by the individual in the P/FDS or Community Living Waiver.

- If an individual who receives residential services (licensed Residential Habilitation, licensed Life Sharing or Supported Living) has a change in need that is an emergency situation or is a temporary change in medical or behavioral needs that the provider cannot meet without additional resources, Supplemental Habilitation may be approved. Please refer to *Section 14.19 Residential Services* for details on including Supplemental Habilitation in an individual's plan.

- If an individual must request an exception to exceed the established limits or service conditions as detailed in the approved waiver service definitions, the Consolidated, P/FDS or Community Living Waiver Variance Form (DP 1086) must be completed. Consult Bulletin 00-18-06 for further information.

- 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 10: Updating ISPs

ISP teams should review services at least annually and as needs change throughout the year. ISP decisions made by teams, Bureau of Hearings and Appeals (BHA) or the Secretary of Human Services, are specific to the circumstances or needs of the individual at the time the decision was made and, in most cases, are not considered permanent or lifetime decisions. It is expected that these types of ISP decisions are revisited at least annually at the Annual Review ISP Meeting. If, at any time, the ISP team or AE determines the services that were included in the ISP are not needed, the ISP should be revised to reflect the current needs of the individual. It is best practice for SCs to ask individuals and their families if they have created, updated, or revised any of the LifeCourse tools and whether they would like to share them with the team to ensure the ISP remains aligned with their vision for a good life.

Guides for understanding how to use HCSIS to update ISPs can be found on the HCSIS LMS page, which contains a variety of information regarding HCSIS, Supports Coordination, and Certified Investigator Training, including instructional web-based courses and job aids. Training courses are available depending on the user's role in the LMS. Users should use LMS to review web-based training courses and other important training and implementation documents such as HCSIS updates and tip sheets. The LMS link is located on the main HCSIS webpage. For more information and instruction in navigating HCSIS, refer to the HCSIS course entitled "Basic HCSIS Navigation".

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

- Plan Creation – A plan creation is used when creating an ISP for the first time in HCSIS (referred to as the initial ISP), when there is not a current ISP in HCSIS or when there is a timespan 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 Fiscal Year. It is possible that the initial ISP will not encompass the 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 FY 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 which is July 1. The FY ISP "expires" at the end of the fiscal year which is June 30. ISPs are developed on a FY basis in order to create service authorizations that encompass the full FY. Authorization takes place by service and each service is assigned a start and end date. The FY ISP can include up to one year of service. The ISP created through a fiscal year renewal will pre-populate with information from the previous ISP. Therefore, care should be taken to ensure that services continue to be accurately reflected. This process of renewing plans on the FY promotes efficiency in provider billing, as well as the ability to generate reports that accurately reflect all services and payments by FY. Additionally, as major changes to the waivers typically occur at the beginning of the FY, it allows for easier maintenance of any changes. If an annual review update and the FY renewal planning activities fall within the same month, it is recommended that the annual review update be completed first.

- Critical Revision – A revision to the ISP is used when an individual experiences a change in need which requires a change in current services, addition of services or a change in the amount of funding required to meet the needs of the individual. A critical revision to an ISP must be approved and authorized by the AE unless it meets auto authorization criteria in which it will be automaticity approved by HCSIS. The ISP team members should discuss and agree on changes made to the ISP before all critical revisions are finalized. If the individual, family member or any other team member disagrees with the content of the ISP, this should be documented on the ISP Signature Form (DP 1032).

- Bi-Annual Review – A bi-annual review is a requirement for Pennhurst Class Action members. A bi-annual review is used for editing or updating an existing ISP that requires a review of the ISP twice a year, or every 6 months. This option will not allow the SC role to modify the plan start and end dates.

- General Update – The category field in HCSIS used to update or edit 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 11: 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 to the individual. Service utilization is one of the ways to assist the ISP team in discussing the management of services. 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 with team members.

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

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

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

- Service Delivery – utilization issue is occurring due to problems with service delivery (i.e., provider staffing resulting in services not being rendered per the authorized frequency and duration, or individual not available for the service to be delivered (hospitalization and the individual doesn't want or need services, illness that limits the person's ability to receive the service at the frequency or duration authorized, vacation, etc.).
- Billing Issues – provider is not billing regularly, successfully, or correctly 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 a temporary need for increased services or supports).
- Permanent Change in Need – an issue is occurring due to a life event that is happening to an individual or their family member, that would cause a permanent change of service need.

SC documentation for service utilization:

- The SC should have conversations about service utilization with the individual, family and ISP team and document those conversations in the individual's service notes and monitoring tools in HCSIS. Documentation should include the reason(s) for any under- or overutilization that has occurred as well as steps taken to address the issue(s). This

information should also be discussed and documented during the annual review ISP meeting.

Section 12: Monitoring of Services

ODP exercises oversight of the ISPs through its standard SC Individual Monitoring processes to ensure that ISPs are implemented as written, as well as, to ensure that ISPs for are developed in accordance with ODP requirements.

SC Individual Monitoring is designed to provide support to individuals and their families, allows for frequent communication to address current needs and ensure individuals' health and safety. In addition, monitoring allows for increased support to plan for services throughout the lifespan.

SC Individual Monitoring verifies that the individual is receiving the appropriate type, amount, scope, duration, and frequency of services to address the individual's assessed needs and desired outcome statements as documented in the approved and authorized Individual Support Plan (ISP). It also ensures that the individual has access to services, has a current back-up plan, and exercises free choice of providers.

Please note: As of January 1, 2023, with the approval of the waiver renewals the provision of SC teleservices is defined as the delivery of direct services using remote technology.

Consolidated and Community Living Waiver SC Individual Monitoring Requirements:

For individuals enrolled in the Consolidated and Community Living Waivers, who receive a monthly service, the SC shall conduct at a minimum a face-to-face monitoring once every two months. A SC teleservice may be used to conduct monitoring for three out of the six required face-to-face monitorings per year when both of the following are met:

- The Supports Coordinator and individual can see and hear each other, the caregiver(s), and the environment using the technology; and
- The Supports Coordinator has given the individual an informed choice to receive the monitoring via teleservices or in-person.

For all individuals receiving Residential Habilitation, Life Sharing, or Supported Living services, teleservices may not be used to conduct monitoring in the individual's home and no more than six months can lapse between face-to-face monitorings at the residential setting. SC teleservices may occur if the location is at another setting such as individual's day service or other location.

SC monitoring location requirements during a six-calendar month timeframe are the following:

- One of the visits must take place at the individual's residence;
- One visit must take place at the individual's day service, which includes any day service based in the community; and
- One visit may take place at:
  - Any location where an authorized service is rendered, OR
  - Any location agreeable to the individual.

In addition, face-to-face monitoring is not required to occur at the place of employment or educational setting but may occur with the consent of the individual and their employer.

EXAMPLE OF A POSSIBLE MONITORING CYCLE

MONTH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUGUST	SEPT	OCT	NOV	DEC
FREQ	X		x		X		X		X		X	
TYPE	F2F		R		F2F		F2F		R		R	
LOC	RES		DAY		OTHER		RES		DAY		OTHER	

P/FDS Waiver SC Individual Monitoring Requirements:

For individuals enrolled in the P/FDS Waiver, who receive a monthly service, the SC shall conduct at a minimum, a face-to-face monitoring once every three calendar months. A SC teleservice may be used to conduct monitoring for one of the four required face-to-face monitorings per year when both of the following are met:

- The Supports Coordinator and the individual can see and hear each other, the caregiver(s), and the environment using the technology; and
- The Supports Coordinator has given the individual an informed choice to receive the monitoring via teleservices or in-person.

Monitoring must be conducted as follows:

- Within a six-calendar month timeframe, at least one of the visits must take place in the individual's home;
- One visit per year must take place at the individual's day service, which includes any day service based in the community; and
- One visit per year may take place at:
  - Any location where an authorized service is rendered; OR
  - Any location agreeable to the individual.

Face-to-face monitoring is not required to occur at the place of employment or educational setting but may occur with the consent of the individual and their employer.

Deviation of monitoring frequency and location requirements for individuals in the Consolidated, Community Living and P/FDS Waivers:

During the time when an individual is receiving a waiver service on a less than monthly basis or on temporary travel, the SC shall conduct monthly phone monitorings with at least one SC teleservice monitoring occurring every three months.

A deviation of monitoring frequency and location is only permitted when an individual:

- only receives a waiver service on a less than monthly basis; or
- is on temporary travel out of the state of Pennsylvania as per ODP's Travel Policy Related to Service Definitions.

A deviation can also include an increase of monitoring and/or a change in the way the monitoring is conducted such as more in person vs. teleservice. This deviation can occur regardless of the frequency of waiver services received and can be based on the risk to the individual. It is especially important to consider risk when the individual has limited ability to communicate and is dependent for daily activities such as eating, hygiene, and ambulation.

Examples of situations or circumstances that may prompt these types of deviations include (but are not limited to):

- Barriers that inhibit the quality of monitorings (i.e., the individual cannot be physically seen or the SC cannot gather enough information to adequately complete the monitoring tool)
- An increase in illness or injury to the individual
- Signs of abuse or neglect
- Any signs that alert the SC to a potential risk

At times, the required frequency of monitorings is interrupted by barriers that are outside of the SC's control. This should be documented in the monitoring tool as an issue.

Examples include (but are not limited to):

- Inability to contact the individual and/or family
- Frequent monitoring cancellations

Targeted Support Management and Base-Funded Case Management Individual Monitoring Requirements:

For individuals enrolled in Targeted Support Management and Base-Funded Case management, at minimum, the SC is required to conduct at least one face-to-face monitoring with the individual annually, and on a separate day from the ISP meeting.

Section 13: 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
Service Unit – Per month
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Base Funding: 0 – 120 years old
Allowable Place of Service: 11-Office; 99-Community

Procedure Code	Service Level	Service Description HCSIS Description
W7318	**Vendor Fiscal/Employer Agent Financial Management Services**	An administrative service that assists individuals and/or their surrogates in the direct employment and management of qualified SSPs and vendors. Monthly Admin Fee

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
Service Unit – Per Month
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0–120 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 HCSIS Description
W7319	**Agency with Choice Financial Management Services**	An administrative service that assists individuals and/or their surrogates in the employment and management of qualified SSPs and vendors. Monthly Admin Fee

VF/EA FMS Start-up Service

A **one-time** start-up service is available to be approved for each individual concurrent with service authorization. The start-up service is for required activities related to the individual's enrollment with the statewide VF/EA FMS. The start-up service is approved for each individual in the month prior to approval of W7318 (the ongoing monthly per individual administrative service). This start-up service **may not** be approved for individuals transitioning from the

existing statewide VF/EA FMS to the new statewide VF/EA FMS and may only be approved for new individuals enrolling with the statewide VF/EA FMS. The VF/EA FMS start-up service may not be approved for the same individual in the same month as any other VF/EA FMS administrative service approved for the new statewide VF/EA FMS.

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

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

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W0191	**VF/EA FMS Start-up Service**	A **one-time** start-up service approved for each individual enrolling with the statewide VF/EA FMS. This start-up service **may not** be approved for individuals transitioning from the existing statewide VF/EA FMS to the new statewide VF/EA FMS and may only be approved for new individuals enrolling with the statewide VF/EA FMS. The VF/EA FMS start-up service may not be approved for the same individual in the same month as any other VF/EA FMS administrative service approved for the new statewide VF/EA FMS. VF/EA FMS Start-up Service

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
Service Unit – Outcome Based
Provider Type **55** - Vendor
Specialties: **267** - Nonemergency; **430** - Homemaker Services; **431** - Homemaker/Chore Services; **543** - Environmental Accessibility Adaptations; **552** - Adaptive Appliances/Equipment; **533** - Educational Service (this should be used for Education Support services as well as registration and fees covered under Family/Caregiver Training and Support); **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 HCSIS Description
W0025	**Agency With Choice and Local Vendor Fiscal/Employer Agent Financial Management Services—Base Funded individuals**	An indirect service that assists individuals who receive base-funded services and/or their surrogates in the employment and management of employee related services (that is, qualified SSPs) and vendor services. The administrative service is billed as something other than a monthly fee. Admin Fee-Base (varies by payment) or Admin Fee-Other

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

Individuals who do not self-direct their services may have situations when vendor services are identified as a need. The needed vendor service can be managed through an Organized Health Care Delivery System (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 10% per transaction, whichever is less.

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

Provider Type **55** - Vendor
Specialty **267** - Non-Emergency
Service Unit – Outcome Based
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W0026		**OHCDS, Transportation Services**	This is an administrative service to pay the administration fee that is charged when the OHCDS provides an administrative service directly related to the delivery of a Transportation vendor service (one time vendor) for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is $25.00 or 10% per transaction, whichever is less. OHCDS Admin Fee/Transportation 1-time Vndr Serv

OHCDS One-Time Respite Camp Vendor Payments

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

Service Unit – Outcome Based
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
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 10% per transaction, whichever is less. OHCDS Admin Fee/Camp 1-time Vndr Serv-Overnight OHCDS Admin Fee/Camp 1-time Vndr Serv-Day

OHCDS One-Time Other Vendor Payments

Provider Type **55** - Vendor
Specialties: **543** - Environmental Accessibility Adaptations; **552** - Adaptive Appliances/Equipment; **533** - Educational Service (this should be used for Education Support services as well as registration and fees covered under Family/Caregiver Training and Support); **553** - Habilitation Supplies
Service Unit – Vendor Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Service Level	Service Description HCSIS Description
W0027	**OHCDS, Other Vendor Services**	This is an administrative service to pay the administration fee that is charged when the OHCDS provides an administrative service directly related to the delivery of a vendor service (one time vendor) other than Transportation or Respite Camp for an individual who is not self-directing their services. The administrative service is billed as a monthly fee which is $25.00 or 10% per transaction, whichever is less. OHCDS Admin Fee/Waiver (varies by payment)

Section 14: Waiver Services

This section contains information on each service reflected in Appendix C of the approved Consolidated, Community Living 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 fees are generally not allowable waiver costs unless they meet the standards in the service definition for Participant-Directed Goods and Services. Entrance fees are not allowable waiver costs. Recreation services and fees may be provided under family support services with base funding or individuals can choose to use their personal funds.

In accordance with 55 Pa. Code §6100.482 (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.

A $41,000 per person per fiscal year total limit is established for all P/FDS Waiver services with the following exceptions:

- Supports Coordination and Supports Broker services
- The limit can be exceeded by $15,000 for Advanced Supported Employment, Supported Employment, or Benefits Counseling services that are authorized on an individual's ISP.
- The limit can be exceeded temporarily to provide needed services for emergency care provision due to the COVID-19 pandemic. This temporary exception ends on 6/30/24 which is the last day of the full state fiscal year in which the Appendix K authority ends.
- Individuals enrolled in the P/FDS Waiver prior to July 1, 2023, can exceed the limit to maintain the number of Community Participation Support and/or Transportation Trip service units authorized in January 2020 or those authorized in the FY22-23 Individual Support Plan, whichever is greater. The purpose of this exception is to ensure that individuals will not lose services due to the adoption of temporary enhanced rates for Community Participation Support and Transportation Trip as the fee schedule rates effective in November 2023. As such, maintenance of Community Participation Support units includes any services authorized to replace Community Participation Support. For example, if a participant was authorized for 400 units of Community Participation support in January 2020 and was then authorized for 400 units of In-Home and Community Support in June 2022 to replace Community Participation Support that has remained unavailable, the 400 units is the maximum amount of In-Home and Community Support and Community Participation Support the individual can receive under this exception. The exceptions will continue for these individuals through June 30, 2025, as long as they remain enrolled in the P/FDS Waiver and the service plan does not exceed the approved exception level. This process will be monitored and reviewed by ODP or the AE.

A $85,000 per person per fiscal year total limit is established for all Community Living Waiver services with the following exceptions:

- Supports Coordination services.
- The limit can be exceeded temporarily to provide needed services for emergency care provision due to the COVID-19 pandemic. This temporary exception ends on 6/30/24 which is the last day of the full state fiscal year in which the Appendix K authority ends.

There is no similar cap associated with the Consolidated Waiver.

Individuals residing in licensed Personal Care Homes (55 Pa. Code Chapter 2600) with eight (8) 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 individual is residing as of July 1, 2008 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 Personal Care Home 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 nursing facility or ICF/IID. 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 their 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.

Expanding Services for Individuals with a Medically Complex Condition

ODP has expanded eligibility for home and community-based services to individuals with a developmental disability due to a medically complex condition. The purpose of this expansion is to ensure that individuals and families have access to services that support an everyday life. These services can assist families to support their loved ones to remain at home as an alternative to congregate institutional settings or transition from a congregate institutional setting.

This expansion became effective on June 1, 2022, for the Consolidated, Community Living and P/FDS Waivers. Individuals who have a developmental disability due to a medically complex condition and who meet the ICF/ORC Level of Care requirements have the option to enroll in a waiver only if they are age 0 to 21. Once an individual reaches age 22, the individual will be given the option to remain enrolled in the waiver after age 22 or transition to another program.

TSM services were expanded effective July 1, 2021, to individuals aged 0 through 21 with a medically complex condition. Individuals must be eligible for MA and have been determined to need an ICF/ORC level of care as determined by the Administrative Entity.

A medically complex condition is a chronic health condition that affects three or more organ systems, and the individual requires medically necessary skilled nursing intervention to execute medical regimens to use technology for respiration, nutrition, medication administration or other bodily functions.

Throughout the ISP Manual, a diamond ◊ indicates a change related to the updated expansion of serving individuals with a developmental disability due to a medically complex condition.

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

Teleservices

Changes to the following services became effective in November 2023 when Appendix K flexibilities expired

Teleservices are the delivery of direct services (where direct service professionals are actively engaged with the individual) using remote technology. The following direct services may be rendered via teleservices (please see service definition for limits and nuances for the services asterisked below):

- *Community Participation Support
- *In-Home and Community Support
- Supported Employment
- Therapy Services
- Supports Broker
- Behavioral Support
- Communication Specialist
- *Companion
- Consultative Nutritional Services
- Music and Art Therapy
- * Supports Coordination
- *Specialty Telehealth and Assessment Team

Note: Further guidance is included in the service definition for each service that has an asterisk(*).

Additional Guidance

This information has been added to ensure person centered planning and individual choice and privacy when receiving teleservices.

Individuals must have an informed choice (understanding all the options available to them, including the benefits and possible risks) to receive direct services in-person or via teleservices. Teleservices may only occur when the ISP team determines that using remote technology is the most appropriate service delivery method to meet the individual's needs (including health and safety needs) and goals. This determination must be based on consideration of all of the following:

- Service delivery complies with the requirements in the service definition, ODP policies, and regulations.
- Teleservices must be provided by means that allow for live two-way communication with the individual; interaction may not be recorded. Live video (seeing the individual and the individual seeing the staff) or audio transmission (such as a staff's voice coming through a device and giving prompts/direction to the individual) is only allowable to persons designated by the individual and designated staff employed by the provider responsible for direct service delivery.
    - Providers can call individuals over the phone as an incidental component of teleservices to check-in with individuals as allowed in the service definition or in emergency circumstances when all other criteria are met.
    - Monitoring of devices is not allowable under teleservices.
- The provider has explained to the individual and everyone else residing in the home the impact that teleservices will have on their privacy.

- The individual must be alerted prior to the activation of any audio communication device unless the individual turns on the audio communication device themselves.
- All live real time audio and video communication devices used to render teleservices in any part of the home or community must include indicators that let the individual know that the equipment is on and operating in audio or video mode.
- How teleservices enhance the individual's integration into the community.
- The request to use teleservices was initiated by a request from the individual and/or the family/representative when appropriate, and not the provider.
- How the individual's needs for in-person support during service provision will be met.
- The provider, in conjunction with the ISP team, has developed a back-up plan that will be implemented should there be a problem with the technology.
- The provider is responsible for ensuring that any technology used to render teleservices are HIPAA compliant and that the delivery of teleservices has been reviewed and accepted by the HIPAA compliance officer.
- The provider is also responsible for providing initial and ongoing training and support to the individual, and anyone designated by the individual, regarding the operation of the technology used during teleservices, including turning it on and off at-will.

Teleservices in Bathrooms:

- Communicating with the individual through video in a bathroom is not allowed.
- ~~o~~ The use of audio communication technology is permitted in a bathroom setting. The use of video communication technology is not permitted in a bathroom setting.

Teleservices in Bedrooms:

- Audio communication is permitted in a bedroom setting.
- Live real time video communication between the individual and a staff person as part of teleservices may only occur in an individual's bedroom when all of the following are met:
  - The individual has chosen to receive teleservices in their bedroom due to a medical condition which makes it difficult or impossible for them to leave their bedroom to receive services in another room in the house or the individual would like privacy from others in the home (family, housemates, etc.) during the receipt of services;
  - The individual turns the video communication device on and off themselves or requests assistance in turning the video communication device on and off;
  - The individual does not share a bedroom with others; and
  - Service delivery via video communication will not be performed as part of any activity during which privacy would generally be expected (while an individual is in a state of undress, during sexual activities, etc.).

Enhanced Communication Rates for Individuals Who are Deaf

The enhanced communication rate is available for services from providers who render services in the Consolidated, Community Living, and P/FDS Waivers and have proficient signing staff to serve signing D/deaf individuals or utilize PA registered, certified Sign Language Interpreters during service provision.

Providers who are interested in applying for this rate must follow the process developed as outlined in ODP Announcement 22-099, Revision to the Enhanced Communication Rate for Services, or its successor. If the provider is approved, the SC will be notified and should refer to the Announcement for further direction.

Adding the Enhanced Communication Rate (U1 Modifier) to Individuals' ISPs**:**

Once the SC has received notification that the individuals is eligible for Enhanced Communication services the following steps should be taken:

- For individuals enrolled in the Consolidated Waiver, SCs should follow the instructions in the January 24, 2014, *HCSIS Enhanced Communication Services (ECS) Job Aid* to allow billing for Enhanced Communication Services.

- For individuals enrolled in the Community Living or P/FDS waiver, SCs will follow the instructions in the January 24, 2014, *HCSIS Enhanced Communication Services (ECS) Job Aid* to allow billing for Enhanced Communication Services. This includes checking the "Harry M Indicator" in HCSIS as described in the Job Aid.

    - Note: Checking the indicator is required based on HCSIS design. This will not make the Community Living or P/FDS Individual a Harry M Class member. Only Consolidated Waiver Individuals who are deaf are Harry M Class Members.

    Additionally, SCs should enter the following information in the "Other Non-Medical Evaluation" section of the ISP for Community Living or P/FDS individuals (see page 7 of the Job Aid). For example:

    Evaluation Area: Deaf Services Assessment
    Name/Type of Evaluation: Community Living or P/FDS (as appropriate)
    Date of Evaluation: 9/9/9999
    In Need of Enhanced Communication Services: Yes

Questions about Enhanced Communication Rates may be directed to the ODP Special Populations Unit at ra-odpdeafservices@pa.gov.

Layout of the Service Definitions in this Manual

Each service definition identified in this section contains:

- The service description
- Suggestions for determining need
- Documentation requirements
- Service limits

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

- What Outcome(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 maintaining, learning or gaining by receiving this service?
- Is there any specific training (beyond general staff orientation) and/or any specific skills needed to provide this service?
- Have the necessary variances been approved?
- What is the amount, frequency and duration of the service needed?
- How many units of service are required to attain the specific Outcome Action(s)?
- How will progress and/or success be measured and reached?
- If progress and/or 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.

Note: Residential Habilitation (licensed) services are available only in the Consolidated Waiver and referenced as such within the manual. Residential Habilitation (unlicensed), Life Sharing (licensed and unlicensed) and Supported Living services are available in the Consolidated and Community Living Waivers and referenced as such, including differences in service definitions, within the manual.

Section 14.1: 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 or increase an individual's ability to exercise choice and control. Assistive Technology services include direct support 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. Leasing of equipment and devices is only allowable short term:
    - For emergency substitution of a device or equipment until repairs are made or a replacement can be purchased; or
    - To allow an individual to try equipment and device(s) to determine whether the equipment or device(s) will be a good fit for the individual's needs.
- Selecting, designing, fitting, customizing, adapting, installing, maintaining, repairing, or replacing assistive technology devices. Repairs are only covered when it is more cost effective than purchasing a new device and are not covered by a warranty;
- Training or technical assistance 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.

Electronic devices **that are not used in the delivery of Remote Supports** are included under Assistive Technology to meet a communication or prompting need or to enable individuals to independently control devices and appliances in their home and community. Examples of electronic devices include tablets, computers and electronic communication aids. There must be documentation that the device is a cost-effective alternative to a service or piece of equipment. When multiple devices are identified as being effective to meet the individual's need, the least expensive option must be chosen. Applications for electronic devices that assist individuals with a need identified are also covered for individuals.

Generators are covered for the individual's residing in primary private home. Generators are not covered for any home other than the individual's primary private residence.

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

Assistive Technology devices **not used in the delivery of remote supports as a method of residential service delivery** costing $750 or more must be recommended by an independent evaluation of the individual's assistive technology needs, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the

individual on the customary environment of the individual. The independent evaluation must be conducted by a licensed physical therapist, occupational therapist, speech/language pathologist or a professional with a current certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). The independent evaluator must be familiar with the specific type of technology being sought and may not be a related party to the Assistive Technology provider. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the individual. The least expensive option from the list must be selected for inclusion on the ISP.

Additional Service Definition Clarification:

- Electronic devices include tablets such as iPads and Samsung Galaxy tablets.
- The Assistive Technology service covers personal emergency response systems (also known as medical alert systems) for individuals who do not receive services 24 hours a day, 7 days a week. This includes the cost of the transmitter (a lightweight, battery powered device that can be worn around the neck, on a wrist band, on a belt, or in a pocket) and the cost of the center that responds when the transmitter is activated.
- Hearing aids for adults (individuals aged 21 or older) are covered as Assistive Technology.
- Supports Coordinators are encouraged to use the Guiding Questions for Developing Technology Options when discussing Assistive Technology during ISP team meetings.
- When the cost of one Assistive Technology device or piece of equipment exceeds $750, it must be recommended by an independent evaluation of the individual's assistive technology needs. When an individual needs multiple devices or pieces of equipment and the combined cost of the devices or equipment exceed $750 **(but no one device or piece of equipment exceeds $750)**, an independent evaluation is not required.
- **The cost of completing assessments and training on devices or equipment used in the delivery of remote supports as a method of residential service delivery may not be authorized and billed under Assistive Technology. These costs are covered under the Residential Habilitation, Life Sharing or Supported Living service.**
- Refer to ODP Announcement 24-015: Implementing Changes To Remote Supports And Assistive Technology In The November Waiver Amendments, for guidance for implementing changes to assistive technology and remote supports in the November 2023 amendments to the Consolidated, Community Living, Person/Family Directed Support (P/FDS).

Determining the need for services:

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

- How will the assistive technology service increase, maintain or improve the individual's functioning?
- Has the individual used an assistive technology device in the past to address a similar need?
  - If yes, what worked well with this device? What didn't work well with this device?

  - If the device being recommended is similar or the same as a device that didn't work well for the individual in the past, why do you think this device will be more successful?
- Was a recommendation obtained from an independent evaluation of the individual's assistive technology needs?
- Have free lending programs been explored for new devices or apps? These programs allow individuals to borrow and use a device or app for a short period of time at no cost.
- Will the device be monitored by paid staff who are not with the individual? If yes, the device is used as part of Remote Supports and Remote Supports procedure codes should be used.
- Is the device cost effective?
  - For electronic devices, is the device a cost-effective alternative to a service or other piece of equipment?

Service limits:

- A lifetime limit of $10,000 per individual for all Assistive Technology. This limit may be extended by ODP using the standard ODP variance process. This lifetime limit includes:
  - A lifetime limit of $5,000 for generators for the individual's primary residence only. The lifetime limit on generators may not be extended using the variance process and generators for a secondary residence are not available through the waiver. While generators have a separate lifetime limit, the amount spent on a generator is included in the overall Assistive Technology lifetime limit of $10,000.
  - Electronic devices. No more than one replacement electronic device is allowed every 5 years.
  - Repairs, warranties, ancillary supplies, software and equipment.

- Assistive Technology provided to individuals living in provider owned, leased or operated settings must comply with 42 CFR 441.301(c)(4)(vi)(A) through (D) related to privacy, control of schedule and activities and access to visitors.

- The following is a **list of items excluded as Assistive Technology** (please note this is not an exhaustive list of excluded items):
  - Durable medical equipment, as defined by 55 Pa. Code Chapter 1123 and the MA State Plan;
  - Hearing aids for children under 21 years of age as they are covered under the EPSDT benefit of Medical Assistance;
  - Air conditioning systems or units, heating systems or units, water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
  - Video monitoring equipment that will be installed or used in the individual's bedroom or bathroom;
  - Recreational or exercise equipment; and
  - Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships.

SC documentation requirements:

- When Assistive Technology is utilized to meet a medical need, documentation must be obtained stating that the service is medically necessary and not covered through the MA State Plan, Medicare and/or private insurance. When Assistive Technology is covered

by the MA State Plan, Medicare and/or private insurance, documentation must be obtained by the Supports Coordinator showing that limitations have been reached before the Assistive Technology can be covered through the Waiver. To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

- Documentation of an independent evaluation and recommendation for one Assistive Technology device or piece of equipment costing $750 or more.
- Documentation that any electronic device requested is a cost-effective alternative to a service or piece of equipment. When multiple electronic devices are identified as being effective to meet the individual's need, the least expensive option must be chosen.
- 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; **55** – Vendor
Specialties: **541** – ISO-Fiscal/Employer Agent; **540**, ISO-Agency with Choice;
552 – Adaptive Appliances/Equipment

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.

Service Unit – Vendor Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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 HCSIS Description
T2028* (For non-medical Assistive Technology)	**SE**	**Assistive Technology**	The purchase or modification of assistive technology for increased functional involvement of individuals in their activities of daily living. Assistive Technology--Non-medical or
T2028*	**SE and UD**		The purchase or modification of assistive technology for increased functional involvement of individuals in their activities of daily living. Assistive Technology - Operating Fee, Non-Medical

T2029* (For medical Assistive Technology)	**SE**		The purchase or modification of assistive technology for increased functional involvement of individuals in their activities of daily living. Assistive Technology--Medical or
T2029	**SE and UD**		The purchase or modification of assistive technology for increased functional involvement of individuals in their activities of daily living. Assistive Technology - Operating Fee, Medical

Modifier SE must be used with each Assistive Technology procedure code as it is used to denote that this is an ODP waiver service. Modifier UD is used to denote the Operating Fee.

Section 14.2: Behavioral Support

"The Behavioral Support Specialist (BSS) provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify challenging behaviors of a disruptive or destructive nature that prevent or interfere with the individual's inclusion in home and family life or community life. The BSS promotes consistent implementation of the Behavior Support Plan (BSP) and Crisis Intervention Plan (CIP) across environments and across people with regular contact with the individual, such as family, friends, neighbors and other providers. Consistency is essential to skill development and reduction of problematic behavior. BSS includes both the development of an initial BSP and ongoing behavioral supports."

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

For individuals who receive Behavioral Support as a discrete service, there are two levels of service that reflect differing levels of provider qualifications and individual needs. Individuals requiring Level 2 support will have demonstrated complex needs, including regression or lack of adequate progress with Level 1 support, or be deemed at high risk for decreased stability in the absence of Level 2 support.

Behavioral Support services includes both the development of (1) an initial Behavior Support Plan by the Behavioral Specialist and (2) ongoing behavioral support:

1. During initial Behavior Support Plan development the Behavioral Specialist must:

- Conduct a Functional Behavior Assessment and an analysis of assessment findings of the behavior(s) to be targeted so that an appropriate Behavior Support Plan may be designed.
- Collaborate with the individual, their family, and their ISP team for the purpose of developing a behavior support plan that must include positive practices and least restrictive interventions. The behavior support plan may not include chemical or mechanical restraints. The behavior support plan may not include physical restraints as behavioral interventions. Physical restraints may only be utilized in accordance with 55 Pa. Code §§6100.348 and 6100.349 in the case of an emergency or crisis to prevent an individual from immediate physical harm to the individual or others. Behavior support plans that include restrictive procedures must be approved by a human rights team prior to implementation. ODP expects that, regardless of the number of providers supporting a person, continuity of care will be maintained through ongoing team communication and collaboration. Ideally, there should be one behavior support plan for the individual that is integrated and comprehensive and incorporates support strategies for all environments. If there is more than one Behavioral Specialist working with the individual, the behavior support plan can reflect joint authorship.
- Develop an individualized, comprehensive Behavior Support Plan consistent with the outcomes identified in the individual's ISP, within 60 days of the authorization start date of the Behavioral Support service in the ISP.
- Develop a crisis intervention plan that will identify how crisis intervention support will be available to the individual, how anyone who supports the individual will be kept informed

of the precursors of the individual's challenging behavior, and the procedures/interventions that are most effective to deescalate the challenging behaviors.
- Upon completion of initial plan development, meet with the individual, the Supports Coordinator, others as appropriate, including family members, providers, and employers to explain the Behavior Support Plan and the crisis intervention plan to ensure all parties understand the plans.

2. Ongoing Behavioral Support: Ongoing support can occur both before and after the completion of the Behavior Support Plan. If the individual needs Behavioral Support before the Behavior Support Plan and crisis intervention plan are developed, the Supports Coordinator must document the need for support. Upon completion of the initial Behavior Support Plan, the Behavioral Specialist provides direct and consultative supports.

Ongoing Behavioral Support includes the following:
- Collection and evaluation of data;
- Conducting comprehensive functional assessments of presenting issues (which may include but are not limited to: aggression, self-injurious behavior, law offending behavior [sexual or otherwise]);
- Updating and maintenance of behavior support plans, which utilize positive strategies to support the individual, based on functional behavioral assessments;
- Presentation of the Behavior Support Component of the Individual Plan (Restrictive Procedure Plan) to Human Rights Teams/Human Rights Committees, including any required documentation, as requested;
- Development of a fading plan for restrictive interventions;
- Conducting training and support related to the implementation of behavior support plans, including positive behavior support strategies, crisis prevention/intervention strategies, and restrictive procedures if applicable for the individual, family members, staff and caregivers;
- Implementation of activities and strategies identified in the individual's behavior support plan, which may include providing direct behavioral support, educating the individual and supporters regarding the underlying causes/functions of behavior and modeling and/or coaching of supporters to carry out interventions;
- Monitoring implementation of the behavior support plan, and revising as needed; and
- Completion of required paperwork related to data collection, progress reporting and development of annual planning material.

Behavioral Support may be provided at the same time as Advanced Supported Employment, Supported Employment or Small Group Employment if the individual needs the service at their place of employment to maintain employment as documented in the ISP.

Services may be provided in the office of the Behavioral Specialist, the individual's home, or in local public community environments necessary for the provision of the Behavioral Support Services. Direct services must be provided on a one-on-one basis. Behavioral Support teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47.

Behavioral Support services may also be delivered in an acute care hospital, in accordance with ODP Bulletin 00-23-01.

Behavioral Support services 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:

- Individuals no longer require separate delineated plans for Crisis Intervention and Restrictive Procedures. The purpose of the Behavior Support Plan is to provide a comprehensive tool that captures all applicable behavioral planning strategies designed to support the person. Behavioral support guidelines, crisis intervention strategies, and relevant restrictive procedures approved by the Human Rights Team should all be included as components of the Behavior Support Plan.
- Regarding Crisis Plan/strategies: Designing crisis strategies that are a proactive plan designed to protect the individual, other individuals, or valuable property. It is designed only for protection during a crisis and not to limit future crises. Crisis strategies should clearly define what a crisis looks like for that individual and should not include any teaching of skills or long-term outcomes. The point of crisis strategies is to get everyone out of the crisis safely. The other sections of the Behavior Support Plan would capture the long-term goals and teaching strategies. We are simply describing the strategies that should be implemented to eliminate the crisis and ensure the health and safety of everyone involved. "
- The primary role of the Behavior Support Staff is to identify and transfer skills to direct service professionals to aid them in more effectively supporting service recipients. Some other goals of the Behavior Support Staff are to capture behavioral needs through formalized assessment strategies, develop and monitor data tracking documentation (which includes making updates to the Behavior Support Plan as needed), identify recommended interventions, describe crisis intervention strategies to help manage dangerous or at-risk behavior, train direct service professionals in the implementation of behavioral strategies, etc. When necessary, the Behavior Support Staff should develop restrictive procedure components of the Behavior Support Plan. Should the development of restrictive procedures become necessary, the restrictive components of the Behavior Support plan will need to be approved by a Human Rights Team before being implemented. The Behavior Support Staff will take lead in presenting the Behavior Support Plan to the Human Rights team detailing the specific behavior to be addressed; an assessment of the behavior including the suspected reason for the behavior; the outcome desired; methods for facilitating positive behaviors; types of restrictive procedures that may be used and the circumstances under which the procedures may be used; a target date to achieve the outcome; the amount of time the restrictive procedure may be applied and the name of the staff person responsible for monitoring and documenting progress with the individual plan.
- There may be cases where both Behavioral Support and Communication Specialist Services are authorized in a service plan. In these instances, the Behavioral Support Specialist should collaborate to ensure the Behavior Support Plan and the Communication Specialist's plan, the Action Plan, are consistent and do not contradict one another. The Behavior Support Plan should include information from the Action Plan and include specific strategies that describe the individual's preferred communication methods and how staff should respond to attempts to communicate in situations that have previously been associated with the behaviors targeted in the Behavior Support Plan.

Determining the need for services:

- Is the individual currently receiving Level 1 Behavioral Support services?

  - If yes, is the individual making progress with the current Level 1 service to achieve outcomes? If the individual is not making progress with Level 1 services, is the individual demonstrating complex needs, including regression, or are they deemed at high risk for decreased stability that might signify that they could benefit from Level 2 Behavioral Support services?
- Does the individual have a Behavior Support Plan?
  - If yes, what does the plan recommend?

Service limits:

- Behavioral Support services can only be provided to adults. All necessary behavioral health services for children under age 21 are covered by Medical Assistance pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.
- The direct provision of Behavioral Support may not be provided at the same time as the direct provision of Therapy services (occupational, physical, speech and language, and orientation, mobility, and vision therapies).
- Counseling and therapy are not included as part of the Behavioral Support service.
- Behavioral Support may only be authorized as a discrete service for an individual receiving Residential Habilitation, Life Sharing or Supported Living services when Behavioral Support is used to support the individual to access Community Participation Support or to maintain employment when provided at the individual's place of employment.
- To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

SC documentation requirements:

Summary of the Behavior Support Plan in the section of the ISP to include:

- Current need for Behavioral Support.
- The formal or informal needs assessment that establishes the need for Behavioral Support.
- A summary of the findings of the Functional Behavioral Assessment:
  - The targeted behaviors; and
  - The function of the targeted behaviors.
- Specific activities that the Behavioral Support Specialist will be completing to support the individualized outcome of the Behavioral Support service.
- Training expectations for staff supporting the individual.
- Documentation related to direct and indirect activities:
  - Specific Crisis Intervention strategies to address dangerous or at-risk behaviors.
  - Identification of any applicable restrictive procedures approved by the Human Rights Team.
  - A summary of the fading plan for any restrictive interventions.
- If restrictive procedures are being used the SC should check the "Restrictive Procedure" box in Behavioral Support Plan screen.

*The ***Health and Safety: Crisis Support Plan*** section of the ISP should be utilized to describe back-up plans for supporting the individual in the event of staffing or other site emergencies.

The procedure code and service unit for Behavioral Support Services:

Provider Types **51** – Home & Community Habilitation; Specialty Code **508 –** Behavioral Support
Provider Type **11** – Mental Health/Substance Abuse; Specialty Code **420 –** Autism Behavioral Specialist
Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 21- Inpatient Hospital ( ); 99-Other (Community)

(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope ( ) when an individual is in the hospital.)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W7095		**Behavioral Supports – Level 1**	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. The individual's family members, staff, or others involved in the individual's life may be included in Behavioral Support activities. Behavioral Supports-Level 1-Initial/Ongoing Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above. 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 Types **19** – Psychologist; Specialty Code **508 –** Behavioral Support,
Provider Type **31** – Physician; Specialty Code **339** – Psychiatry and Neurology,
Provider Type **51** - Home & Community Habilitation; Specialty Codes **117** - Licensed Social Worker, **559** – Behavioral Specialist Consultant

Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 21- Inpatient Hospital( ); 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description

			HCSIS Description
W8996		**Behavioral Supports – Level 2**	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. The individual's family members, staff, or others involved in the individual's life may be included in Behavior Support activities. Behavioral Supports-Level 2-Initial/Ongoing Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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 14.3: Benefits Counseling

Benefits Counseling is a direct service designed to inform, and answer questions from, an individual about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. Through an accurate individualized assessment, this service provides information to the individual regarding the full array of available work incentives for essential benefit programs including Supplemental Security Income, SSDI, Medicaid, Medicare, housing subsidies and food stamps.

The service also will provide information and education to the individual regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits Counseling provides work incentives counseling and planning services. It is provided to individuals considering or seeking competitive integrated employment or career advancement or to individuals who need problem solving assistance to maintain competitive integrated employment.

Benefits Counseling must be provided in a manner that supports the individual's communication style and needs and shall meet at a minimum what is required under the Americans with Disabilities Act. This service may be provided in person or virtually based on the individual's informed choice, after the pros and cons of each method are explained to the individual.

Benefits Counseling may only be provided after Benefits Counseling services provided by a Community Work Incentives Coordinator through a Pennsylvania-based federal Work Incentives Planning and Assistance (WIPA) program were sought and it was determined and documented by the Supports Coordinator that such services were not available either because of ineligibility or because services are not available within 30 calendar days This process must be completed when there has been an interruption in service where the individual has not received Benefits Counseling services in more than nine months.

This service can be delivered in Pennsylvania.

Determining the need for services:

- Is the individual considering or seeking competitive integrated employment or career advancement?
  - If no, does the individual need problem-solving assistance to maintain competitive integrated employment?
- Is the individual or their family reluctant to seek competitive integrated employment because they are afraid of the individual losing government benefits?
- Were services through a Pennsylvania-based federal Work Incentives Planning and Assistance program sought and determined not available?

Service limits:

- Benefits Counseling may not be provided at the same time as the direct provision of any of the following: Small Group Employment; Supported Employment; job acquisition and job retention in Advanced Supported Employment; Transportation; Therapies; Education

Support; Music, Art and Equine Assisted Therapy; Consultative Nutritional Services and Communication Specialist.

- Benefits Counseling services are limited to a maximum of 60 (15-minute) units which is equal to 15 hours per individual per fiscal year for any combination of initial benefits counseling, supplementary benefits counseling when an individual is evaluating a job offer/promotion or a self-employment opportunity, or problem-solving assistance to maintain competitive integrated employment.

SC documentation requirements:

- Documentation that services through the WIPA were sought for the individual and not available either because of ineligibility or because of services not being available within 30 calendar days.

The procedure code and service unit for Benefits Counseling:

Provider Type **53** – Employment Competitive
Specialty **530 –** Job Finding
Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & 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 HCSIS Description
W1740	**SE**	**Benefits Counseling**	This direct service is designed to inform an individual about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. It will also provide information on essential benefit programs. Benefits Counseling Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with the Procedure Code in this table for the direct provision of this service. 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.

Modifier SE must always be used for Benefits Counseling as it is used to denote that this is an ODP waiver service.

Section 14.4: Communication Specialist Services

This is a direct and indirect service that supports individuals with nontraditional communication needs. Communication Specialist teleservices may be provided in accordance with teleservice requirements listed in this manual under Teleservices on page 47.

Nontraditional communication may consist of:

- Sign Language, including American Sign Language, Sign Language from other countries, such as Spanish Sign Language; Signed Exact English, or a mixture of American Sign Language and signed English,
- Tactile, or Protactile Sign Language
- Lip Reading Visual-Gestural Communication (gestures, facial expressions, and body language use and analysis without grammar rules of language)
- Paralinguistics, Haptics, Touch Cues
- Artifacts, Texture Cues, and/or Objects of Reference
- Braille
- Print and Symbol Systems
- Eye-Gaze and other Speech Generating Devices
- Other communication methods as identified by the Department

This service builds an ongoing framework and system to support the participant's communication needs. The team then integrates that framework into all aspects of the individual's life.

This service includes a comprehensive review of all available information, the development of strategies to support the individual based upon the review, and the provision of interventions and training to the individual, staff, parents, and caregivers. Services must be required to meet the current needs of the individual, as documented and authorized in the service plan.

During the communication plan development, the Communication Specialist must conduct a comprehensive review of the individual's communications needs and skills (both expressive and receptive) across settings. The comprehensive review includes the individual's:

- Current methods of communication ;
- Preferred methods of communication;
- Supplementary communication methods;
- Communication methods that have proven to be effective in daily communication;
- Team's knowledge and application of the individual's current and preferred communication methods;
- Any existing documents related to communication including but not limited to, Speech and Language Pathology assessments, behavior assessments, and/or other relevant assessments; and
- Environmental elements conducive to effective communication.

The Communication Specialist may complete additional evaluations, if deemed necessary that do not fall under the scope of the Speech and Language Pathologist (SLP) and are included in the ODP required training. The Communication Specialist must collaborate with the individual, persons designated by the individual, and the individual's team for the purpose of implementing a communication plan. The plan should person-specific and include:

- The individual's best communication methods, both expressive and receptive;
- Current barriers to effective communication, including environmental elements and team knowledge and implementation in both familiar and unfamiliar settings;
- Measurable steps to address and eliminate barriers from all aspects of the individual's everyday life; and
- Recommendations for other services, if applicable.

Upon plan completion, the Communication Specialist should meet with the individual, the Supports Coordinator, and others as appropriate, including family members, providers, and employers to ensure all parties understand the plan. An in-depth review of the communication plan should be completed at the annual service plan meeting and the communication plan should be monitored for effectiveness on an ongoing basis (and updated as necessary to meet the individual's communication needs.)

The service includes:

- Assisting the individual to be a more effective and independent communicator;
- Implementing activities and strategies identified in the individual's communication plan;
- Monitoring implementation of the communication plan;
- Training, modeling, and/or coaching the support team to carry out the communication plan across all settings;
- Helping to establish, modify, or maintain environments that best support effective communication;
- Providing assistance to remove communication barriers;
- Educating SCOs, AEs, providers and other appropriate entities about a individual's specific needs related to communication access, legal responsibilities and cultural and linguistic considerations;
- Consulting with the support team, as needed;
- Routine reporting of activities, data, and/or progress;
- Identifying relevant resources for supporting effective communication;
- Maintaining communication support tool(s) for the individual such as software updates and adding or removing names, pictures, and/or information that is specific to the individual, in collaboration with a licensed SLP, when applicable; and
- Participating in in the development of and continued implementation of the individuals' ISP, as appropriate.

There may be situations where the service plan includes both Communication Specialist services and other services that address communication, such as Speech and Language Therapy, Behavior Support, and Assistive Technology. All parties responsible for implementing communication goals must collaborate to ensure goals and plans are consistent.

For individuals who utilize sign language, the provider must have the ability to sign at Intermediate Plus level or above as determined by the Sign Language Proficiency Interview. For individuals who utilize braille, the provider must have proof of appropriate training.

Teaching American Sign Language (ASL) is not covered under this service unless the "sign" that is being taught is individual-specific (sign productions unique to the individual). Traditional ASL lessons are not included in the service.

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

Additional Service Definition Clarification:

There may be cases where both Behavioral Support and Communication Specialist Services are authorized in a ISP. In these instances, the Communication Specialist should collaborate to ensure the Action Plan and the Behavior Support Specialist's plan, the Behavioral Support Plan, are consistent and do not contradict one another. The Action Plan should include information from the Behavioral Support Plan and include specific strategies that describe the individual's behaviors and how staff should respond to situations that have previously been associated with the individual's preferred communication methods in the Action Plan.

The indirect service includes those components listed as allowable in the service definition where the Communication Specialist is completing activities while the individual is not present. This includes activities such as reviewing the individual's communication needs and educating SCOs, AEs and other appropriate entities about an individual's specific needs.

Educating SCOs, AEs and others does not always need to be done in person and may be done virtually or over the phone.

Determining the need for services

- Does the individual primarily communicate in ways other than speaking and hearing words?
- Would the individual's communication (expressively and receptively) be improved if those providing support (whether unpaid or paid) were educated about the individual's unique communication needs?
- Is the individual experiencing any communication barriers (expressively or receptively) that this service could be used to help remove?
- Does the individual use behaviors to communicate?
- Does the individual require special considerations for communication due to hearing or vision loss?
- Did the individual have an assessment completed that identified a communication need?
- Did the individual have a Communication Assessment or any other assessment or professional recommendation for Communication Specialist or similar services?

Service limits:

- This service does not include any of the following activities that fall under the scope of Speech Language Pathologists unless they are provided under the direction of or in consultation with a licensed Speech Language Pathologist:
  - Preventing, screening, identifying, assessing, or treating known or suspected disorders relating to speech, feeding and swallowing, or communication disorders.
  - Screening individuals for speech, language, voice, or swallowing disorders.
  - Teaching individuals, families and other caregivers speech reading and speech and language interventions.
  - Teaching individuals, families and other caregivers and other communication partners how to use prosthetic and adaptive devices for speaking and swallowing.

- Using instrumental technology to provide nonmedical diagnosis, nonmedical treatment and nonmedical services for disorders of communication, voice and swallowing.

- The rates for the following services include Communication Specialist services: Residential Habilitation, Life Sharing and Supported Living. As such, individuals who are authorized to receive one of these services may only be authorized to receive Communication Specialist services as a discrete service when it is used to support the individual during Community Participation Support.
- The direct portion of Communication Specialist services cannot be provided at the same time as the direct portion of the following: Benefits Counseling and Consultative Nutritional services.
- To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.
- Communication Specialist services are limited to a maximum of 240 (15-minute) units, which is equal to 60 hours per individual per fiscal year. There is no limit if the service is provided as part of the Residential Habilitation, Life Sharing, or Supported Living rate.

SC documentation requirements:

- The need for Communication Specialist services should be documented in the "Communications" section of the ISP.

The procedure code and service unit for Communication Specialist Services:

Provider Type **58** – Communication Services
Specialty **582** - Communication Specialist; **583** - Communication Specialist Deaf & Hard-of-Hearing
Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0-120 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 HCSIS Description
T1013		**Communication Specialist**	This service determines the individual's communication needs and educates the individual and his or her caregivers on those needs and the best way to meet them in his or her daily life. Communication Specialist Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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 14.5: Community Participation Support

Community Participation Support provides opportunities and support for community inclusion and building interest in and developing skills and potential for competitive integrated employment. Services should result in active, valued participation in a broad range of integrated activities that build on the individual's interests, preferences, gifts, and strengths while reflecting their desired outcomes related to employment, community involvement and membership. To achieve this, each individual must be offered opportunities and needed support to participate in community activities that are consistent with the individual's preferences, choices, and interests. Each individual's preferences, choices, skills, strengths and interests may change based on their experiences, and as a result, providers must have conversations at least quarterly about community activities in which the individual would like to participate. These conversations can be more frequent than quarterly but must occur within 3 months of the previous conversation. The conversation should at a minimum inform the development of quarterly progress reports. Documentation must be completed and could be contained in services notes or progress notes.

Community Participation Support should include a comprehensive analysis of the individual in relation to the following:

• Strongest interests and personal preferences for community activities,
• Skills, strengths, and other contributions likely to be valuable to employers or the community, and
• Conditions necessary for successful community inclusion and/or competitive integrated employment.

For individuals who receive facility-based Community Participation Support services, the information for the comprehensive analysis is completed as part of the annual assessment that the facility is required to update each year and distribute to the individual, the Supports Coordinator, and others as requested by the individual.

Community Participation Support is intended to flexibly wrap around or otherwise support community life secondary to employment as a primary goal. This service involves participation in integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Providers with service locations where more than 10% of individuals who are receiving services are spending less than 25% of their time in community settings on average are required to describe the following for the service location in the provider's Quality Management Plan required by 55 Pa Code § 6100.45 and its Action Plan:

- The number/ percent of individuals not receiving at least 25% of their services in community settings,
- The number of individuals who want to increase the amount of time they spend in the community,
- Action steps for increasing time in the community for each individual identified in the previous bullet, including timeframes for achieving each action step,
- Barriers to supporting individuals with engaging in community activities, including action steps to address the barriers and timeframes for achieving each action step,
- The methods used by the provider to offer options to receive services in integrated community settings in-line with each individual's preferences, choices and interests for community activities and the frequency such options will be offered,
- Successful community experiences, such as building relationships, employment opportunities and natural supports for individuals served, and

- The staff position responsible for reviewing and updating the information demonstrating the efforts to provide exposure and opportunities to participate in community activities in the:
    - Action Plan of the Quality Management Plan, at least quarterly, and
    - Quality Management Plan, at least annually.

This service is expected to result in the individual developing and sustaining a range of valued social roles and relationships; building resources and experiences in the community; increasing independence; increasing potential for employment; and experiencing meaningful community participation and inclusion. Activities include support for the following:

- Developing skills and competencies necessary to pursue competitive integrated employment;
- Assisting individuals with contacting relevant agencies and obtaining documents needed to access employment supports and services that educate individuals on the impact of employment on current benefits. Examples of this assistance include helping an individual with contacting the Ticket to Work Help Line, obtaining their Benefits Planning Query statement from their local Social Security office, or completing other paperwork or releases that are needed to obtain services through the Work Incentives Planning and Assistance program;
- Participating in community activities, organizations, groups, associations or clubs to develop social networks;
- Identifying and participating in activities that provide purpose and responsibility;
- Fine and gross motor development and mobility;
- Participating in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, hiking group, walking group, etc.);
- Participating in community adult learning opportunities;
- Participating in volunteer opportunities;
- Opportunities focused on training and education for self-determination and self-advocacy;
- Learning to navigate the local community, including learning to use public and/or private transportation and other transportation options available in the local area;
- Developing and/or maintaining social networks and reciprocal relationships with members of the broader community (e.g. neighbors, coworkers, and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur;
- Assisting individuals, caregivers, and providers with identifying and utilizing supports not funded through the waiver that are available from community service organizations, such as churches, schools, colleges/universities and other postsecondary institutions, libraries, neighborhood associations, clubs, recreational entities, businesses and community organizations focused on exchange of services (e.g. time banks); and
- Assisting individuals and caregivers with providing mutual support to one another (through service/support exchange) and contributing to others in the community.

The service includes planning and coordination for:

- Developing skills and competencies necessary to pursue competitive integrated employment;
- Promoting a spirit of personal reliance and contribution, mutual support and community connection;
- Developing social networks and connections within local communities;

- Emphasizing, promoting, and coordinating the use of unpaid supports to address individual and family needs in addition to paid services; and
- Planning and coordinating an individual's daily/weekly schedule for Community Participation Supports.

For individuals aged 18 and older, fading of the service and less dependence on paid support for ongoing participation in community activities and relationships is expected. Fading strategies, similar to those used in Supported Employment, should be utilized whenever appropriate. Fading support is covered to increase independence for individuals for whom the provider has coordinated community activities in which the individual is supported through unpaid supports and/or as a component of the fading strategy where access to provider staff and immediate teleservices are needed as a back-up Fading support is used when an individual is engaged in a community activity that was arranged by the Community Participation Support provider but where the Community Participation Support provider staff is not physically present, and the individual is supported by unpaid supports. In these circumstances, Community Participation Support staff are on-call or providing teleservices as a back-up to the unpaid support. A staff person cannot render fading support and direct services at the same time. The use of fading support can address the health and safety of the individual to support the unpaid support in a circumstance when the unpaid support needs additional guidance to address an individual's health and safety or care needs. As outlined in Appendix D-2-a, the Supports Coordinator is responsible for verifying that fading supports are appropriate to meet the individual's needs. The provider may bill for fading support when all of the following conditions are met:

- The service is authorized in the ISP based on the ISP team determination that fading support is the most appropriate service delivery method to meet the individual's needs based on review of the following information;
    - The community activity was coordinated by the provider of Community Participation Support services;
    - The individual does not receive Residential Habilitation services;
    - The individual requires fading support for health and safety reasons;
    - The provider, in conjunction with the ISP team, has developed a back-up plan that will be implemented should there be a problem with the technology, or the needed unpaid support person is not available (See Appendix D-1-e in the Consolidated, Community Living, and Person/Family Directed Support waivers for further guidance on back-up plans);
    - The individual and/or unpaid support person(s) have been trained to successfully utilize any devices or equipment necessary for the provision of fading support. This includes training on how to turn off any device(s) or equipment if they choose to do so;
    - The provider informs the individual, and anyone identified by the individual, of what impact the fading support will have on the individual's privacy (if any). This includes the following:
        - The individual must give consent for protected health information to be shared with the unpaid support person(s), when applicable;
        - Any technology used must be HIPAA compliant; and
        - The provider will implement reasonable HIPAA safeguards to limit incidental uses or disclosures of protected health information when the individual is in community locations. This includes using lowered voices, not using speakerphone, or recommending that the individual and/or unpaid support person(s) move to a reasonable distance from others when discussing protected health information.

- Community Participation Support teleservices are available immediately to the individual and staff can be available for in person direct services within a maximum of 30 minutes (less if agreed upon by the service plan team).
- Effective communication must be provided, including use of any necessary auxiliary aids or services, to ensure that the individual can receive and convey information consistent with the requirements of the Americans with Disabilities Act. If there are impacts on the individual's privacy, the provider must then obtain either the individual's consent in writing or the written consent of a legally responsible party for the individual. This process must be completed prior to the utilization of fading support; and
- On-call staff can be available for direct service within a maximum of 30 minutes (less if agreed upon by the service plan team).

Only activities completed by direct service professionals as specified in the service definition are compensable as Community Participation Supports services.

Personal care assistance is included as a component of Community Participation Support but does not comprise the entirety of the service. The service also includes transportation as an integral component of the service, for example, transportation to a community activity. The Community Participation Support provider is not, however, responsible for transportation to and from an individual's home.

This service may be provided in the following settings:

- Community locations – Locations must be non-disability specific and meet all federal standards for home and community-based settings. When provided in community locations, this service cannot take place in licensed facilities, or any type of facility owned, leased or operated by a provider of other ODP services. Services are provided in a variety of integrated community locations that offer opportunities for the individual to achieve his or her personally identified goals for developing employment skills, community inclusion, involvement, exploration, and for developing and sustaining a network of positive relationships. To bill community codes, a maximum of 3 individuals can be served simultaneously by any one provider at a community location at any one time. When more than 3 individuals receive services by any provider at a community location at any one time, facility codes must be billed.

- Community hubs – These settings primarily serve as a gathering place prior to and after community activities. Individuals' time will be largely spent outside of the community hub, engaged in community activities.

    - Community hubs should be non-disability specific, accessible, provide shelter in inclement weather, and be locations used by the general public. Community hubs could be locations that are focused on a specialty area of interest for individual(s) served (for example, employment interest area, volunteer site, related to arts, outdoors, music or sports).

      A community hub could be a private home but is not the home of support staff or any individual employed by, or on the board or similar committee responsible for executive decisions of, the provider of the service. The individual's home may only serve as a hub on an occasional and incidental basis. The use of a community hub must be driven by the interest of the individual(s) served. A

maximum of 6 individuals can be served by any one provider at any one point in time in a community hub.

- Adult Training Facilities (subject to licensure under 55 Pa. Code Chapter 2380) – Community Participation Support may be provided in Adult Training Facilities which meet all federal standards for home and community-based settings.

- Older Adult Daily Living Centers (subject to licensure under 6 Pa. Code Chapter 11) – For individuals 60 years or older, or individuals with dementia or dementia-related conditions, Community Participation Support may be provided in Older Adult Daily Living Centers which meet all federal standards for home and community-based settings. Individuals under 60 years of age receiving services in an Older Adult Daily Living Center prior to 7/1/17 may continue to receive services in these settings.

- Vocational Facilities (subject to licensure under 55 Pa. Code Chapter 2390) – Community Participation Support may be used to provide prevocational services in Vocational Facilities. Facilities must meet all federal standards for home and community-based settings.

Facility-based prevocational services focus on the development of competitive worker traits through work as the primary training method. The service may be provided as:

- Occupational training used to teach skills for a specific occupation in the competitive labor market and includes personal and work adjustment training designed to develop appropriate worker traits and teach understanding work environment expectations.

- Work related evaluation involving use of planned activities, systematic observation, and testing to formally assess the individual, including identification of service needs, potential for employment, and employment objectives.

This service may be used to provide prevocational services in facilities and community locations. All individuals receiving prevocational services must have a competitive integrated employment outcome included in their ISP. There must be documentation in the ISP regarding how and when the provision of prevocational services is expected to lead to competitive integrated employment.

Prevocational services assist individuals in vocational skill development, which means developing basic skills and competencies necessary for an individual to pursue competitive integrated employment. This includes the development and implementation of a preliminary plan for employment that identifies the individual's basic work interests, and skills and gaps in skills for the individual’s work interests, including how those will be addressed. It may include situational assessments, which means spending time at an employer's place of business to explore vocational interests and develop vocational skills. Vocational skill development also includes identifying available transportation to help the individual get to and from work and teaching the individual and their family (as appropriate) about basic financial opportunities and benefits information for a move into competitive integrated employment.

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

Additional Service Definition Clarification:

Using Multiple Procedure Codes

When making any changes to the Community Participation Support procedure codes, ISP teams should consider including more than one procedure code in the ISP. Circumstances that would require multiple procedure codes include but are not limited to:

- Different staffing ratios based on activity and need. For example, the individual typically will be supported at a 1:2 or 1:3 ratio in community locations but there is an activity that occurs one time each week for which the individual will need 1:1.

To minimize the number of critical revisions necessary to ISPs, Supports Coordinators may calculate additional units of service for each procedure code to provide a cushion (up to approximately 10% over the expected number of units for each procedure code). Total authorizations may not exceed the P/FDS and Community Living Waiver caps or an approved P/FDS individual cap exception.

More guidance about using multiple procedure codes can be found in the following ODP communications:

- 24-040 – Version 4 of the Community Participation Support (CPS) Question and Answer Document (Q&A)
- 19-098 – Clarification on Identification of Staffing Ratios for Facility Time in Community Participation Support Service

Community Participation Support teleservices may be rendered in homes where individuals reside in accordance with the requirements listed in this manual under Teleservices on page 47. Teleservices cannot be used to provide enhanced levels of Community Participation Support because direct in-person assistance is required.

Community Participation Support teleservices may only be rendered to an individual in their Residential Habilitation home when the individual:

- Routinely (routinely means regularly, as part of the usual way of doing things) participates in Community Participation Support services in-person outside the home; and
- Has a medical or behavioral condition that precludes their in-person participation for a temporary period of time not to exceed 26 consecutive weeks.

Prevocational Services for Individuals Under the Age of 25

Individuals who are under the age of 25 are not required to be referred to OVR when they will be working on skill development and/or participating in activities for which they will not receive subminimum wage. It is not allowable, however, for these prevocational activities to occur in a licensed vocational facility unless OVR has closed their case or the individual has been determined ineligible for OVR services.

Individuals who are under the age of 25 also may not receive prevocational services that pay subminimum wage unless they have been referred to OVR and OVR has determined that the individual is ineligible for OVR services or has closed the OVR case (except if the case was closed for one of the reasons noted in the current OVR Referral Process bulletin). This includes prevocational services that pay subminimum wage in any setting including:

- A licensed Vocational Facility (55 Pa. Code Chapter 2390).
- A licensed Adult Training Facility (55 Pa. Code Chapter 2380).

- A Community Hub.
- A Community Location.
- Any service location that holds a 14c certificate.

SCs should consult Bulletin 00-19-01, *OVR Referrals for ODP Employment Related Services,* or its successor, and the waivers for the most current guidance for individuals under the age of 25 who are seeking prevocational Community Participation Support services.

Intensive Staffing Determinations

A variance form (DP 1086) must be completed and approved for the individual to receive the following levels of support:

- 1:1 enhanced staffing, 2:1 staffing and/or 2:1 enhanced staffing for Community Participation Support.

The need for these enhanced levels of service must be reviewed every 6 months and this variance form must be completed based upon that review. Please note: Enhanced levels of service are not available for Community Participation Support services provided in Older Adult Daily Living Centers.

If an individual requires supplemental staffing during this service, the Community Participation Support provider is responsible to provide the staffing.

Determining the need for services:

- Does the individual have an outcome for employment?
- Is the individual interested in developing skills and competencies necessary to pursue competitive integrated employment?
- Is the individual interested in developing skills and competencies necessary to become part of their community?
- Is the individual interested in pursuing activities that support health and wellness, lifelong learning, self-advocacy or greater connection to people, businesses, public services, and organizations in their community?
- When separate or distinct units are requested for planning and coordination, does the individual's outcome connected to the CPS service necessitate additional planning and coordination outside of standard programmatic planning?
- To determine the ability for an individual to receive enhanced and 2:1 levels of Community Participation Support, the following decision tree shall be applied:

Question 1: Does the participant have a medical or behavioral support need?

- If NO - STOP. Enhanced and 2:1 levels of service are not supported for the participant
- If YES - Proceed to Question 2 for enhanced levels of service. Proceed to Question 3 for the non-enhanced 2:1 level of service.

Question 2 (this question only applies for enhanced levels of service) - Is the participant's medical or behavioral need:

1) Severe enough that it cannot be met through the service definition as written, i.e. requires specific behavioral or medical support to access the service as written in the service definition specifications?

AND / OR

2) Of a nature that it must be met by someone with one of the licenses, certificates, or degrees specified in the qualifications?

- If NO – STOP. Enhanced levels of service are not supported for the participant.
- If YES –Proceed to Question 3.

Question 3 - Was a Waiver Variance Form completed and approved for Enhanced Levels of Service in accordance with ODP's Variance Process?

- If NO – Enhanced and 2:1 levels of service may not be added to the ISP.
- If YES – Enhanced and 2:1 levels of service may be added to the ISP.

Service limits:

- Handicapped employment as defined in Title 55, Chapter 2390 may not be funded through the Waiver.
- Prevocational services may not be funded through the Waiver if they are available to individuals through program funding under the IDEA. Documentation must be maintained in the individual's file to satisfy assurances that the service is not otherwise available through a program funded under the IDEA.
- An individual may be authorized for a maximum of 40 units of fading support per week. The cost of purchasing devices, maintenance of the devices and service fees may not be billed under this service definition.

- Community Participation Support services may not be provided at the same time as the direct provision of any of the following: Companion; In-Home And Community Supports; Small Group Employment; job finding or development and job coaching and support in Supported Employment; job acquisition and job retention in Advanced Supported Employment; Transportation; 15-minute unit Respite; Therapies; Education Support; Shift Nursing; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services.
- The direct provision of Community Participation Support as well as the fading support component shall not be rendered on the same days and times that Remote Supports is rendered.
- Community Participation Support may not be provided in a licensed Adult Training Facility or a licensed Vocational Facility that is newly funded on or after January 1, 2020 and serves more than 25 individuals in the facility at any one time including individuals funded through any source.
    - A newly funded facility is one that is applying for a new license to provide Community Participation Support under Title 55, Chapter 2380 or Chapter 2390. This includes any facility that is relocating to a new service location unless a facility already exists at that service location and holds a license to operate as the same type of CPS facility as the relocating program.
- Starting January 1, 2023, Community Participation Support services may not be provided in any facility required to hold a 2380 or 2390 license that serves more than 150 individuals at any one time, including individuals funded through any source.
- This service is generally provided between 8am to 5pm weekdays but is not restricted to those hours of the day. Alterations from typical day/work hours should be based on the individual's natural rhythms and/or preferred activities (not for convenience of a provider).
- Consolidated Waiver only – An individual may be authorized for a maximum of 14 hours per day of the following services, including teleservices (whether authorized alone or in combination with one another):
    - In-Home and Community Support.
    - Companion.
    - Community Participation Support.

  A variance may be made to the 14 hour per day limitation in accordance with ODP policy when the individual has a physical health, mental health or behavioral need that requires services be provided more than 14 hours per day.
- When Community Participation Support services are not provided with any other employment service (Small Group Employment, Supported Employment or Advanced Supported Employment) and the individual is not competitively employed, the hours of authorized Community Participation Support cannot exceed 40 hours (160 15-minute units) per individual per calendar week.
- When the individual is competitively employed, the total number of hours for Community Participation Support, Supported Employment and/or Small Group Employment (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per individual per calendar week.
- Enhanced services by a licensed nurse (1:1 Enhanced or 2:1 Enhanced, where one of the staff members is a nurse) can only be provided to adults (individuals age 21 and older). All medically necessary nursing services for children under age 21 are covered through Medical Assistance pursuant to the EPSDT benefit.
- Individuals may receive a maximum of 520 hours (2080 15-minute units) of Community Participation Support teleservices per fiscal year.

✎SC documentation requirements:

- Prevocational services may be provided without referring an individual to OVR if the individual is age 25 or older. When an individual is under the age of 25, prevocational services may only be authorized as a new service in the ISP when documentation has been obtained that OVR has closed the individual's case or that the individual has been determined ineligible for OVR services in accordance with the current OVR Referral Process bulletin.
- Individuals receiving prevocational services must have an employment outcome included in their ISP. Because these individuals have an employment outcome, the answer to "Does this consumer have employment/volunteer goals?" in the Employment/Volunteer Information section of their ISP should be "yes".
- Individuals who do not receive prevocational services should have outcomes that reflect activities supported by the Community Participation Support service such as becoming part of their community or pursuing activities that support health and wellness, lifelong learning, self-advocacy or greater connection to their community.
- The SC shall document the date that a referral to OVR was made in the Additional Comments box of the Educational/Vocational Information section of the ISP, when applicable.
- When OVR is operating under a closure of the order of selection, the SC shall follow documentation requirements as enumerated in Bulletin 00-19-02, *OVR Referrals During a Period when OVR's Order of Selection is Closed*, or its successor.
- When a provider requests separate or additional units of planning and coordination, they must describe in detail how this will achieve and/or enhance the individual's outcome(s) connected to the CPS service. The SC should indicate the specific number of units requested and at what frequency the provider intends on using it.

The procedure codes, modifiers, and service units for Community Participation Support:

Provider Type **51** – Home & Community Habilitation
Specialty **514** – Adult Training-2380; **515** – Prevocational-2390; **525** – Community Integration

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 18-120 years old;
Base Funding: 18-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
Community Participation Support (CPS) Community Procedure Codes			
W9351		Level 2 or Basic	CPS provided in community settings at a staff-to-individual ratio of 1:2 or 1:3. CPS Community 1:2 or 1:3
W9352		Level 1	CPS provided in community settings at a staff-to-individual ratio of 2:3.

			CPS Community 2:3
W5996		Level 3	CPS provided in community settings at a staff-to-individual ratio of 1:1. CPS Community 1:1
W5997	**TD or TE**	Level 3 Enhanced	CPS provided in community settings at an enhanced staff-to-individual ratio of 1:1. CPS Community 1:1 Enhanced or CPS Community 1:1 Enhcd LPN/RN
W5993		Level 4	CPS provided in community settings at a staff-to-individual ratio of 2:1. CPS Community with 2:1
W5994	**TE or TD**	Level 4 Enhanced	CPS provided in community settings at an enhanced staff-to-individual ratio of 2:1. CPS Community 2:1 Enhanced or CPS Community 2:1 Enhcd LPN/RN
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure codes above for the direct provision of the service. 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.
CPS Facility Procedure Codes			
W7222		Basic	CPS provided in facility settings at a staff-to-individual ratio of 1:11 to 1:15. CPS Facility 1:11 to 1:15
W7223		Level 1	CPS provided in facility settings at a staff-to-individual ratio of 1:7 to 1:10. CPS Facility 1:7 to 1:10
W7226		Level 2	CPS provided in facility settings at a staff-to-individual ratio of 1:4 to 1:6. CPS Facility 1:4 to 1:6
W7224		Level 3	CPS provided in facility settings at a staff-to-individual ratio of 1:2 to 1:3. CPS Facility 1:2 to 1:3
W7244		Level 4	CPS provided in facility settings at a staff-to-individual ratio of 1:1. CPS Facility 1:1

W9353	**TD or TE**	Level 4 Enhanced	CPS provided in facility settings at an enhanced staff-to-individual ratio of 1:1. CPS Facility 1:1 Enhcd or CPS Facility 1:1 Enhcd LPN/RN
W7269		Level 5	CPS provided in facility settings at a staff-to-individual ratio of 2:1. CPS Facility 2:1
W9356	**TD or TE**	Level 5 Enhanced	CPS provided in facility settings at an enhanced staff-to-individual ratio of 2:1. CPS Facility 2:1 Enhcd or CPS Facility 2:1 Enhcd LPN/RN
CPS Community Fading Support Code			
W9400			Fading support needed to fade direct support to individuals participating in community activities. CPS: Community Fading Support
Teleservices Codes for CPS: Starting No Later Than January 1, 2024			
W0065	**U1**		Community Participation Supports 1:1 to 1:5 remote
W0066	**U1**		Community Participation Supports 1:6 and above remote

Modifiers for Community Participation Support
TD – Used to identify services rendered by a RN

TE – Used to identify services rendered by an LPN

U1 - Utilized with the appropriate procedure code to allow providers, who are approved by the Department, to receive the Enhanced Communication Services Rate.

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 Community Participation Support in an Older Adult Daily Living Center:

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & 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 HCSIS Description
W7094		**Community Participation Support – Older Adult Daily Living Centers (6, Pa. Code Chapter 11)**	This service is made available to individuals in licensed Older Adult Daily Living Centers. Licen Day Hab., Older Adult Daily Living Centers
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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 14.6: Companion Services

Companion services are direct services provided to individuals age 18 and older who live in private homes for the limited purposes of providing supervision or assistance that is designed to ensure the individual's health, safety and welfare or to perform activities of daily living for the individual. This service is intended to assist the individual to participate more meaningfully in home and community life.

This service may be provided in home and community settings, including the individual's competitive employment workplace. To the extent that Companion services are provided in community settings, the settings must be inclusive rather than segregated. Companion services shall not be provided in a licensed setting, unlicensed residential setting or camp. This does not preclude this service from being utilized to assist an individual to volunteer in a nursing facility or hospital or occasionally visit a friend or family member in a licensed setting or unlicensed residential setting.

Companion services are used in lieu of In-Home and Community Support when a habilitative outcome is not appropriate or feasible (i.e. when the professional providing the service mainly does activities for the individual or supervises the individual versus assisting the individual to learn, enhance or maintain a skill). While Companion services are mainly used to provide supervision and assist with socialization, as an incidental part of the service companions may supervise, assist or even perform activities for an individual that include: grooming, household care, meal preparation and planning, ambulating, and medication administration in accordance with regulatory guidance.

This service can be used for hours when the individual is sleeping and needs supervision and/or assistance with tasks that do not require continual assistance, or non-habilitative care to protect the safety of the individual.

- For example, Companion services 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 or solely needs routine monitoring for conditions other than post-surgical care and convulsive (grand mal) epilepsy.

Caregivers with whom the individual lives may not provide Companion services when the individual has been sleeping 5 or more hours and does not require direct care or supervision during those asleep hours. When direct care or supervision is provided, the caregiver may be reimbursed.

This service can also be used to supervise individuals during socialization or non-habilitative activities when necessary to ensure the individual's safety.

Transportation necessary to enable participation in community activities outside of the home in accordance with the individual's ISP that is 30 miles or less per day is included in the rate paid to agency providers. Mileage that is needed to enable participation in community activities that exceeds 30 miles on any given day should be authorized on the ISP and billed by the agency as Transportation Mile. Transportation is not included in the wage range for Companion services provided by Support Service Professionals in individual directed services. As such, Transportation services should be authorized and billed as a discrete service. When Transportation services are authorized and billed as a discrete service (regardless of whether the services are delivered by an agency or Support Service Professional) Companion is compensable at the same time for the supervision, assistance and/or care provided to the

individual during transportation. Companion services cannot be used to solely transport an individual as this would be considered a Transportation service available in the waiver. The individual must have a need for supervision, assistance or the performance of tasks on the individual's behalf while in the home and community locations for which transportation is necessary.

Companion can only be provided to individuals age 18 and older. All medically necessary personal care is covered through Medical Assistance for individuals aged 18 to 20 pursuant to the EPSDT benefit and cannot be provided as a part of Companion services. Medically necessary personal care can only be covered for individuals aged 21 and older as a part of Companion services.

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

Companion services may also be delivered in an acute care hospital in accordance with ODP Bulletin 00-23-01.

Companion teleservices may be provided during awake hours in accordance with the requirements listed in this manual under Teleservices on page 47. Companion teleservices may not be provided during overnight asleep hours.

Determining the need for services:

- Is the individual aged 18 to 20? If yes, does the individual require medically necessary personal care?
- Does the individual need supervision or assistance to ensure their health, safety and welfare or a direct support professional to perform activities of daily living for them?
- Are Companion services to be used during overnight hours when the individual is sleeping? If so, does the individual require continual assistance or non-habilitative care to protect their safety? Is the direct support professional rendering the overnight Companion service to an individual who lives with the direct support professional? If yes, what direct care or supervision does the individual need while sleeping 5 or more hours?
- Does the individual require support with personal care needs while working in a job that meets the definition of competitive integrated employment? Can these supports be reasonably and appropriately met by coworkers within the workplace?

Service limits:

- Consolidated Waiver Only - An individual may be authorized for a maximum of 14 hours per day of the following services, including teleservices (whether authorized alone or in combination with one another):
  - In-Home and Community Support.
  - Companion.
  - Community Participation Support.

  A variance may be made to the 14 hour per day limitation in accordance with ODP policy when the individual has a physical health, mental health or behavioral need that requires services be provided more than 14 hours per day.

- Companion services that are authorized on an ISP may be provided by relatives/legal guardians of the individual. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized Companion or a combination of Companion and In-Home and Community Support (when both services are authorized in the service plan).
- Companion services may not be provided at the same time as any of the following: Small Group Employment, In-Home and Community Supports, Respite (15-minute unit or Day), Shift Nursing and the direct portion of Community Participation Support.

✎SC documentation requirements:

- The Outcomes section of the ISP must include supervision, assistance and/or care the companion will be providing and why it is necessary. This includes documentation regarding whether the direct support professional will be awake or asleep overnight and how the asleep direct support professional will assure the individual's health and safety during those overnight hours. If the direct support professional lives with the individual, Companion can only be authorized for direct care and supervision provided when the individual sleeps 5 or more hours.
- Companion may be provided at the same time as Supported Employment, Advanced Supported Employment, Residential Habilitation, Life Sharing, and Supported Living at the individual's place of community integrated employment for the purpose of supporting the individual in-person with non-skilled activities, supervision and/or personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or others and is outside the scope of the Supported Employment or Advanced Supported Employment service. Documentation must be maintained in the ISP about the methods that were considered and/or tried to support the personal care needs at the job site before it was determined that Companion was necessary to enable the individual to sustain competitive integrated employment.
- Please see section 14.19 for information about how Companion can be provided on the day an individual transitions into or out of a residential home.

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).

Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 18-120 years old
Base Funding: 18-120 years old
Allowable Place of Service: 12-Home; 21- Inpatient Hospital (🩺); 99-Other (Community)

(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope (🩺) when an individual is in the hospital.)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W1724		Basic	The provision of the service at a staff-to-individual ratio of 1:3. Companion Services (Basic Staff Support)
W1725		Level 1	The provision of the service at a staff-to-individual ratio of 1:2. Companion Services (Level 1)
W1726* 🩺		Level 2	The provision of the service at a staff-to-individual ratio of 1:1. Companion Services (Level 2)
	U1		Enhanced Communication Service - This modifier can be utilized with the Procedure Code marked with an asterisk in this table for the direct provision of this service. 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
Service Unit -15 minutes

Allowable Modifiers	Service Level	Service Description HCSIS Description
U4 Only used with W1726	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 professional as part of the wage. Companion Services (Level 2) - U4
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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 14.7: Consultative Nutritional Services

Consultative Nutritional Services are direct and indirect services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/service plan that are not covered by the Medicaid State Plan and are necessary to improve or sustain the individual's health status and improve the individual's independence and inclusion in their community. The service may include assessment, the development of a home treatment/service plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. Consultative Nutritional teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47. This service may be delivered in the individual's home or in the community as described in the service plan. This service requires a recommendation by a physician.

Training family or other caregivers and development of a home program for caregivers to implement the recommendations of the Licensed Dietitian-Nutritionist are included in the provision of this service.

Consultative Nutritional Services can only be provided to adult individuals. All medically necessary Consultative Nutritional Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Consultative Nutritional Services may only be funded for adult individuals through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the individual's insurance or insurance limits have been reached. An individual's insurance includes Medical Assistance (MA), Medicare and/or private insurance. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

Determining the need for services:

- Has this service been recommended by a physician?
- Does the ISP team have concerns about the individual's health related to malnutrition, obesity, diabetes or other conditions? If so, has the individual's physician been consulted?
- Is a service plan, including training and technical assistance around the plan, needed to meet the individual's nutritional needs?

Service limits:

- Consultative Nutritional Services are limited to 48 (15-minute) units which is equal to 12 hours per individual per fiscal year.
- This service does not include the purchase of food.
- Individuals authorized to receive Residential Habilitation, Life Sharing or Supported Living services may not be authorized to receive Consultative Nutritional Services. Please see section 14.19 for information about an exception on the day an individual transitions into or out of a residential home.
- This service cannot be provided in a provider owned, leased, rented or operated licensed or unlicensed setting (this includes hospitals and nursing homes).

- Direct Consultative Nutritional Services may not be provided at the same time as the direct provision of any of the following: Benefits Counseling; Supported Employment; Small Group Employment; Community Participation Support; 15-minute unit Respite; Shift Nursing; Communication Specialist; Transportation; Therapies; Music, Art and Equine Assisted Therapy, and Education Support.

SC documentation requirements:

- Documentation of the physician's recommendation for the service.
- Documentation of the treatment plan which should contain the following:
  - The goal(s) for the Consultative Nutritional Services;
  - The anticipated date by which the goals will be achieved; and
  - The family and/or caregivers who will be trained in implementing the recommendations in the treatment plan.

The procedure code and service units for Consultative Nutritional Services:

Provider Type **23** - Nutritionist
Specialty **230** - Registered Nutritionist
Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21 - 120 years old;
Base Funding: 21 - 120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
S9470	**SE**	Consultative Nutritional Services	This direct and indirect service is designed to assist unpaid caregivers and/or paid support staff in carrying out an individual's treatment/service plan with the goal of improving or sustaining the individual's health status and improve the individual's independence and inclusion in their community. Consultative Nutritional Services
	U1		Enhanced Communication Service - This modifier can be utilized with the Procedure Code in this table for the direct provision of this service. 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.

SE modifier - Must always be used for Consultative Nutritional Services as it is used to denote that this is an ODP waiver service.

Section 14.8: Education Support Services

Education Support consists of education and related services as defined in Sections (22) and (25) 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). To receive Education Support services through the waiver, students attending eligible institutions and who are eligible for Federal Student Aid and/or PA State Grant funding must apply. Education Support Services are limited to payment for the following:

- Tuition for adult education classes offered by a college, community college, technical school or university (institution of postsecondary education). This includes classes for which an individual receives credit, classes that an individual audits, classes that support paid or unpaid internships, remedial classes and comprehensive transition programs. At least 75% of the time the individual spends on campus must be integrated with the general student population.
- While tuition for online classes is generally excluded from reimbursement under Education Support Services, hybrid classes that are provided both in-person and online are covered under Education Support Services. This is the same for classes that are typically provided in-person but change to online due to emergency situations in alignment with the institution of postsecondary education's policy or protocol.
- General fees charged to all students. This includes but is not limited to fees such as technology fees, student facilities fees, university services fees and lab fees.
- On campus peer support. This is support provided by the institution of postsecondary education's staff (they cannot be contracted staff) or other students attending the institution of postsecondary education. The support assists the individual to learn roles or tasks that are related to the campus environment such as homework assistance, interpersonal skills and residential hall independent living skills.
- Classes (one communication education professional and one individual or a group of no more than four learners taught collectively by a communication education professional) to teach individuals who are deaf American Sign Language, Visual Gestural Communication or another form of communication. To receive this type of education, individuals must be age 21 and older or under 21 years of age with a high school diploma. The individual must also have been assessed as benefitting from learning American Sign Language or another form of communication.
- Adult education or tutoring program for reading or math instruction.

Individuals authorized for Education Support services must have an employment outcome or an outcome related to skill attainment or development which is documented in the ISP and is related to the Education Support need.

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

Additional Service Definition Clarification:

Student Aid and Other Resources for Payment

Individuals wanting to obtain a certification or a degree from an educational institution must apply for Federal Student Aid through the Free Application for Federal Student Aid (FAFSA). An online or hard copy of the application can be obtained at https://studentaid.gov/h/apply-for-

aid/fafsa. Federal Student Aid is responsible for managing the student financial assistance programs under the Higher Education Act of 1965. The programs provide grants, loans, and work-study funds to students attending college or career schools. The individual does not need to apply for FAFSA for the following reasons:

1. The individual does not have a high school diploma or a General Educational Development (GED), unless the individual is applying for a comprehensive transition and postsecondary (CTP) program.
2. The individual is not pursuing a degree or a certification.

To complete the FAFSA requirement for the Educational Support services, the individual must obtain the Student Aid Report (SAR) from FAFSA. If the individual is awarded any grants (financial aid that does not need to be repaid) such as the Pell Grant or the Federal Supplemental Educational Opportunity Grant, the individual must accept that award to pay for their post-secondary education costs. The individual can choose to accept or decline other Student Aid that is offered, such as loans or work-study. Once the individual obtains the SAR and has accepted the grants, the SC must obtain the documentation showing completion of the FAFSA.

Individuals who will be attending a CTP program need to apply for Federal Student Aid. Federal Student Aid could lead to a grant that unlike a loan, does not have to be repaid. An individual who is only applying for a CTP program, does not need to have a high school diploma or a GED to apply for FAFSA and receive grants. More information about grants and CTP programs can be accessed at https://studentaid.gov/understand-aid/eligibility/requirements/intellectual-disabilities. Further, individuals who will be attending a CTP program must be referred to OVR unless there is a closed order of selection, as expenses for CTP programs may be eligible for funding through OVR.

Individuals who have expressed a desire to attend a post-secondary education program will need to apply for FAFSA and should also be encouraged to additionally apply for scholarships.

Integration with the General Student Population

When determining whether a post-secondary education program meets the standard that the individual spends at least 75% of their time “on campus” integrated with the general student population, the individual’s time spent in the following locations and participating in the following activities that are part of the post-secondary education program must be counted:

- Classes;
- Internships;
- Housing (when the housing is part of the college program);
- Activities arranged by peer mentors or on-campus support; and
- Any other activities the individual participates in that are located on the post-secondary education program’s campus.

On-Campus Peer Supports

On-Campus Peer Supports is a component that the post-secondary education program can voluntarily choose to provide and bill as Education Support services. In addition to site-based training, On-Campus Peer Supports may include related assessments, on campus job development (finding/coaching, apprenticeships, internships, etc.), advocacy, travel instruction, and other services needed to maintain the given role (student, residential hall individual, student

employee, or student life individual). The charge for On-Campus Peer Supports is billed as a flat fee that is established by the post-secondary education program. On-Campus Peer Supports does not replace the support that the college or university is required to offer via the Office of Disability Services (also known as a 504 Accommodation). There is no cost to the individual to receive services from the Office of Disability Services if they meet the college or university's eligibility requirements.

Units of Service

When developing the ISP, the Supports Coordinator should enter units as follows:

- One unit per class in which the individual will enroll. For example, if the individual has registered for three classes, then the Supports Coordinator should enter three units of Education Support in the ISP).
- One unit of On-Campus Peer Support per semester, regardless of the number of hours of support that will be delivered during the semester.

Determining the need for services:

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

- Does the individual have an employment Outcome Statement or other Outcome Actions related to skill attainment or development in the ISP related to the Education Support Service need?
- Does the Education Support Service relate directly to the Outcome selected by the individual?
- Is the individual age 21 or younger? If yes, why isn't this service provided for the individual through the Department of Education?
- If the individual will attend a college, community college, technical school, or university, including CTP programs, was Federal Student Aid sought as specified in the Additional Service Definition Clarification section?
- Does the individual need on-campus support? If yes, will the post-secondary education program provide the support as part of their program or will the individual need discrete Companion or In-Home and Community Support services?
- Is the individual deaf and has been assessed as benefitting from learning American Sign Language or another form of communication?

Service limits:

- The provision of Education Support services may not be provided at the same time as the direct provision of any of the following: Community Participation Support; Small Group Employment; Supported Employment; job acquisition and job retention in Advanced Supported Employment; Benefits Counseling; Transportation; Therapies; Music, Art and Equine Assisted Therapy; Consultative Nutritional Services and 15-minute unit Respite. When on campus peer support is offered by the institution of postsecondary education and authorized in the service plan as Education Support, In-Home and Community Supports and Companion cannot be authorized at the same time as the on-campus peer support.
- Individuals can receive a maximum of:

  - $40,000 toward tuition for classes and general fees in the individual's lifetime for any Education Support Services received. Education Support Services received by a individual prior to January 1, 2023 count towards the lifetime limit of $40,000. For example, if an individual was at the lifetime limit prior to January 1, 2023 and needs Education Support Services after January 1, 2023, they would be eligible to receive an additional $5,000 worth of services, if needed.
  - Any Education Support services that the individual received prior to July 1, 2017 will not be counted toward this limit; and
  - $5000 per semester of on campus peer support for individuals taking at least 6 credit hours of classes per semester. On-campus peer support cannot be reimbursed through Education Support when the individual takes fewer than 6 credit hours of classes per semester.
    - Payment for on-campus peer support does not count towards the $40,000 tuition and general fees lifetime limit.
- The following list includes items excluded as Education Support services (please note this is not an exhaustive list of excluded items):
  - Room and board.
  - Payment for books.
  - Payment for recreational classes, activities and programs offered through recreational commissions, townships, boroughs, etc.
  - Tuition for adult education classes offered by online universities.
  - Tuition for online classes.
  - Tuition for adult education classes provided on disability specific campuses.

SC documentation requirements:

- Documentation of verification that services are not available for funding through OVR or available through IDEA for individuals who are still in school.
- Documentation that Federal Student Aid was applied for and granted or not granted, if the individual will attend a college, community college, technical school, or university, including CTP programs.
- When adding peer support, the number of course credits being taken *per semester* must be included.
- When attending an institution of post-secondary education, there must also be documentation that the individual will spend at least 75% of their time on campus integrated with the general student population. This documentation could include, but is not limited to, an activity schedule for the individual.
- 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.

Service Unit – Vendor Based Goods and Services
Age Limits & Funding:
Consolidated, Community Living & 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** **HCSIS Description**
W7284*		**Education Support Services**	Education Support Services consist of adult education classes offered by a college, community college, technical school or university (institution of postsecondary education). Individuals must have an employment outcome, or an outcome related to skill attainment or development which is documented in the service plan and is related to the Education Support need. Education Support Services-Outcome Based
	U1		Enhanced Communication Service - This modifier can be utilized with the Procedure Code in this table for the direct provision of this service. 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 14.9: Employment Services

Supporting individuals to achieve competitive integrated employment is a cornerstone of ODP policies, principles and practices. Act 36 of 2018, the Employment First Act, states that competitive integrated employment is "the first consideration and preferred outcome" for "working-age Pennsylvanians with a disability." Competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits like workers without disabilities performing the same work, and fully integrated with coworkers without disabilities.

In support of the Employment First Act and philosophy, ODP administers these employment-based waiver services: Advanced Supported Employment, Small Group Employment and Supported Employment. These services encourage and support individuals through a process that is expected to lead to an employment outcome.

ODP expects AEs to institute standard practices to promote employment by ensuring employment goals are reflected in the ISP when appropriate as outlined in this manual. To facilitate the conversation with individuals and families regarding employment options, all Supports Coordinators and supervisors should utilize the employment trainings and resources including the LifeCourse Toolkit and *Pathway to Employment Guidance for Conversations*. A myriad of employment resources are available on the Employment Page of the home.myodp.org website.

For services that require a referral to OVR, the Supports Coordinator should make a referral to OVR as soon as the individual mentions that they are interested in employment or is actively seeking employment for which the individual will require services to maintain. The referral process is detailed in the current *OVR Referrals for ODP Employment Related Services* bulletin or when OVR is operating under a closed order of selection, the current *OVR Referrals During a Period when OVR's Order of Selection is Closed* bulletin. The bulletin and related attachments can be found on the DHS website.

Please note: Supports Coordinators shall not make referrals to OVR simply to obtain documentation of an ineligibility determination or a closure letter in order to get employment services through the waiver. The referral is made to ensure the individual has availed themselves of the expertise of OVR in the pursuit of the goal of competitive integrated employment as the first consideration and preferred outcome for the individual.

✎SC documentation requirements for employment:

- The SC shall document all discussions regarding employment in a service note in HCSIS.
- The Employment Screen in the ISP should be filled out for all individuals who have employment services.
- Individuals receiving employment services must have an employment outcome included in their ISP. Because these individuals have an employment outcome, the answer to "Does this consumer have employment/volunteer goals?" in the Employment/Volunteer Information section of their ISP should be "yes".
- The SC shall document the date that a referral to OVR was made in the Additional Comments box of the Educational/Vocational Information section of the ISP. The SC shall also document the referral to OVR using the Supports Coordinator's Checklist for a Referral for OVR Services, which is Attachment 6 of Bulletin 00-19-01 or its successor.

Advanced Supported Employment

Advanced Supported Employment is an enhanced version of supported employment services provided by qualified providers. The service includes discovery, job development, systematic instruction to learn the key tasks and responsibilities of the position, and intensive job coaching and supports that lead to job stabilization and retention.

DISCOVERY

Discovery is a targeted service for an individual who wishes to pursue competitive integrated employment but, due to the impact of their disability, their skills, preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments that compare the individual to others or arbitrary standards of performance and/or behavior.

Discovery involves a comprehensive analysis of the individual in relation to the following:

- Strongest interests toward one or more specific aspects of the labor market;
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment; and
- Conditions necessary for successful employment or self-employment.

Discovery includes the following activities: observation of the individual in familiar places and activities, interviews with family, friends and others who know the individual well, observation of the individual in an unfamiliar place and activity, identification of the individual's strong interests, and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the individual and others who know the individual well, and observation of the individual during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized competitive integrated employment or self-employment.

JOB ACQUISITION

Job development, which can include customized employment or self-employment, is based on individualizing the employment relationship between employees and employers and negotiating on behalf of the individual in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the individual.

Systematic instruction refers to a strategic, carefully planned sequence for instruction, from simple to complex, with clear and concise objectives driven by ongoing assessment. It is carefully thought out and designed before work commences.

JOB RETENTION

Intensive job coaching includes assisting the individual in meeting employment expectations, performing business functions, addressing issues as they arise, and includes travel training and diversity training to the specific business where the individual is employed. It provides support to assist individuals in stabilizing a competitive integrated job (including self-employment) including ongoing support and may include activities on behalf of the individual to assist in maintaining job placement.

Eligibility for Advanced Supported Employment is limited to individuals whose preferences, skills, and employment potential cannot be best determined through traditional, standardized means due to the impact of their disability. Specifically, the individual:

1. Has been found ineligible for or has a closed case with Office of Vocational Rehabilitation (OVR) services and chooses not to be re-referred or it has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, then OVR services are considered to not be available to the individual; and
2. Has never had job skills training or development, has never had any work related experiences (including volunteer experiences) or in the past 2 years, with the use of Supported Employment services, has not been able to secure a competitive integrated job or has not been able to keep a competitive integrated job for more than 6 months; and
3. Meets one of the following criteria:
    a. Is currently in an activity receiving a sub-minimum wage; or
    b. After consulting with a credentialed provider, it is the opinion of the service plan team that the level of support provided through this service is needed to secure sustained competitive integrated employment.

In the event that OVR closes the order of selection, the following process will be followed from the effective date until the closure is lifted:

- A individual who has been referred to OVR but does not have an approved Individualized Plan for Employment (IPE) may receive Advanced Supported Employment.
- An individual who has not been referred to OVR may receive Advanced Supported Employment without a referral to OVR.

In addition to the criteria above, to be eligible for job development, systematic instruction or intensive job coaching under Advanced Supported Employment, the individual must have received the discovery service under Advanced Supported Employment through its completion or the completion of the discovery/profile phase through OVR and the case was closed.

Advanced Supported Employment is paid on an outcome basis. Providers are paid for three separate outcomes.

1. Discovery Profile – The production of a detailed written Discovery Profile, using a standard template prescribed by the Department or one that meets the professional credential required for this service, which summarizes the process, learning and recommendations to inform identification of the individual's individualized goal(s) and strategies to be used in securing competitive integrated employment, and the production of a visual resume and individualized plan for employment, using a standard template prescribed by the Department or one that meets the professional credential required for this service.
2. Securing a Job – A job evidenced by an offer letter, email, documented phone call or other documentation from an employer offering the individual employment that meets the definition of competitive integrated employment or evidence of self-employment.
3. Retention of Job – Successful retention on the job, evidenced by the individual working a minimum of 5 hours per week for at least 4 months.

Discovery activities may be provided within a variety of settings including residential habilitation settings when identified as a need in the service plan or vocational facilities and adult training facilities when these facilities are where the individual's employment or volunteer experience occurred that is being assessed and when identified as a need in the ISP.

Behavioral Support may be provided at the same time as Advanced Supported Employment if the need is documented in the ISP.

Companion may be provided at the same time as Advanced Supported Employment for the purpose of supporting the individual with non-skilled activities, supervision and/or incidental personal care that cannot, or would be inappropriate to, be provided with the support from coworkers or other natural supports and is outside the scope of the Advanced Supported Employment service. Documentation must be maintained in the ISP about the methods that were considered and/or tried to support the non-skilled activities, supervision and/or incidental personal care at the job site before it was determined that Companion was necessary to enable the individual to sustain competitive integrated employment.

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

Additional Service Definition Clarifications:

- The Centers for Medicare and Medicaid Services (CMS) defines self-employment as the operation of a trade or business by an individual or by a partnership in which an individual is a member.

- When developing the ISP, the Supports Coordinator should enter one unit for each Advanced Support Employment outcome (one unit for Discovery Profile, one unit for Job Acquisition, one unit for Job Retention). The Supports Coordinator can insert more than one Advanced Support Employment outcome in the ISP if the planning team determines that the outcomes should be achieved within the next year.

- The individual is not required to receive all three outcomes from the Advanced Supported Employment service. The Discovery Profile outcome is required to be received through Advanced Supported Employment prior to receiving the Job Acquisition outcome or Job Retention outcome, unless a discovery profile has already been completed by OVR and OVR later closed the case. An individual could choose to receive the Discovery Profile and Job Acquisition outcome through Advanced Supported Employment and then choose to receive job coaching through Supported Employment.

Determining the need for services:

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

- Is this individual interested in competitive integrated employment?
- Does the individual meet the following criteria?
    - OVR referral criteria has been met per ODP Bulletin 00-19-01, 00-19-02 or their successors;

    - Has never had job skills training or development, has never had any work related experiences (including volunteer experiences) or in the past 2 years, with the use

of Supported Employment services, has not been able to secure a competitive integrated job or has not been able to keep a competitive integrated job for more than 6 months; and

  - Meets one of the following criteria:
    - Is currently in an activity receiving a sub-minimum wage; or
    - After consulting with a credentialed provider, it is the opinion of the ISP team that the level of support provided through this service is needed to secure sustained competitive integrated employment.
- Prior to adding job acquisition or job retention to the ISP, has a Discovery profile been developed for the individual through Advanced Supported Employment, or has a Discovery profile been completed through OVR and the case was closed?

Service limits:

- The direct provision of job acquisition activities may not be provided in a vocational facility or adult training facility.
- Job retention activities may not be provided in a Vocational Facility (55 Pa. Code Chapter 2390), Adult Training Facility (55 Pa. Code Chapter 2380), Child Residential Rehabilitation Services for the Mentally Ill (55 Pa. Code Chapter 5310) or any licensed or unlicensed home that provides residential habilitation services funded by ODP.
- The direct provision of job acquisition and job retention may not be provided at the same time as the direct provision of any of the following: In-Home and Community Supports; Community Participation Support; Small Group Employment; Benefits Counseling; 15-minute unit Respite; Transportation; Therapies; Education Support and Music, Art and Equine Assisted Therapy.
- Individuals authorized to receive Advanced Supported Employment services may not also be authorized to receive Supported Employment services during the same time period. For example: If an individual is authorized for Supported Employment from 7/1/2022-11/1/2022, they may not be authorized for Advanced Supported Employment for any point in time, including hours, days, or weeks, during that date segment.
- Advanced Supported Employment services furnished under the waiver may not include services available under section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17).

SC documentation requirements:

- The SC must document that the individual has a closed case or is ineligible for OVR services, or that OVR services are not available. SCs should refer to bulletin 00-19-01 or its successor for specific documentation requirements for the ISP and information on what documentation must be kept in the individual's file.
- When OVR is operating under a closure of the order of selection, the SC will follow documentation requirements as enumerated in Bulletin 00-19-02, *OVR Referrals During a Period when OVR's Order of Selection is Closed,* or its successor.

The procedure code and service unit for Advanced Supported Employment:

Provider Type **53** - Employment-Competitive
Specialties: **534** – Supported Employment
Service Unit – Outcome Based

Age Limits & Funding:
Consolidated, Community Living & 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 HCSIS Description
W7235	**UD**		Discovery Profile Outcome: This service involves a comprehensive analysis of the individual's skills and interests to prepare the individual for employment or self-employment. Adv Supp Emplymnt-Discovery
H2023	**UD**		Job Acquisition Outcome: This service is focused on matching the needs of the employer with the assessed strengths, skills, needs, and interests of the individual, with the goal of helping the individual find competitive integrated employment (or self-employment). Adv Supp Emplymnt-Job Acquisition
H2025	**UD**		Job Retention Outcome: This service provides support to assist individuals in stabilizing a competitive integrated job (including self-employment). Adv Supp Emplymnt-Job Retention >= 4 Mths
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure codes above for the direct provision of this service. 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.

UD modifier - Must be used for Advanced Supported Employment services as it is used to denote that this is an ODP service.

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 – UD
2nd – U1

Small Group Employment

Small Group Employment services are direct services consist of supporting individuals in transitioning to competitive integrated employment through work that occurs in a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations such as an integrated industry, business, or community setting. The goal of Small Group Employment services is acquisition of knowledge, skills and experiences that lead to competitive integrated employment, including self-employment. Individuals receiving this service must have a competitive integrated employment outcome included in their service plan, and it must be

documented in the service plan how and when the provision of this service is expected to lead to competitive integrated employment. Work that individuals perform during the provision of Small Group Employment services must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work.

Small Group Employment service options include mobile work force, work station in industry, affirmative industry, and enclave. Each of these options are delivered in integrated business, industry or community settings that do not isolate individuals from others in the setting who do not have disabilities. Services must be provided in a manner that promotes engagement in the workplace and interaction between individuals and people without disabilities including co-workers, supervisors, and customers, if applicable.

Small Group Employment services are only billable when the individual is receiving direct support during the time that he or she is working and receiving wages through one of these options or during transportation to a work site.

A Mobile Work Force uses teams of individuals, supervised by a training/job supervisor, who conduct service activities at a location 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 work standards. A Work Station in Industry is an employment station arranged and supported by a provider within a community business or industry site, not within a licensed facility site. An example would be three seats on an assembly line within a computer chip assembly factory. The provider has a contract with the business to ensure that those three seats are filled by adults with disabilities that they support.

Affirmative Industry is a business that sells products or services where at least 51% of the employees do not have a disability. Supervisory personnel and staff of providers who are paid to render the Small Group Employment service cannot be counted in the percentage of employees who do not have a disability.

Enclave is a business model where a small group of individuals with a disability are employed by a business/industry to perform specific job functions while working alongside workers without disabilities.

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

Small Group Employment includes supporting the individual with personal care needs that cannot, or would be inappropriate to, be provided with the support from coworkers or others.

Small Group Employment services may not be rendered under the Waiver until it has been verified that the service is not available in the student’s (if applicable) complete and approved

Individualized Education Program (IEP) developed pursuant to IDEA. Documentation must be maintained in the file of each individual receiving Small Group Employment services to satisfy this state assurance.

Small Group Employment services may be provided without referring an individual to OVR as OVR does not provide Small Group Employment services.

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

Additional Service Definition Clarification:

- Individuals who are receiving the Affirmative Industry or Enclave options of the Small Group Employment service may be paid directly by their employers. As stated in the service definition, individuals receiving the Mobile Work Force or Work Station options will be paid by the provider of the service.
- Since Small Group Employment is not employment that is in a fully integrated setting, employment through the Small Group Employment service is not considered competitive integrated employment.

Determining the need for services:

The following additional questions should be used to establish a determination of need for Small Group Employment services:

- Does the individual receive minimum wage or higher? If the individual receives below minimum wage, Community Participation Support must be chosen.
- Is this individual currently successful (meeting or exceeding outcome actions) in a prevocational environment?
- Would the individual benefit from a supportive environment to increase appropriate work skills?

Service limits:

- Individuals authorized to receive Small Group Employment services may not receive the direct portion of the following services at the same time: In-Home and Community Supports; Companion; Community Participation Support; 15-minute unit Respite; Supported Employment; job acquisition and job retention in Advanced Supported Employment; Benefits Counseling; Transportation; Therapies; Education Support; Music, Art and Equine Assisted Therapy, and Consultative Nutritional services.
- When Small Group Employment services are not provided with any other employment service (Supported Employment, Advanced Supported Employment and/or Community Participation Support) the hours of authorized Small Group Employment cannot exceed 40 hours (160 15-minute units) per individual per calendar week.
- When Small Group Employment services are provided in conjunction with Supported Employment and/or Community Participation Support the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per individual per calendar week.
- Small Group Employment may not be provided in an Adult Training Facility or a Vocational Facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations.

- Federal financial participation cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
    - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services; or
    - Payments that are passed through to users of small group employment services.
- Small Group Employment services are only billable when the individual is receiving direct support during the time that the individual is working and receiving wages through one of the four service options or during transportation to a work site.

SC documentation requirements:

- If the individual is a student with a complete and approved Individualized Education Program (IEP), documentation must be maintained in the individual's file verifying that Small Group Employment services are not available to the individual through his or her IEP. The SC shall contact a school official to confirm and record that conversation in a service note.
- Progress needs to be documented such that the trainer is phased out as the individual meets established production goals in work station and affirmative industry.
- The employment/volunteer information section of the ISP must be completed for individuals receiving employment services, including that competitive integrated employment was discussed as a priority before Small Group Employment services were considered.

The procedure codes and service units for Small Group Employment Services:

Provider Type **51** - Home & Community Habilitation
Specialty **516** - Transitional Work Services
Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & 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 HCSIS Description
W7237		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:10 to >1:6. Small Group Employment (Base)-15 min
W7239		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5. Small Group Employment (Level 1)-15 min
W7241		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1. Small Group Employment (Level 2)-15 min
W7245		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 1:1. Small Group Employment (Level 3)-15 Mins
	U1		Enhanced Communication Service - This modifier can be utilized with all the Procedure Codes in this

			table for the direct provision of this service. 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.

Supported Employment

Supported Employment services are direct and indirect services that are provided in a variety of community settings for the purposes of supporting individuals in obtaining and sustaining competitive integrated employment. Supported Employment teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47. Competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits like workers without disabilities performing the same work, and fully integrated with coworkers without disabilities.

Supported Employment services include activities such as training and additional supports including worksite orientation, job aide development, coordination of accommodations and ensuring assistive technology that may be needed by the individual to obtain and sustain competitive integrated employment is utilized as specified in the plan. Payment will be made only for the training and supports required by the individual and will not include payment for the training or supervisory activities that should be rendered as a normal part of the job.

Supported Employment services consist of three components: career assessment, job finding or development, and job coaching and support.

CAREER ASSESSMENT

Career assessment is a person-centered, individualized employment assessment used to assist in the identification of potential career options, including self-employment, based upon the interests and strengths of the individual. Career assessment may include discovery activities and may be provided within a variety of settings, including residential habilitation settings when identified as a need in the service plan, or vocational facilities and adult training facilities when these facilities are where the individual's employment or volunteer experience occurred that is being assessed and when identified as a need in the service plan. Career assessment activities, on average, should be authorized for no longer than 6 consecutive months and should result in the development of a career assessment report. When an individual requires career assessment activities in excess of 6 consecutive months, an explanation of why the activities are needed for an extended period of time should be included in the service plan.

Career assessment includes:

- Gathering and conducting a review of the individual's interests, skills, and work or volunteer history.
- Conducting situational assessments to assess the individual's interest and aptitude in a particular type of job.
- Conducting informational interviews.
- Identifying types of jobs in the community that match the individual's interests, strengths and skills.
- Assisting individuals with contacting relevant agencies and obtaining documents needed to access employment supports and services that educate individuals on the impact of

employment on current benefits. Examples of this assistance include helping an individual with contacting the Ticket to Work Help Line, obtaining their Benefits Planning Query statement from their local Social Security office, or completing other paperwork or releases that are needed to obtain services through the Work Incentives Planning and Assistance program.

- Developing a career assessment report that specifies recommendations regarding the individual's needs, interests, strengths, and characteristics of potential work environments. The career assessment report must also specify training or skills development necessary to achieve the individual's career goals.

JOB FINDING OR DEVELOPMENT

Job finding or development includes employer outreach and orientation, job searching, job development, resume preparation and interview assistance. Other activities may include participation in individual planning for employment, development of job-seeking skills, development of job skills specific to a job being sought, job analysis, assisting individuals with contacting relevant agencies and obtaining documents needed to access employment supports and services that educate individuals on the impact of employment on current benefits, consulting with the Office of Vocational Rehabilitation (OVR), benefits counseling agencies, or Ticket to Work employment networks on behalf of an individual, or self-employment assistance. Job finding or development may be provided in a variety of settings including residential habilitation settings when identified as a need in the ISP. The direct portion of job finding or development may not be provided in a vocational facility or adult training facility. Examples of this assistance include helping an individual with contacting the Ticket to Work Help Line, obtaining their Benefits Planning Query statement from their local Social Security office, or completing other paperwork or releases that are needed to obtain services through the Work Incentives Planning and Assistance program.

Job finding or development may include customized job development. Customized job development means individualizing the employment relationship between employees and employers in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the individual, either through task reassignment, job carving, or job sharing. Job finding or development may also include negotiating the conditions for successful employment with a prospective employer including tasks, wages, hours and support.

JOB COACHING AND SUPPORT

Job coaching and support consists of training the individual on job assignments, periodic follow-up, or ongoing support with individuals and their employers. This may include systematic instruction. 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 include direct intervention with an employer, employment-related personal skills instruction, support to re-learn job tasks, training to assist individuals in using transportation to and from work, worksite orientation, job aide development, coordination of accommodations, assisting individuals with contacting relevant agencies and obtaining documents needed to access employment supports and services that educate individuals on the impact of employment on current benefits, ensuring assistive technology is utilized as specified in the plan, maintenance of appropriate work and interpersonal behaviors on the job, follow-along services at the work site after OVR-funded services are discontinued or OVR referral requirements are satisfied, and technical assistance and instruction for the individual's

coworkers that will enable peer support. Examples of this assistance include helping an individual with contacting the Ticket to Work Help Line, obtaining their Benefits Planning Query statement from their local Social Security office, or completing other paperwork or releases that are needed to obtain services through the Work Incentives Planning and Assistance program.

Job coaching and support may not be provided in a vocational facility, adult training facility, Child Residential and Day Treatment Facilities (55 Pa. Code Chapter 3800), Community Residential Rehabilitation Services for the Mentally Ill residential programs (55 Pa. Code Chapter 5310) or any licensed or unlicensed home that provides residential habilitation services funded by ODP.

As part of an individual's ongoing use of job coaching and support, the provider will develop a fading plan or fading schedule within 6 months of the first day of service delivery. The fading plan or fading schedule will address how use of this service will decrease as the individual's productivity and independence on the job increases and as unpaid supports through coworkers and other on-the-job resources are developed. Ongoing use of job coaching and support is limited to providing supports for individuals not otherwise available through the employer such as support offered through regular supervisory channels, reasonable accommodation required under the Americans with Disabilities Act, available and appropriate unpaid supports, or on-the-job resources available to employees who do not have a disability.

Supported Employment services may not be rendered under the Waiver until it has been verified that:

- The services are not available in the student's (if applicable) complete and approved Individualized Education Program (IEP) developed pursuant to IDEA;
- OVR has closed the individual's case or has stopped providing services to the individual;
- It has been determined that OVR services are not available. If OVR has not made an eligibility determination within 120 days of the referral being sent, or a individual has received an offer of competitive integrated employment prior to OVR making an eligibility determination, then OVR services are considered to not be available to the individual; or
- The individual is determined ineligible for OVR services.

A individual does not need to be referred to OVR if:

- The individual is competitively employed and solely needs extended supports to maintain the individual's current job.
- The individual is competitively employed and is seeking job assessment or job finding services to find a new job, unless the purpose is job advancement which can be provided by OVR.

In the event that OVR closes the order of selection, the following process will be followed from the effective date until the closure is lifted:

- An individual who has been referred to OVR but does not have an approved Individualized Plan for Employment (IPE) may receive Supported Employment.
- An individual who has not been referred to OVR may receive Supported Employment without a referral to OVR.

Documentation referenced above must be maintained in the file of each individual receiving Supported Employment services.

It is not allowable for providers of Supported Employment services to also be the employer of the individual to whom they provide Supported Employment services.

Behavioral Support may be provided at the same time as Supported Employment if the need is documented in the ISP.

Companion services may be provided at the same time as Supported Employment for the purpose of supporting the individual with non-skilled activities, supervision and/or incidental personal care that cannot, or would be inappropriate to, be provided with the support from coworkers or others and is outside the scope of the Supported Employment service. Documentation must be maintained in the ISP about the methods that were considered and/or tried to support the non-skilled activities, supervision and/or incidental personal care needs at the job site before it was determined that Companion services were necessary to enable the individual to sustain competitive integrated employment.

Supported Employment services can be delivered in Pennsylvania and in states contiguous to Pennsylvania. The direct portion of this service may be delivered in any state when an individual is traveling out of state for work-related trips such as for training, conferences, or business trips that are directly related to their employment.

Additional Service Definition Clarifications:

- Supported Employment services may not be used to help an individual secure, learn and maintain a volunteer experience. Community Participation Support, however, may be used to help an individual secure, learn and maintain a volunteer experience.

- If after 3-4 months of volunteering at that position, Supported Employment/Career Assessment could be utilized to observe and document/describe the individual's skills/aptitude and interests in that volunteer experience and conduct informational interviews with the people with whom the individual volunteers. The information gained through the observations and informational interviews would become part of the person's Discovery Profile or career assessment report.

Determining the need for services:

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

- Is this individual interested in competitive integrated employment (which includes self-employment)?
- Has the individual had any prior work experience? (Individuals may use this service regardless of whether they have prior work experience. When the individual does not have any prior work experience the ISP team is encouraged to discuss whether Supported Employment or Advanced Supported Employment is the best service to meet the individual's employment goals.)
- Is the individual currently competitively employed and solely needs extended supports to maintain their current job?
- Is the individual currently competitively employed and is seeking career assessment or job finding services to find a new job?
- Is the individual seeking career advancement?

- Is this individual currently meeting or exceeding Outcome actions in a prevocational or small group employment 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 they successfully maintain competitive integrated employment with support?
- If the individual is receiving ongoing job coaching and support, what does the fading plan or schedule say?

Service limits:

- Job coaching and support may not be provided in a vocational facility, adult training facility, Child Residential and Day Treatment Facilities (55 Pa. Code Chapter 3800), Community Residential Rehabilitation Services for the Mentally Ill residential programs (55 Pa. Code Chapter 5310) or any licensed or unlicensed home that provides residential habilitation services funded by ODP.
- 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.
- The direct portion of Supported Employment may not be provided at the same time as the direct portion of any of the following: In-Home and Community Supports; 15-minute unit Respite; Small Group Employment; Benefits Counseling; Transportation; Therapies; Education Support; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services. Transportation costs associated with driving the individual to and from activities related to Supported Employment are included in the rate for this service. As such, providers of Supported Employment services are responsible for any needed transportation of the individual to complete Supported Employment activities, except for driving the individual to their place of employment.
- The direct provision of job finding and development and job coaching and support may not be provided at the same time as Community Participation Support.
- Individuals authorized to receive Supported Employment services may not be authorized to receive Advanced Supported Employment during the same time period.
- When an individual is authorized for Job Finding and Development, the SC, in conjunction with the individual and ISP team, should discuss whether a small amount of Job Coaching and Support should also be authorized on the ISP. The team could request approval for a reasonable amount of Job Coaching and Support to cover the timeframe that Job Coaching and Support may be needed after the individual obtains competitive integrated employment, but prior to the approval on the ISP of the ongoing use of the service with the accurate frequency and duration. Under these circumstances, Job Coaching and Support can be authorized for up to 40 hours and must fall within the cap of the waiver, if applicable.
- When Supported Employment services are not provided with any other employment service (Small Group Employment, Advanced Supported Employment or Community Participation Support) and the individual is not competitively employed, the hours of

authorized Supported Employment cannot exceed 40 hours (160 15-minute units) per individual per calendar week based on a 52-week year.
- When Supported Employment services are provided in conjunction with Community Participation Support and/or Small Group Employment the total number of hours for these services (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per individual per calendar week based on a 52-week year.
- When the individual is competitively employed, the total number of hours for Supported Employment, Community Participation Support and/or Small Group Employment (whether utilized alone or in conjunction with one another) cannot exceed 50 hours (200 15-minute units) per individual per calendar week based on a 52-week year.

SC documentation requirements:

- Career assessment activities, on average, should be authorized no longer than 6 consecutive months and should result in the development of a career assessment report. When an individual requires career assessment activities in excess of 6 consecutive months, an explanation of why the activities are needed for an extended period of time should be included in the ISP.
- The provision of job finding and development services will be evaluated during individual monitoring by the SC to assess the continued need for the service and whether the service is assisting the individual with the outcome of finding community employment. If the service is not assisting the individual with this outcome, the SC will convene an ISP team meeting to identify changes to the Supported Employment service to realize this outcome or other service options to meet the individual's needs.
- The provision of job coaching and support services, including the fading plan, 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 SC must document that the individual has a closed case or is ineligible for OVR services, or that OVR services are not available. SCs should refer to bulletins 00-19-01 (or its successor) and 00-19-02 for specific documentation requirements for the ISP and information on what documentation must be kept in the individual's file.
- When an OVR referral has been made, the SC must keep a copy of the letter from OVR that documents whether the individual is eligible or ineligible for OVR services or that 120 calendar days have passed since the individual was referred to OVR and no eligibility determination was made, in the individual's file.
- When OVR is operating under a closure of the order of selection, the SC shall follow documentation requirements as enumerated in Bulletin 00-19-02, *OVR Referrals During a Period when OVR's Order of Selection is Closed,* or its successor.

The procedure code and service unit for Supported Employment Services:

Provider Type **53** - Employment-Competitive
Specialty: **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).

Service Unit – 15 minutes
Age Limits & Funding:
Consolidated, Community Living & 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 HCSIS Description
W7235*		Basic	Career Assessment: This service is used to assist in the identification of potential career options, including self-employment, based upon the interests and strengths of the individual. Supported Employment - Career Assessment Staffing Ratio – 1:1
H2023*		Basic	Job Finding and Development: This service, includes employer outreach and orientation, job searching, job development, resume preparation and interview assistance. Supported Emplymnt-Job Finding/Job Development Staffing Ratio – 1:1
H2025		Basic	Job Coaching and Support: This service consists of training the individual on job assignments, periodic follow-up, or ongoing support with participants and their employers. Supported Emplymnt-Job Support-1:2 Staffing Ratio – 1:2
W9794*		Level 1	Job Coaching and Support: This service consists of training the participant on job assignments, periodic follow-up, or ongoing support with individuals and their employers. Supported Emplymnt-Job Support - 1:1 Staffing Ratio – 1:1
	U1		Enhanced Communication Service - This modifier should be utilized with all of the Procedure Codes in this table for the direct provision of this service. 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
Service Unit – 15 minutes

Allowable Modifiers	Service Level	Service Description HCSIS Description
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 professional as part of the wage. Supported Employment - Career Assessment-U4 Supported Emplymnt-Job Finding/Job Development-U4 Supported Emplymnt-Job Support - 1:1 - U4
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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

Section 14.10: Family/Caregiver Training and Support

This service provides training (which could include specific training events, workshops, seminars, or conferences) and counseling services for unpaid family members or caregivers who provide support to an individual. For purposes of this service an unpaid family member or caregiver is defined as any person who provides uncompensated care, training, guidance, companionship or support to the individual such as a family member, spouse, neighbor, friend, partner, companion, or coworker.

This service is intended to develop, strengthen and maintain healthy, stable relationships among the individual and all members of the individual's informal network, to support achievement of the goals in the individual's ISP. Family/Caregiver Training and Support also assists the individual's unpaid family member or caregiver with developing expertise so that they can help the individual acquire, retain or improve skills that lead to meaningful engagement and involvement with others and in the community.

Family/Caregiver Training and Support services are intended to increase the likelihood that the individual will remain in or return to the family or unpaid caregiver's home, or so that the individual will successfully live in their own home or apartment in the community.

Family/Caregiver Training and Support services must be aimed at assisting unpaid family members or caregivers who support the individual to understand and address the individual's needs and strengthen the relationship between the individual and caregiver. Family/Caregiver Training and Support services must be necessary to achieve the expected outcomes identified in the individual's ISP and must be related to the role of the unpaid family member or caregiver in supporting the individual in areas specified in the ISP.

Emphasis in the Family/Caregiver Training and Support service may address such areas as:

- The acquisition of coping skills by building upon the strengths of the individual and unpaid family member or caregiver;
- Supporting unpaid family members or caregivers to support the individual during times of difficulty, crisis, loss, change, and transition;
- Working with unpaid family members or caregivers to improve communication with and support of one another;
- Coaching unpaid family members or caregivers in acquiring healthy approaches to reducing stress and balancing responsibilities; and
- Other areas so that all unpaid family members or caregivers can most effectively support the desired outcomes of the individual as described in the ISP.

Family/Caregiver Training and Support may include instruction about treatment regimens and other services included in the ISP and includes updates as necessary to safely maintain the individual at home and in the community during transitions throughout the lifespan. Services must be aimed at assisting the unpaid family member or caregiver in meeting the needs of the individual, and all training and counseling needs must be included in the ISP. The Family/Caregiver Training and Support provider must provide this service in a manner consistent with the individual's Behavior Support Plan (which incorporates the crisis intervention plan).

In addition to services available from a qualified provider, Family/Caregiver Training and Support may also be achieved through the unpaid family member or caregiver's attendance at specific training events, workshops, seminars or conferences by payment of registration and training fees, provided the formal instruction is relevant to the individual's needs as identified in the ISP.

The Family/Caregiver Training and Support provider must maintain documentation on strategies, interventions and progress relating to the stated goals of the service as indicated in the ISP.

Training and counseling provided to unpaid family members or caregivers may be delivered in Pennsylvania and in states contiguous to Pennsylvania. Registration fees for training opportunities may occur anywhere.

Payment or reimbursement for costs of travel, meals, and/or overnight lodging is not a covered expense.

Additional Service Definition Clarification:

- Family/Caregiver Training and Support is only available to family members and other caregivers who are not paid to provide services, except for transportation. Family members and other caregivers who are only paid to provide transportation can use the service. Family members and other caregivers who are paid to provide any other services should receive training about the individual from their employer.

Determining the need for services:

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

- How will the service develop, strengthen, and maintain healthy, stable relationships for the individual?
- How will the service support achievement of the goals/outcomes in the individual's ISP? What strategies, interventions and progress related to the goals/outcomes of the service have been documented by the provider?
- How will the service assist the individual's unpaid family member or caregiver with developing expertise so that they can help the individual acquire, retain, or improve skills that lead to meaningful engagement and involvement with others, including members of their community?
- Is the training or counseling relevant to the individual's needs as identified in the ISP?

Service limits:

- The amount of training and counseling provided to unpaid family members or caregivers is limited to a maximum of 80 (15-minute) units which is equal to 20 hours per individual per fiscal year.
    - In the event that these services would be needed beyond this limit to assure the individual's health and welfare, based on the unpaid family member or caregiver's request or provider assessment that additional services would be needed, the SC will

convene an ISP meeting to explore alternative resources to assure the individual's health and welfare through other supports and services.

- The amount of training or registration fees for the unpaid family member or caregiver's registrations costs at specific training events, workshops, seminars or conferences is limited to $500 per individual per fiscal year, provided the formal instruction is relevant to the individual's needs as identified in the ISP.
  - This cannot be used for lodging, meals or transportation.
- This service may not be provided in order to train or counsel paid caregivers. The waiver may not pay for services for which a third party, such as the family members' health insurance, is liable. Family/Caregiver Training and Support services do not duplicate mental health services to treat mental illness that Medical Assistance provides through a 1915(b) waiver (Behavioral HealthChoices).
- Individuals who are authorized to receive Residential Habilitation or Life Sharing services may not be authorized to receive Family/Caregiver Training and Support. Please see section 14.19 for information about an exception on the day an individual transitions into or out of a residential home.

SC documentation requirements:

- Documentation from the provider on strategies, interventions and progress relating to the stated goals of the service as indicated in the ISP.
- 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 Family/Caregiver Training and Support (Training and Counseling Services):

Provider Type **51** - Home & Community Habilitation, **19** - Psychologist
Specialty **117** – Licensed Social Worker; **122** – Marriage & Family Counselor; **190** – General Psychologist; **202** – Family Psychologist

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. Individuals who self-direct their services may have claims submitted by provider type 54, specialties 540 and 541, for the asterisked procedure codes below.)

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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 HCSIS Description

90846*	**SE**	Participant not present during provision of service	Training and counseling services for unpaid family members or caregivers who provide support to an individual. Fmly/Crgvr Spprt-Cnslng-no Participant Present
90847*	**SE**	Participant present during the provision of service	Training and counseling services for unpaid family members or caregivers who provide support to an individual. Fmly/Crgvr Spprt-Cnslng-w/Participant Present Staffing Ratio – 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with the Procedure Codes in this table for the direct provision of this service. 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.

SE Modifier - Must always be used for Family/Caregiver Training and Counseling (direct service, not the registration and training fees) as it is used to denote that this is an ODP service.

The procedure code and service units for Family/Caregiver Training and Support (Fees for Training Events):

Provider Type **55** – Vendor
Specialty **533** - Educational Service (this should be used for registration and fees for unpaid family members or caregivers to attend seminars, workshops, training events, etc.)

Provider Type **51** - Home & Community Habilitation,
Specialty **117** – Licensed Social Worker; **122** – Marriage & Family Counselor; **190** – General Psychologist; **202** – Family Psychologist (this should be used for registration and fees for unpaid family members or caregivers to attend seminars, workshops, training events, etc.)

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 or the rendering vendor may submit a claim directly for the procedure code W7062 for the registration and fees covered under this service. 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.)

Service Unit: Vendor Based Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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 HCSIS Description
W7062		Family/ Caregiver Training	Registration and training fees for family member or caregivers to attend training events, workshops, seminars, or conferences. Family/Caregiver Support-Training and Support

◊ Section 14.11: Family Medical Support Assistance

The Family Medical Support Assistance service assists with management of services in the individual's private home related to the medical needs of individuals with a Needs Group 3 or higher who use medically necessary technology and require nursing. This is a direct and indirect service that does not involve direct care. Providers are required to render the following two components of the service.

1. Family support assistant - Provides assistance to individuals and their families with scheduling and communication between and among unpaid supports and paid services such as skilled nursing services, home health services, medical services, and behavioral health services in the individual's home including:
    - Supporting the family with coordinating and scheduling medical and behavioral health appointments and assisting with medical visits (both in office and via remote technology);
    - Understanding the concerns of the individual, family and other designated persons about medical providers or services and assisting with mitigating those concerns when possible;
    - Directly assisting the individual, family and other designated person(s) with the discharge process from a hospital, clinic, or nursing home setting with going home.
        - The discharge process may include accompanying the family and other designated person(s) when bringing the individual home if transportation is an issue, assisting with obtaining discharge information and educating the family, other designated person(s) and the individual on the discharge information, and ensuring that the individual's home is set up for home care and treatment based on the individual's needs;
    - Assisting with communication with insurance providers to facilitate understanding of coverage of needed medical services;
    - Assisting in obtaining, organizing and maintaining necessary inventory of needed medication, supplies, and equipment;
    - Identifying barriers that prevent individuals from accessing effective and necessary medical services and supports and collaborate with ISP team members regarding possible ways to reduce those barriers;
    - Providing training and consultative assistance on implementation of non-medical aspects of the ISP to the family or Children Youth and Family supervised family and team members; and
    - Training staff and unpaid supports coming into the home on non-medical aspects of the ISP and roles and responsibilities of team members in implementation of non-medical aspects of the ISP.

Nursing Oversight – This is different than shift nursing rendered through the waivers or skilled nursing rendered through Medical Assistance state plan. Shift nursing rendered through the waivers and skilled nursing rendered through Medical Assistance state plan provide only for direct nursing services. Nursing oversight does not involve the provision of direct nursing services. Nursing oversight is completed by a licensed nurse and includes the following:

- Assessment of the individual's medical condition;
- Completion of Health Risk Screening Tool Clinical Reviews in accordance with ODP protocols;

- Identification of training needs related to the individual's medically complex condition and providing training to the individual, unpaid caregivers, and paid professionals;
- Training and consultative assistance on implementation of medical aspects of the ISP to the family or Children Youth and Families supervised family and team members;
- Training staff and unpaid supports coming into the home on medical aspects of the ISP and roles and responsibilities of team members of implementation of medical aspects of the ISP;
- Helping the individual, family and any other designated persons or waiver service providers understand the individual's medical condition and impact on the individual's behavioral or emotional health;
- Consulting with doctors and other healthcare professionals; and
- Supervision and evaluation of the individual's medical and/or behavioral health needs or anything that maintains the individual's best state of health.

The family support assistant and nurse who provides the nursing oversight work as a team to:

- Support each individual, family and other supporters and service providers.
- Communicate with the Supports Coordinator on a regular basis to ensure that the ISP is up-to-date and that the Supports Coordinator is aware of any needed coordination, location, and/or monitoring of supports and services that fall under the scope of the Supports Coordination service.
    - Professionals rendering the Family Medical Support Assistance service must work collaboratively with the individual's Supports Coordinator and ISP team.

Determining the need for services:

- The individual has medical needs and has a Needs Group 3 or higher who use medically necessary technology and requires nursing.
    - The individual's medical needs require assistance with the management of multiple medical services and supports.

Service limits:

- Family Medical Support Assistance may not replace the role of or perform the functions of a Supports Coordinator. No duplicate payments will be made**.**

- The family support assistant may provide this or any other service to no more than 8 individuals.

- A licensed nurse may provide this or any other service to no more than 16 individuals.

- Family Medical Support Assistance is available to individuals who live in private homes.

    - This service is not available to individuals who receive Life Sharing, Supported Living or Residential Habilitation services.

- Relatives who do not live with the individual or are not responsible for direct care of the individual may render this service.

- Family Medical Support Assistance may not be used to provide direct care to the individual.

SC documentation requirements:

- There must be documentation that the individual:
- has a Needs Group 3 or higher
- uses medically necessary technology and
- requires nursing.

The procedure code and service unit for:

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

Specialty **092** - Family Health

Service Unit:
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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 HCSIS Description
W0064	U1	1:1	Family Medical Support Assistance 1:1

Modifier U1 - This modifier can be utilized for the direct provision of this service. 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 14.12: Home Accessibility Adaptations

Home accessibility adaptations are an outcome-based vendor service that consists of certain modifications to the private home of the individual (including homes owned or leased by parents/relatives with whom the individual resides and Life Sharing homes that are privately owned, rented, or leased by the host family/life sharer or individual). The modification(s) must be necessary due to the individual's disability or medical needs, to ensure the health, security of, and accessibility for the individual, or which enable the individual to function with greater independence in the home.

For Individuals who need home accessibility adaptations to transition from an institutional setting to a private home (including a Life Sharing home) the adaptations can occur no more than 180 days prior to the individual moving into their residence. A provider or OHCDS may not bill for home accessibility adaptations until the individual moves out of the institutional setting and into the individual's residence.

Home modifications consist of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition.

All modifications shall meet the applicable standards of manufacture, design, and installation and shall be provided in accordance with applicable building codes.

The following are covered as modifications to a household:

- Accessible alerting systems for smoke/fire/CO2 for individuals with sensory impairments.
- Widened doorways, landings, and hallways.
- Handrails that are considered a structural home modification.
- An additional doorway needed to ensure the safe egress of the individual during emergencies, when a variance is approved by the ODP Regional Office.
- Swing clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Replacement of glass windowpanes with a shatterproof or break resistant material for individuals with behavioral issues as noted in the individual's ISP.
- Slip resistant flooring.
- Kitchen counter, major appliance, sink and other cabinet modifications.
- Modifications to existing bathrooms for bathing, showering, toileting and personal care needs.
- Bedroom modifications of bed, wardrobe, desks, shelving, and dressers.
- Workroom modifications to desks and other working areas.
- Modifications needed to accommodate an individual's special sensitivity to sound, light or other environmental conditions.

In addition to the modifications listed above, the following home accessibility adaptations are also included for individuals with medical needs for any of the following:

- Air conditioning for rooms frequently accessed by the individual if the individual has a medical need for specific temperature regulation.
- Electrical rewiring if the individual needs life-support equipment.
- Installation of specialized electric and plumbing systems that are necessary to accommodate the individual's medical equipment and supplies.

- Installation of flooring supports needed to support the weight of the individual's medical equipment.

For home accessibility durable medical equipment used by individuals with a mobility impairment to enter and exit their home or to support activities of daily living covered by medical assistance in the state plan (such as ramps, lifts, stair glides, handrails, and grab bars), Home Accessibility Adaptations shall only include the following:

- Extended warranties for the home accessibility durable medical equipment.
- Repairs needed as a result of the installation, use or removal of the home accessibility durable medical equipment or appliance.
- Any of the following required to install home accessibility durable medical equipment:
    - Adding internal supports such that the support requires access to the area behind a wall or ceiling or underneath the floor to install home accessibility durable medical equipment.
    - Constructing retaining walls or footers for a retaining wall if needed to install home accessibility durable medical equipment.
    - Modifications to an existing deck.
    - Widening a doorway.
    - Upgrades to the home's electrical system.
    - Demolition of drywall or flooring.

Home Accessibility Adaptations do not include modifications that:

- Are not specifically identified in the service definition.
- Are not of direct medical or remedial benefit to the individual.
- Are not needed as a result of the individual's medical needs or disability.
- The family or caregiver would be expected to make for an individual without a disability.
- Are for general maintenance of the home.
- Are part of room and board.
- Have a primary benefit for a caregiver, staff person, family member, or the public at large.
- Are used in the construction of a new home or any new room in the home.
- Are durable medical equipment.

Adding total square footage to the home is excluded from this service, unless an adaptation to an existing bathroom is needed to complete the home accessibility adaptation (e.g., necessary to configure a bathroom to accommodate a wheelchair).

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

This service must be delivered in Pennsylvania.

Additional Service Definition Clarification:

ODP Announcement 21-064 and Medical Assistance bulletin 09-21-04 provide additional information about the expanded coverage of home accessibility durable medical equipment through the Medical Assistance state plan for individuals with a mobility impairment.

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

Service limits:

- Maximum state and federal funding participation is limited to $20,000 per individual during a 10-year period. The 10-year period begins with the first utilization of authorized Home Accessibility Adaptations. A new $20,000 limit can be applied when the individual moves to a new home or when the 10-year period expires.
    - This service may only be used to adapt the individual's primary residence. In situations of joint custody (as determined by an official court order) or other situations where an individual divides their time between official residences in Pennsylvania, the adaptations must be allowable services and must be completed within the overall monetary limit of $20,000 for this service.

- A variance may be made to the $20,000 limit when approved by ODP for maintenance or repair to existing home accessibility adaptations when it is not covered by a warranty or homeowners insurance and the maintenance or repair is more cost effective than replacing the home accessibility adaptation.

- Individuals authorized to receive Residential Habilitation services may not be authorized to receive Home Accessibility Adaptations.

SC documentation requirements:

- At least three bids must be obtained for Home Accessibility adaptations that cost more than $1,000. The least expensive bid must be chosen, unless there is documentation from the ISP team that justifies not choosing the lowest bid. If three contractors, companies, etc., cannot be located to complete the Home Accessibility Adaptations, documentation of the contractors or companies contacted must be kept in the individual's file.
- 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 individual.

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

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.

Service Unit: Vendor Based Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 12-Home

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W7279*	**Home Accessibility Adaptations**	This service consists of modifications to the private home of the individual. The modification(s) must be 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. Maximum limit for home adaptations is $20,000 per individual for a 10-year period. Home Accessibility Adaptations

Section 14.13: Homemaker/Chore

Homemaker/Chore services are provided to individuals who live in private homes.

HOMEMAKER

Homemaker services enable the individual or the family member(s) or friend(s) with whom the individual resides to maintain their primary private home. Homemaker Services include cleaning and laundry, meal preparation, and other general household care. Homemaker services also include infection control measures and intensive cleaning such as cleaning medical equipment and disinfecting the home.

CHORE

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

Homemaker/Chore services can only be provided in the following situations when there is no other relative, caregiver, landlord, community/volunteer agency, provider agency staff, or third-party payer that is capable of or responsible for the provision:

1. When an individual and household members are temporarily unable to perform Homemaker/Chore functions covered under the service definition. Examples include:
    - If an individual has a temporary medical need due to a hospitalization or from a surgery, and as a result, the caregiver does not have time to perform the Homemaker/Chore functions due to the increased care needs of the individual.
    - If the caregiver who usually performs the Homemaker/Chore functions has a temporary medical condition that renders them unable to perform the Homemaker/Chore functions. There is no one else that is capable of or responsible for the provision of the Homemaker/Chore functions.
    - The household member who usually performs the Homemaker/Chore functions is temporarily absent and there is no one else that is capable of or responsible for the provision of the Homemaker/Chore functions.
2. When an individual or household member is permanently unable to perform the Homemaker/Chore functions. Examples include:
    - The individual has a medical need or disability that requires constant direct care which results in the caregiver not having time on a routine basis to perform Homemaker/Chore functions.
    - The caregiver has more than 1 child and Homemaker/Chore services would enable the caregiver to spend more time providing care to the child individual who has a medical need or disability.

The ISP team is responsible for determining whether a person is temporarily or permanently unable to perform the Homemaker/Chore functions. The ISP team's determination must be documented in the ISP.

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 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 the function?
- Is any other relative, caregiver, landlord, community/volunteer agency or third-party payer capable of or responsible for their provision?

Service limits:

- Homemaker and Chore services are limited to 40 hours per individual per fiscal year when the individual or family member(s) or unpaid caregiver(s) with whom the individual resides is temporarily unable to perform the homemaker/chore functions. A person is considered temporarily unable when the condition or situation that prevents him or her from performing the homemaker/chore functions is expected to improve. There is no limit when the individual lives independently or with family members or unpaid caregivers who are permanently unable to perform the homemaker/chore functions.
- A person is considered permanently unable when the condition or situation that prevents them from performing 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 the homemaker/chore functions. The ISP team's determination should be documented in the ISP.
- Individuals authorized to receive Homemaker/Chore services may not be authorized to receive the following services as Homemaker/Chore tasks are built into the rates for these services: Residential Habilitation Services, Life Sharing or Supported Living. Please see section 14.19 for information about an exception on the day an individual transitions into or out of a residential home.

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 the homemaker functions. See the service limits section for more guidance.
- Homemaker services: The SC will document what the homemaker will be doing and continue to monitor that the tasks are occurring.
- Chore services: The SC will document what the chore service provider will be doing and continue to monitor that the tasks are occurring.
- For rental properties, the SC should examine the lease agreement and document any findings of that examination.

The procedure code and service unit for Homemaker 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).

Service Unit: 1 hour
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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** **HCSIS Description**
W7283*	**UA**	Homemaker (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 the function; and no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision. All temporary Homemaker and Chore services are limited to 40 hours per fiscal year. Homemaker, Temporary-1 Hour
W7283*		Homemaker (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 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 the functions. Homemaker, Permanent-1 Hour

Modifier UA – Must be used to identify that the Homemaker service is a temporary service.

Service Unit: 1 hour
Provider Type **54**, Intermediate Service Organization
Specialty **540**, ISO-Agency With Choice

Allowable Modifiers	**Service Level**	**Service Description** **HCSIS Description**

U4*	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 professional as part of the wage. Homemaker Temporary-1 Hour-U4 Homemaker Permanent-1 Hour-U4

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

The procedure code and service unit for Chore Services:

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

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

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

Service Unit: 1 hour
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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** **HCSIS Description**
W7282*	**UA**	Chore (Temporary)	Indirect services needed to maintain the home in a clean, sanitary, and safe condition. This service may only be provided when the individual, or anyone else in the household, is temporarily incapable of physically performing the function; and no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision. All temporary Homemaker and Chore services are limited to 40 hours per fiscal year. Chore, Temporary-1 Hour
W7282*		Chore (Permanent)	Indirect services needed to maintain the home in a clean, sanitary, and safe condition. This service may only be provided when the individual, or anyone else in the household, is permanently incapable of physically performing 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 the functions. Chore, Permanent-1 Hour

Modifier UA – Must be used to identify that the Chore service is a temporary service.

Service Unit: 1 hour
Provider Type **54**, Intermediate Service Organization
Specialty **540**, ISO-Agency With Choice

Allowable Modifiers	**Service Level**	**Service Description** **HCSIS Description**
U4*	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 professional as part of the wage. Chore, Temporary-1 Hour-U4 Chore, Permanent-1 Hour-U4

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 14.14: Housing Transition and Tenancy Sustaining Services

This service includes pre-tenancy and housing sustaining supports to assist individuals in being successful tenants in private homes owned, rented or leased by the individuals.

Housing Transition services are direct and indirect services provided to individuals. Indirect activities that cannot be billed include driving to appointments, completing service notes and progress notes, and exploring resources and developing relationships that are not specific to an individual's needs, as these activities are included in the rate. The following direct and indirect activities are billable under Housing Transition:

- Conducting a tenant screening and housing assessment that identifies the individual's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
- With the individual, developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the individual's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
- Assisting with the process of searching for a home that is in an integrated setting that is dispersed in the community in a noncontiguous location not located on a campus setting. Housing transition cannot be used to find homes that are in any development or building where more than 25% of the apartments, condominiums or townhouses have ODP waiver funded individuals residing.
- Assisting with the housing application process, including assistance with applying for housing vouchers/applications.
- Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.
- Ensuring that the living environment is safe and ready for move-in.
- Assisting in arranging for and supporting the details of the move.
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized to assist individuals with planning, locating and maintaining a home of their own.
- Assistance with establishing and building a relationship for community integration.
- Assistance with obtaining and identifying resources to assist the individual with financial education and planning for housing. Activities include assistance with budgeting for house and living expenses. Assistance with completing applications for subsidies or other entitlements such as energy assistance, or public assistance. Assistance with identifying financial resources to assist with housing for the individual including special needs trusts and ABLE accounts.
- Working with the Supports Coordinator and service plan team to identify needed assistive technology (such as home security devices) or home accessibility adaptations, which are necessary to ensure the individual's health and well-being.
- Assistance with coordinating the move from a congregate living arrangement or from a family home to a more independent setting; providing training on how to be a good tenant.
- Working collaboratively with other service providers and unpaid supports.
- Assistance with identifying resources to secure household furnishings and utility assistance. Activities will include identifying and coordinating resources that may assist

with obtaining a security deposit, first month rent, or any other costs associated with the transition.

This service is also available to support individuals to maintain tenancy in a private home owned, rented or leased by the individual. The availability of ongoing housing-related services in addition to other long-term services and supports promotes housing success, fosters community integration and inclusion, and develops a network of relationships. These tenancy support services are:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- Education and training on the role, rights and responsibilities of the tenant and landlord.
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
- Assistance with activities such as supporting the individual in communicating with the landlord and/or property manager; developing or restoring interpersonal skills in order to develop relationships with landlords, neighbors and others to avoid eviction or other adverse lease actions; and supporting the individual in understanding the terms of a lease or mortgage agreement.
- Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
- Assistance with the housing recertification process.
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

This service can be delivered in Pennsylvania.

Determining the need for services:

- Is the individual interested in moving into a home, apartment, condominium, etc., that the individual will own, rent or lease (independently or with roommates)?
  - If yes, does the individual need assistance searching for a home, completing paperwork, locating resources, etc.?
- Is the individual currently residing in a home, apartment, condominium, etc., that the individual owns, rents or leases (independently or with roommates)?
  - If yes, does the individual need support through tenancy sustaining services?

Service limits:

- Housing Transition and Tenancy Sustaining services are limited to 640 (15-minute) units, which is equal to 160 hours per individual per fiscal year.
- Tenancy support services may not be authorized for individuals who are authorized to receive Residential Habilitation, Life Sharing or Supported Living services. Housing Transition services may be authorized when the individual has a plan to move from the home where Residential Habilitation or Life Sharing is provided into a private home that the individual will own, rent or lease.

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

SC documentation requirements:

- Housing Transition: The SC will document what the service provider will be doing and continue to monitor that the tasks are occurring.
- Tenancy Sustaining Services: The SC will document what the service provider will be doing and continue to monitor that the tasks are occurring.

The procedure code and service unit for Housing Transition and Tenancy Sustaining Services:

Provider Type **51** - Home & Community Habilitation
Specialty **571**, Home Finding

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 16 - 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 HCSIS Description
H0043			Pre-tenancy and housing sustaining supports to assist individuals in being successful tenants in private homes owned, rented or leased by the individuals. Housing Transition/Tenancy Sustaining services Staffing Ratio – 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with the Procedure Code in this table for the direct provision of this service. 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 14.15: In-Home and Community Support

In-Home and Community Support is a direct service provided in home and community settings to assist participants in acquiring, maintaining and improving the skills necessary to live in the community, to live more independently, and to participate meaningfully in community life. To the extent that In-Home and Community Support is provided in community settings, the settings must be inclusive rather than segregated.

Services consist of assistance, support and guidance (physical assistance, instruction, prompting, modeling, and positive reinforcement) in the general areas of self-care, health maintenance, decision making, home management, managing personal resources, communication, mobility and transportation, relationship development and socialization, personal adjustment, participating in community functions and activities and use of community resources. The type and amount of assistance, support and guidance are informed by the assessed need for physical, psychological and emotional assistance established through the assessment and person-centered planning processes. The type and amount of assistance are delivered to enhance the autonomy of the participant, in line with his or her personal preferences and to achieve their desired outcomes.

The In-Home and Community Support provider must provide the level of services necessary to enable the participant to meet their outcomes. This includes ensuring the following assistance, support and guidance (prompting, instruction, modeling, positive reinforcement) will be provided to the participant as needed to enable them to:

1. Carry out activities of daily living such as personal grooming and hygiene, dressing, making meals, maintaining a clean environment.
2. Learn and develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying through prescribed therapies and exercises, awareness and avoidance of risk including environmental risks, exploitation and abuse; responding to emergencies in the home and community such as fire or injury; knowing how and when to seek assistance.
3. Manage their medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, and keeping health logs and records. This may also include assistance, support and guidance in the administration of medications in accordance with applicable regulatory guidance, positioning the individual, taking vital statistics, performing range of motion exercises as directed by a licensed professional, applying prescribed treatments and monitoring for seizure activity.
4. Manage their mental health diagnosis and emotional wellness including self-management of emotions such as disappointment, frustration, anxiety, anger, and depression; applying trauma informed care principles and practices; and accessing mental health services. This includes implementation of the Behavior Support component of the plan, the Crisis Intervention component of the plan and/or the Skill Building component of the plan which may involve collecting and recording the data necessary to evaluate progress and the need for revisions to the plan.
5. Participate in the development and implementation of the service plan and to direct the person-centered planning process including identifying who should attend and what the desired outcomes are.
6. Manage their home including locating a private home, arranging for utility services, paying bills, routine home maintenance, and home safety.
7. Achieve financial stability through activities such as; managing personal resources, general banking and balancing accounts, record keeping and managing savings accounts and utilizing programs such as ABLE accounts.

8. Communicate with providers, caregivers, family members, friends and others face-to-face and through the use of the telephone, correspondence, the internet, and social media. The service may require knowledge and use of sign language or interpretation for individuals whose primary language is not English.
9. Develop and maintain relationships with members of the broader community (examples include but are not limited to: neighbors, coworkers, friends and family) and to manage problematic relationships.
10. Exercise rights as a citizen and fulfill their civic responsibilities such as voting and serving on juries; attending public community meetings; to participate in community projects and events with volunteer associations and groups; to serve on public and private boards, advisory groups, and commissions, as well as develop confidence and skills to enhance their contributions to the community.
11. Participate in preferred activities of community life such as shopping, going to restaurants, museums, movies, concerts, dances and faith-based services.
12. Make decisions including providing guidance in identifying options/choices and evaluating options/choices against a set of personal preferences and desired outcomes. This includes assistance with identifying supports available within the community.
13. Use a range of transportation options including buses, trains, cab services, driving, and joining carpools, etc.
14. Develop their personal interests, such as hobbies, appreciation of music, and other experiences the individual enjoys or may wish to discover.
15. Identification of risk to the individual and the implementation of actions such as reporting incidents as required by ODP, the Older Adults Protective Services Act, the Adult Protective Services Act and the Child Protective Service Law, applicable regulations and/or calling emergency officials for immediate assistance.
16. Successfully parent their child(ren). This includes assessing parenting competency, as well as modeling and teaching parenting skills such as discipline techniques, child development, health and safety issues and decision-making skills.

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

Staff providing the In-Home and Community Support must be awake during overnight hours for the purpose of performing tasks that require continual assistance as identified in the service plan to ensure medical or behavioral stability and that are able to be performed by a trained non-medically licensed individual. These tasks include the following:

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

If the individual only needs supervision or assistance with tasks that do not meet the criteria above such as evacuation in the event of an emergency during overnight hours, the appropriate service during this time is Companion services.

Transportation necessary to enable participation in community activities outside of the home in accordance with the individual's ISP is included in the rate paid to agency providers. Mileage that is needed to enable participation in community activities that exceeds 30 miles on any given day should be authorized on the ISP and billed by the agency as Transportation Mile. Transportation is not included in the wage range for In-Home and Community Support services provided by Support Service Professionals in individual directed services. As such, Transportation services should be authorized and billed as a discrete service. When Transportation services are authorized and billed as a discrete service (regardless of whether the services are delivered by an agency or Support Service Professional) In-Home and Community Support is compensable at the same time for the supervision, assistance and/or care provided to the individual during transportation. In-Home and Community Support services cannot be used to solely transport an individual as this would be considered a Transportation service available in the waiver. The individual must have a need for assistance, guidance or support with tasks while in the home and community locations for which transportation is necessary.

In general, this service is provided in an individual's private home, other community setting, or in an acute care hospital when the individual is hospitalized. In-Home and Community Support shall not be provided in a licensed setting, unlicensed residential setting or camp. This does not preclude this service from being utilized to assist an individual to volunteer in a nursing facility or hospital or occasionally visit a friend or family member in a licensed setting or unlicensed residential setting.

In-Home and Community Support services may also be delivered in an acute care hospital, in accordance with ODP Bulletin 00-23-01.

When In-Home and Community Support is provided to an individual who is younger than 18 years of age, this service may only be used to provide extraordinary care. Relatives and legally responsible individuals are responsible to meet the needs of an individual who is younger than 18 years of age, including the need for assistance and supervision typically required for children at various stages of growth and development. In-Home and Community Support may only be used to meet the exceptional needs of the individual who is under age 18 that are due to their disability and are above and beyond the typical, basic care for a child that all families with children may experience.

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:

- In-Home and Community Support services shall not be rendered in a property or a room owned, rented, or leased by providers with the purpose of providing services solely to individuals with a disability. This does not preclude this service from being utilized to assist

an individual to volunteer in a nursing facility or hospital or visit a friend or family member in a licensed setting or unlicensed residential setting.

- There are no restrictions on how many people with disabilities are present at a community location in which In-Home and Community Support is provided. However, we must be careful that we do not create segregated environments and experiences within public spaces.

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

In-Home and Community Support teleservices cannot be used to provide overnight or enhanced levels of service because direct in-person assistance is required. In-Home and Community Support teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47.

Determining the need for services:

- Is the outcome of this service for the individual to learn, acquire, maintain and/or improve a skill?
- What are the specific skills the individual needs to acquire maintain or improve?
- Is there a measurable Outcome?
- 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?

Enhanced levels of service and the non-enhanced 2:1 level of service where the direct service professional does not have a degree - To determine the ability for an individual to receive enhanced and 2:1 levels of In-Home and Community Support, the following decision tree shall be applied:

Question 1 - Does the individual have a medical or behavioral support need?

- If NO - STOP. Enhanced and 2:1 levels of service are not supported for the individual
- If YES - Proceed to Question 2 for enhanced levels of service. Proceed to Question 3 for the non-enhanced 2:1 level of service.

Question 2 (this question only applies for enhanced levels of service) - Is the individual's medical or behavioral need:

1) Severe enough that it cannot be met through the service definition as written, i.e. requires specific behavioral or medical support to access the service as written in the service definition specifications?

AND / OR

2) Of a nature that it must be met by someone with one of the licenses, certificates, or degrees specified in the qualifications?

- If NO – STOP. Enhanced levels of service are not supported for the individual.
- If YES – Enhanced levels of service are supported for the participant. Proceed to Question 3 for 2:1 enhanced levels of staffing. Add 1:1 Enhanced levels of service to the ISP.

Question 3 (applies to both levels of 2:1 staffing, non-enhanced and enhanced) - Was a *Waiver Variance Form* completed and approved for Enhanced Levels of Service in accordance with ODP's Variance Process?

- If NO – 2:1 levels of service (enhanced or non-enhanced) may not be added to the ISP.
- If YES – Enhanced and 2:1 levels of service may be added to the ISP.

Service limits:

- Consolidated Waiver Only - An individual may be authorized for a maximum of 14 hours per day of the following services, including teleservices (whether authorized alone or in combination with one another):
  - In-Home and Community Support.
  - Companion.
  - Community Participation Support.

  A variance may be made to the 14 hour per day limitation in accordance with ODP policy when the individual has a physical health, mental health or behavioral need that requires services be provided more than 14 hours per day.

- In-Home and Community Support services that are authorized on an ISP may be provided by relatives and legal guardians of the individual. When this occurs, any one relative or legal guardian may provide a maximum of 40 hours per week of authorized In-Home and

Community Support or a combination of In-Home and Community Support and Companion (when both services are authorized in the service plan).

- Individuals who are authorized to receive Residential Habilitation, Life Sharing or Supported Living services may not be authorized to receive In-Home and Community Support. Please see section 14.19 for information about an exception on the day an individual transitions into or out of a residential home.
- In-Home and Community Support services may not be provided at the same time as the direct provision of any of the following: Respite (15-minute and Day); Companion; Community Participation Support; Small Group Employment; Supported Employment; job acquisition and job retention in Advanced Supported Employment and Shift Nursing.
- To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.
- Enhanced services by a licensed nurse (1:1 Enhanced or 2:1 Enhanced, where one of the staff members is a nurse) can only be provided to adults (individuals age 21 and older). All medically necessary nursing services for children under age 21 are covered through Medical Assistance pursuant to the EPSDT benefit.

SC documentation requirements:

- The Outcomes section of the ISP must include the assistance, support and guidance (prompting, instruction, modeling, reinforcement) the individual needs as part of this service.
- For 2:1 staffing (both enhanced and non-enhanced), the individual's behavioral or medical need for this level of staffing must be documented in the ISP.
- For enhanced levels of service (2:1 and 1:1), the individual's behavioral or medical need for this level of staffing as well as the license(s), certificate(s) or degree(s) that direct service professionals must possess to provide the enhanced level(s) of service must be documented in the ISP.

The procedure codes, modifiers, and service units for In-Home and Community Support 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).

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 21- Inpatient Hospital (🩺); 99-Other (Community)

(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope (🩺) when an individual is in the hospital.)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W7058		Basic	The provision of the service at a staff-to-individual ratio range of 1:3. In-Home & Commnty Supprts (Basic)
W7059		Level 1	The provision of the service at a staff-to-individual ratio range of 1:2. In-Home & Commnty Supprts (Lvl 1)
W7060*		Level 2	The provision of the service at a staff-to-individual ratio of 1:1. In-Home & Commnty Supprts (Lvl 2)
W7061*		Level 2 Enhanced	The provision of the service at a staff-to-individual ratio of 1:1 with a staff member who is certified or has a bachelor's degree or is a nurse. In-Home & Commnty Supprts (Lvl 2 Enh)
	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. In-Home & Commnty Supprts (Lvl 2 Enh) RN or LPN
W7068*		Level 3	The provision of the service at a staff-to-individual ratio of 2:1. In-Home & Commnty Supprts (Lvl 3)
W7069*		Level 3 Enhanced	The provision of the service at a staff-to-individual ratio of 2:1 with one staff member who is certified or has a bachelor's degree or is a nurse and one staff member with at least a high school diploma. In-Home & Commnty Supprts (Lvl 3 Enh)
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 with one staff member who is a nurse and one staff member with at least a high school diploma. In-Home & Commnty Supprts (Lvl 3 Enh) RN or LPN
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Procedure Codes and modifiers in this table for the direct provision of this service. 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.

Modifier TD – Must be used when the service is provided by a Registered Nurse (RN).
Modifier TE – Must be used when the service is provided by a Licensed Practical Nurse (LPN).

Service Unit: 15 minutes
Provider Type **54** - Intermediate Service Organization

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

Allowable Modifiers	Service Level	Service Description
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 professional 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.
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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 14.16: Music Therapy, Art Therapy and Equine Assisted Therapy

Direct therapy services provided to an individual who may or may not have a primary diagnosis of mental illness, but who could benefit by the provision of therapy to maintain, improve or prevent regression of the individual's condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community. Music and Art Therapy teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47. Services and intended benefit must be documented in the ISP. Therapy services consist of the following individual and group therapies for no more than 4 individuals that are not primarily recreational or diversionary:

- Art Therapy;
- Music Therapy; and
- Equine Assisted Therapy.

The initial session of Music Therapy, Art Therapy or Equine Assisted Therapy must include an assessment of the individual's need for the service. If additional sessions are indicated following the assessment of need, therapists providing these services must develop a treatment plan that reflects individualized, attainable goals to be achieved during the remaining sessions.

Music Therapy and Art Therapy can only be provided to adults (individuals age 21 and older). All Music Therapy and Art Therapy for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Music Therapy and Art Therapy may only be funded for adults through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the individual's insurance, insurance limitations have been reached, or the service is not covered by Medical Assistance or Medicare or limitations for Medical Assistance or Medicare have been reached. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Equine Assisted Therapy can be provided to individuals of any age as it is not covered by Medical Assistance. For school age individuals, Supports Coordinators must document that Equine Assisted Therapy is not covered through the individual's individualized education plan (IEP) or through the individual's insurance (if the individual has private insurance coverage in addition to Medical Assistance).

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

Determining the need for services:

- Could the individual benefit from the provision of therapy to maintain, improve or prevent regression of their condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community?
- What does the treatment plan developed by the provider recommend in regard to additional sessions?

Service limit:

- Music Therapy, Art Therapy and Equine Assisted Therapy may not be provided at the same time as the direct provision of the following: Community Participation Support;

Small Group Employment; Supported Employment; Advanced Supported Employment; Benefits Counseling; 15-minute unit Respite; Transportation; Therapies; Education Support and Consultative Nutritional Services.

- The cumulative maximum limit of any combination of Music Therapy, Art Therapy, or Equine Assisted Therapy, including teleservices is 104 (15-minute) units which is equal to 26 hours per individual per fiscal year.

SC documentation requirements:

- Services and intended benefit must be documented in the ISP.
- Music Therapy and Art Therapy may only be funded for adults through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and either not covered by the individual's insurance, insurance limitations have been reached, or the service is not covered by Medical Assistance or Medicare or limitations for Medical Assistance or Medicare have been reached.
- For school age individuals, Supports Coordinators must document that Equine Assisted Therapy is not covered through the individual's individualized education plan (IEP) or through the individual's insurance (if the individual has private insurance coverage in addition to Medical Assistance).

The procedure code, modifiers, and service units for Music Therapy, Art Therapy and Equine Assisted Therapy:

Music Therapy

Provider Type **17** – Therapist
Specialty **175** – Music Therapist

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 21-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
G0176	**SE**	Music Therapy	Direct services provided to a participant who could benefit by the provision of therapy to maintain, improve or prevent regression of the individual's condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community. Music Therapy Staffing Ratio 1:1
G0176	**SE, HQ**		Direct services provided to a participant who could benefit by the provision of therapy to maintain, improve or prevent regression of the participant's condition and assist in the acquisition, retention or improvement of

			skills necessary for the participant to live and work in the community. Staffing Ratio 1:2 -1:4
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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.

Modifier SE – Must be used to identify that Music Therapy is being provided.
Modifier HQ- Must be used to identify that the Music Therapy service is being provided at the Staffing Ratio 1:2 -1:4.

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 – SE
2nd - U1

Art Therapy

Provider Type **17** – Therapist
Specialty **174** – Art Therapist

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 21-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	**Allowable Modifiers**	**Service Level**	**Service Description** **HCSIS Description**
G0176		Art Therapy	Direct services provided to an individual who could benefit by the provision of therapy to maintain, improve or prevent regression of the individual's condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community. Art Therapy Staffing Ratio – 1:1
G0176	**HQ**	Art Therapy	Direct services provided to an individual who could benefit by the provision of therapy to maintain, improve or prevent regression of the individual's condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community.

			Art Therapy Staffing Ratio – 1:2-1:4
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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.

Modifier HQ- Must be used to identify that the Art Therapy service is being provided at the Staffing Ratio 1:2 -1:4.

Equine Assisted Therapy

Provider Type **17** – Therapist
Specialty **169** – Equine Assisted Therapy

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 99-Other (Community)

Procedure Code	**Allowable Modifiers**	**Service Level**	**Service Description** **HCSIS Description**
S8940		Equine Assisted Therapy	Direct services provided to an individual who could benefit by the provision of therapy to maintain, improve or prevent regression of the individual's condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community. Equine Assisted Therapy Staffing Ratio 1:1
S8940	**HQ**	Equine Assisted Therapy	Direct services provided to an individual who could benefit by the provision of therapy to maintain, improve or prevent regression of the individual's condition and assist in the acquisition, retention or improvement of skills necessary for the individual to live and work in the community. Equine Assisted Therapy Staffing Ratio 1:2-1:4

	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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.

Modifier HQ- Must be used to identify that the Equine Assisted Therapy service is being provided at the Staffing Ratio 1:2 -1:4.

Section 14.17: Participant-Directed Goods and Services
EFFECTIVE 1/1/2023 THIS SERVICE IS NOW INCLUDED IN THE CONSOLIDATED WAIVER

Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through other services offered in this waiver, the Medical Assistance State Plan, or a responsible third party. Participant-Directed Goods and Services must address an identified need in the individual's ISP and must achieve one or more of the following objectives:

- Decrease the need for other Medicaid services.
- Promote or maintain inclusion in the community.
- Promote the independence of the individual.
- Increase the individual's health and safety in the home environment.
- Develop or maintain personal, social, physical or work-related skills.

Participant-Directed Goods and Services may not be used for any of the following:

- Personal items and services not related to the individual's intellectual disability, developmental disability or autism;
- Experimental or prohibited treatments;
- Entertainment activities, including vacation expenses, lottery tickets, alcoholic beverages, tobacco/nicotine products, movie tickets, televisions and related equipment, and other items as determined by the Department; or
- Expenses related to routine daily living, including groceries, rent or mortgage payments, utility payments, home maintenance, gifts, pets (excluding service animals), self-employment/business related expenses and other items as determined by the Department.
- Items and services that the individual has the funds to purchase;
- Items and services that are excluded from receiving Federal Financial Participation, including but not limited to room and board payments which include the purchase of furnishings and services provided while an individual is an inpatient of a nursing facility or ICF/ID.

Additional Service Definition Clarification

Participant-Directed Goods and Services are only available for individuals who choose to self-direct this and/or other services through one of the participant-directed services models; agency with choice or vendor/fiscal employer agent. Participant-Directed Goods and Services may be the only service that an individual chooses to self-direct. However, they must be enrolled in one of the participant-directed service models. When an individual seeks to receive Participant-Directed Goods and Services, SCs are expected to examine, discuss, and document the possibility of self-directing other services with the individual and use Participant-Directed Goods and Services as a vehicle to promote self-direction in general. This clarification aligns with the *Everyday Lives: Values In Action* recommendation to promote self-direction, choice and control.

Determining the need for services:

- What is/are the objective(s) of the Participant-Directed Goods and Services? Do the objectives align with the service definition requirement?
- Is the good or service covered through another service in the Consolidated, Community Living or P/FDS waiver, Medical Assistance or another responsible third party?

Service limit:

- Participant-directed Goods and Services are limited to $2,000 per individual per fiscal year through one of the participant-directed services models.

SC documentation requirements:

- The good or service that will be purchased and the objective the good or service will achieve must be documented in the ISP.
- The SC needs to ask the individual if they have funds to purchase the item or service. The individual's attestation about the availability of funds must be documented in the ISP. The SC does not need additional documentation, such as a bank statement, to verify the availability of funds.

The procedure code, modifiers, and service units for Participant-Directed Goods and Services:

Participant-Directed Goods and Services

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

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

Service Unit: Vendor Based Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0-120 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 HCSIS Description
T5999*	**SE**	Participant-Directed Goods and Services	Services, equipment and supplies not otherwise provided that promote the individual's independence and inclusion in the community. Participant-Directed Goods and Services

Modifier SE – Must be used to denote that this is an ODP service.

Section 14.18: Remote Supports

The purpose of Remote Supports services is to assist individuals aged 16 and older in obtaining and/or maintaining their independence and safety within their private home and in the community and to decrease the need for assistance from others. Remote Supports is used during periods of time that direct services are not required. Remote Supports involve the use of technology that uses two-way real time communication in the individual's home or community that allows awake staff from an agency who is offsite to monitor and respond to the individual's health and safety needs. Interaction with a professional occurs as needed as part of remote supports but is not the main function of the service. Remote Supports shall be provided in real time, not via recording, and during service provision staff must be awake and not have duties other than Remote Supports. Staff responsible for monitoring devices and equipment and responding to the individual's needs must be physically located in the provider agency's secure facility.

Remote Supports include the following:

- Staff who monitor and respond to the individual's needs;
- The technology utilized in the home and community that is monitored by the staff;
- The technology utilized for two-way real time communication (if different from above);
- The equipment necessary to operate the technology; and
- The costs for delivery, installation, adjustments, monthly testing, monitoring, maintenance and repairs to the technology and equipment necessary to operate the technology.

Please note: For individuals who use remote support through their Residential Habilitation, Life Sharing, or Supported Living service, the equipment and technology can be billed through W6087. Please see section 14.19 for more information.

Internet services are not covered as part of Remote Supports.

Remote Supports are fully integrated into the individual's overall system of services and supports. A Remote Supports implementation plan must be completed by the Remote Supports provider and reviewed by the ISP team in accordance with ODP policy. The Remote Supports implementation plan must include:

- How the individual's rights including the individual's right to privacy of person and possessions will be protected;
    - Recording of the individual via audio or video is prohibited. Live video or audio transmission is only allowable to persons designated by the individual and designated staff employed by the provider responsible for direct service delivery.
    - Without exception, the use of video monitoring equipment in bedrooms and bathrooms is prohibited. Video monitoring allows the individual to be seen, but the staff is not engaging or communicating with the individual.
    - Individuals or unpaid supports who will be present during the provision of Remote Supports must be able to turn off all audio or video monitoring devices used in any of part of the home or community during the provision of service.
    - If it is determined through the person-centered planning process that a individual needs audio monitoring equipment in a bedroom or bathroom, the individual must be alerted prior to the activation of any audio communication device unless the individual turns on the audio communication device themselves.

- Live real-time video communication (this means the individual and staff are communicating and engaging with each other) between the individual and a staff person may only occur in the individual's bedroom when all of the following are met:
  - The individual has chosen to receive services in their bedroom due to a medical condition which makes it difficult or impossible for them to leave their bedroom to receive services in another room in the house or the individual would like privacy from others in the home (family, housemates, etc.) during the receipt of services;
  - The individual turns the video communication device on and off themselves or requests assistance in turning the video communication device on and off;
  - The individual does not share a bedroom with others; and
  - Service delivery via video communication will not be performed as part of any activity during which privacy would generally be expected (while a individual is in a state of undress, during sexual activities, etc.).
- Sensors and other non-audio/video devices are permitted in bedrooms and bathrooms as part of the ISP.

- How the individual's health, welfare and safety needs will be met, including completion of a back-up plan that will be implemented if there is a problem with Remote Supports;
- The training individuals and any other designated persons will receive to enable the individual and others to successfully utilize the technology and equipment; and
- How Remote Supports are more cost effective than other waiver services.

The Remote Supports provider is responsible for informing the ISP team, including the individual and anyone identified by the individual of the impact the Remote Supports will have on the individual's privacy. This includes information about whether the individual or designated persons identified in the service plan can turn off the Remote Supports device or equipment if they choose to do so. This information must be provided in a form of communication that is understood by the individual.

Once Remote Supports have been approved on the ISP, the Remote Supports provider is responsible for the following:

- Training the individual, family, natural supports and any support professionals that will assist the individual in the use of the equipment initially and ongoing as needed. This includes information about whether the individual can turn off the Remote Supports technology or equipment if they choose to do so.
- Compliance with ODP's incident management policy.
- Development of progress notes in compliance with 6100.227.
- Delivery of the equipment to the individual's residence and when necessary, to the room or area of the home in which the equipment will be used.
- Installation of the equipment, including assembling the equipment or parts used for the assembly of the equipment.
- Adjustments and modifications of the equipment.
- Transferring the technology and equipment to a new home when the individual moves. This only applies when the new home is in an area served by the provider.
- Continuously monitoring the functioning of the technology.
- Developing and implementing a policy or plan to address technology malfunctions.

- Maintaining technology and equipment and ensuring necessary repairs are made to the technology and equipment. Replacement of technology and equipment is covered when the technology or equipment no longer meets the individual's needs, is obsolete, functionally inadequate, unreliable, or no longer supported by the manufacturer.
- Ensuring the Remote Supports equipment meets the following:
    - Includes an indicator that lets the individual know that the equipment is on and operating. The indicator shall be appropriate to meet the individual's needs.
    - Is designed so that it can be turned off only by the individual or designated person(s) indicated in the service plan.
    - Has 99% system uptime that includes adequate redundancy.
    - Has adequate redundancy that ensures critical system functions are restored within three hours of a failure. If a service is not available, the provider must be alerted by the equipment within ten minutes.
    - If a main hub is part of the installed system, it must be A/C powered, and include a backup battery capable of maintaining a charge to ensure the continued connectivity of the Remote Supports equipment if power loss occurs. There must be a mechanism to alert staff when a power outage occurs that provides a low battery alert, and an alert if the system goes down so that back-up support, if required, is put in place until service is restored. A main hub, if required, must be able to connect to the internet via one or more different methods; hard-wired, wireless, or cellular. The main hub must also have the ability to send notifications via one or more different modes; text, email or audio, as well as the ability, if in the Remote Supports implementation plan, to connect to an automated or consumer support call center that is staffed 24 hours a day, 7 days a week.
    - Has a latency of no more than 10 minutes from when an event occurs to when the notification is sent (via text, email or audio).
    - Has the capability to include environmental controls that are able to be added to, and controlled by, the installed Remote Supports system if identified in the Remote Supports implementation plan.
    - Has a battery life expectancy lasting six months or longer, and notification must be given by the equipment if a low battery condition is detected.
    - Is connected to a secure network system requiring authentication, authorization, and encryption of data that complies with 45 C.F.R. §§ 164.102 - 164.534. The provider must ensure that access to computer, video, audio, sensor, and written information is limited to authorized persons.
- Compliance with 55 Pa. Code §§6100.301 – 307 regarding transition to a new provider.

All items purchased through Remote Supports shall meet the applicable standards of manufacture, design, and installation. Items reimbursed with Waiver funds shall be in addition to any equipment or supplies provided under the MA State Plan. Excluded are those items that are not of direct medical or remedial benefit to the individual or are primarily for a recreational or diversionary nature. Items designed for general use shall only be covered to the extent necessary to meet the individual's needs and be for the primary use of the individual.

If the individual receives Behavioral Support Services, the Remote Supports services must be consistent with the individual's behavior support plan.

Remote Supports Equipment and Technology that is purchased, not leased, through this service is the property of the individual and must accompany the individual when the individual moves into a new home.

Remote Supports can only be rendered simultaneously with the following in-person direct services for 120 calendar days after installation, training, and full use by the individual has begun to help the individual safely transition to independent use of Remote Supports:

- In-Home and Community Support
- Companion
- Respite

During the 120-calendar day transition period, in-person direct In-Home and Community Support, Companion, and Respite services may only be authorized on the ISP and billed for completion of the following activities that are not included in the Remote Supports service:

- Providing prompting, ongoing instruction, modeling and/or supervision to enable the individual's independent use of the Remote Supports technology equipment and devices;
- Facilitating and evaluating the individual's independent use of Remote Supports technology equipment and devices;
- Communicating progress or concerns regarding the individual's independent use of Remote Supports to the service plan team, including the Remote Supports provider; and
- Performing activities outlined in the In-Home and Community Support, Companion, or Respite service definition needed by the individual during the 120-calendar day transition period. These in-person direct activities do not duplicate the activities outlined in the Remote Supports service.

An ISP meeting must be held when it becomes evident that an individual will not be able to independently use Remote Supports within 120 calendar days. Alternative service options that will meet the individual's needs must be explored and added to the ISP.

Additional Service Definition Clarification

- The rates for these procedure codes are entered as Individualized Rates in the ISP
- This service may only be provided by a qualified provider agency. The Remote Supports service may not be authorized as a PDS service or through an OHCDS.
    - When remote supports are provided as a method of residential service delivery and technology or equipment used will be billed through W6087, the residential provider must be authorized as the provider of W6087.
- In-Home and Community Support, Companion or Respite may only be provided at the same time as the Remote Support service for 120 calendar days to help the individual transition to independent use of Remote Supports. After this time In-Home and Community Support, Companion, or Respite may be authorized in the ISP but not at the same times that Remote Supports is authorized.
- Refer to ODP Announcement 24-015: Implementing Changes To Remote Supports And Assistive Technology In The November Waiver Amendments, for additional guidance including a decision tree to help ISP teams determine whether a device used by an individual should be covered by Remote Supports or Assistive Technology.
- The technology that is monitored by staff in delivery of the Remote Supports service (in private homes, residential homes, and community settings) that is authorized and billed through W6087 may be purchased or leased.

Service limit:

- The Remote Supports services is to assist individuals aged 16 and older in obtaining and/or maintaining their independence and safety within their private home and in the community and to decrease the need for assistance from others. The following limits apply to individuals who receive remote supports as a method of Life Sharing, Residential Habilitation, or Supported Living service delivery:
    - The Remote Supports service (procedure code W6088 which covers staff who monitor and respond to the individual's needs) may not be authorized as this is covered in the rate paid for the residential service.
    - The technology and equipment used for a specific individual in the delivery of remote supports may be authorized through procedure code W6087 (Remote Supports Equipment and Technology.
    - Technology and equipment that will be used by multiple individuals is covered in the residential rate and may not be authorized through the Remote Supports service.
- The direct provision of Community Participation Support services as well as the fading support component shall not be rendered on the same days and times that Remote Supports is rendered.

SC documentation requirements:

- An outcome statement must be created specifically for the Remote Supports service.
    - In the section titled "Relevant Assessments Linked to Outcome" a reference to the Remote Supports Implementation Plan must be included.
    - Relevant information about the Remote Supports Implementation Plan must also be included in the "Other Non-Medical Evaluations" section of the ISP.
    - The Supports Coordinator must enter the technology costs and hourly service delivery costs that are charged by the provider to the general public for Remote Supports.

The procedure codes and service unit for Remote Support:

Provider Type 51, Home & Community Habilitation
Specialties: 364, Remote Supports

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

(Please Note: The Remote Supports services is to assist individuals age 16 and older in obtaining and/or maintaining their independence and safety within their private home and in the community and to decrease the need for assistance from others.)

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W6087	Remote Supports	Remote Support – Technology/Equipment
W6088	Remote Supports	Remote Support - Service

Section 14.19: Residential Services (Consolidated and Community Living Waivers Only)

Residential services for ODP include Residential Habilitation, Life Sharing and Supported Living.

The service definitions in the waivers for each of these services encompass a full range of supports and services necessary to meet each individual's needs. The service definitions for residential services are broad to support the full range of activities that occur in an individual's home and community such as personal care, cooking, interaction with housemates, developing relationships, participating in the ISP, budgeting and banking, activities in the community, etc.

NOTE: These services are offered to individuals enrolled in the Consolidated Waiver:

- Residential Habilitation
- Life Sharing
- Supported Living

These services are offered to individuals enrolled in the Community Living Waiver:

- Residential Habilitation (Unlicensed only)
- Life Sharing
- Supported Living (Needs Groups 1 and 2 only)

◊ Residential Habilitation and Life Sharing services may be provided to individuals with a developmental disability due to a medically complex condition. Procedure codes for this service in Life Sharing are found in the Life Sharing section below.

SC Monitoring for all Residential Services:

- Teleservices, may not be used to conduct monitoring in the participant's home; and
- No more than six months can lapse between face-to-face monitorings at the residential home.

Please refer to Section 12: Monitoring of Services for more information.

Encouraging Individuals To Achieve Greater Independence: Transitioning From Residential Habilitation to Life Sharing/Supported Living

ODP encourages individuals to achieve greater independence and choice through the opportunity to transition from living in a home where licensed Residential Habilitation is provided into a home where Life Sharing or Supported Living services are provided. Therefore, the Supports Coordinator will be involved with conversations with the individual and their team members regarding the opportunity. Please review the waiver language and ODP Announcement 22-068: Transition to Independent Living Payments, to learn more about the two transition payments for the residential provider if the individual successfully transitions between services.

Needs Groups and Needs Level

The Needs Level represents the needs level of an individual derived from the Supports Intensity Scale, known as SIS. There are seven (7) Needs Levels. The Needs Group represents Needs Level groupings.

After in-depth data analysis, certain Needs Levels were found to strongly correlate with one another and, thus, were placed in groupings. For example, individuals who have been assessed with a SIS Needs Level 3 or 4, have been found to have very similar financial levels of need and therefore, are assigned to the same Needs Group, which, in this example, would be Needs Group 3. The relationship between the Needs Group and Needs Level is as follows:

Needs Level	Needs Group	Represented in HCSIS Service Description	Modifier
1	1	NG 1	U5
2	2	NG 2	U6
3 and 4	3	NG 3	U7
5, 6 and 7	4	NG 4	U8

Modifiers are used to represent the Needs Group associated with the individual. This means that each individual residing in the home could have a different modifier (and rate) based upon their specific Needs Group. These modifiers will be attached to the Residential Habilitation, Life Sharing, and Supported Living procedure codes and should be used when billing services that use a Needs Group. The modifiers will be visible on the Service Detail screen in HCSIS.

Needs Group 5 only applies to Residential Habilitation homes. ODP has made some changes regarding the Needs Exception Allowance (NEA) which impacts Needs Group 5. Starting January 1, 2024, those individuals with a NEA will transition automatically to Needs Group 5 for the new rate. Please see ODP Communication 23-083 for more information.

Other Services Allowed to be on ISP with a Residential Service
Individuals authorized to receive Residential Habilitation, Life Sharing, and Supported Living services may also have the following services authorized on their ISP. For more information, please refer to the specific service definition.

- Assistive Technology. The devices or equipment must meet the Assistive Technology service definition requirements.
- Behavioral Support;
    - Behavioral Support is included in the rate and may only be authorized as a discrete service when it is used to support an individual to access Community Participation Support or to maintain employment when provided at the individual's place of employment.
- Communication Specialist
    - May only be authorized as a separate and discrete service when it is used to support the individual during Community Participation Support.
- Companion services may be authorized as a discrete service when it is used to support an individual in-person at their place of community integrated employment in alignment with the Companion service definition.
    - Companion provided through teleservices for this purpose is not permitted.
- Housing Transition and Tenancy Sustaining Services – Only Housing Transition activities may be provided for Residential Habilitation, Life Sharing, or Supported Living. Residential providers are responsible for tenancy sustaining services in residential homes.

    - Housing Transition services may be authorized when the individual has a plan to move from the home where Residential Habilitation or Life Sharing is provided into a private home that the participant will own, rent or lease.
- Remote Supports Equipment and Technology (procedure code W6087) to purchase or lease equipment or technology that will be used exclusively by an individual for the delivery of remote supports as a method of the residential service delivery.
    - Items purchased through Remote Supports
        - These items shall meet the applicable standards of manufacture, design, and installation. Items reimbursed with Waiver funds shall be in addition to any equipment or supplies provided under the MA State Plan. Excluded are those items that are not of direct medical or remedial benefit to the individual or are primarily for a recreational or diversionary nature. Items designed for general use shall only be covered to the extent necessary to meet the individual's needs and be for the primary use of the individual.

- Respite is only allowed with the Life Sharing service on the ISP);
- Shift Nursing is allowed on the ISP with Residential Habilitation, Supported Living, and Life Sharing);
    - Can only be authorized in limited circumstances; reference the Shift Nursing service definition for the exceptions.
- Supports Brokers services when the individual has a plan to self-direct their services through a participant-directed services model in a private home where residential services are not provided.
- Music, Art, Equine Therapies (Only allowed for Life Sharing and Residential Habilitation)
- Therapy Services (Speech, Occupational Therapy, Physical Therapy, Orientation and mobility)
- Transportation: is included in the residential rate and may not be billed as a discrete service, unless the transportation is to or from a job that meets the definition of competitive integrated employment and that need is documented in the individual's ISP.
- Vehicle Accessibility Adaptations (Only allowed on ISP with Supported Living or Life Sharing);
    - When the vehicle being adapted and utilized by the individual is not owned, leased or rented by the provider.
- Home Accessibility Adaptations (Only allowed on ISP with Supported Living or Life Sharing).

Other Services NOT Allowed to be on ISP with a Residential Service
Individuals authorized to receive Residential Habilitation, Supported Living, or Life Sharing services **may NOT** have the following services authorized on their ISP on the day the residential service is provided. The following services can be authorized and provided, however, in a private non-residential home on the day an individual moves into a residential home or out of a residential home into a private non-residential home:

- Consultative Nutritional Services;
- Family/Caregiver Training and Support;
- Homemaker/Chore;

- Housing Transition and Tenancy Sustaining Services – (The activities related to the Tenancy Support portion of this service is not allowed to be provided for any residential service);
- In-Home and Community Supports;
- Remote Supports service (procedure code W6088): The costs of staff who monitor devices and equipment and respond to the individual's needs are built into the residential rate and cannot be authorized on the ISP;
- Specialized Supplies.

Residential Services and Behavioral Supports

Even though Behavioral Supports is not a discrete and separate billable service for those who have a Residential service on their ISP, (behavioral support is included as part of the Residential service), the residential provider must follow the guidance in the Behavioral Support service definition. The residential provider must have behavioral specialists (direct, contracted or in a consulting capacity) available who as part of the residential service. Behavioral specialists are responsible for completing assessments, developing and updating Behavior Support Plans and Crisis Intervention Plans, and training other agency staff. A Functional Behavioral Assessment and comprehensive behavioral support plan must be completed within 60 days of identification by the ISP team of an individual's need for assistance from a behavioral specialist.

✎SC documentation requirements:

Please see the SC Requirements under the Behavioral Support section in this ISP Manual

Guidance Regarding Day Units
All residential services are authorized as a day unit.

A day is defined as a period of a minimum of 8 hours of non-continuous (in other-words, not all 8 hours must be provided back-to-back) care rendered by a residential provider within a 24-hour period beginning at 12:00 a.m. and ending at 11:59 p.m. On-call support or remote supports as a method of residential service delivery may be included as part of the 8 hours of care.

There are two exceptions to the day unit rule as follows:

1. When an individual is admitted to a hospital the residential provider may not bill for Residential Habilitation, Life Sharing or Supported Living the day the individual is admitted regardless of how many hours of care the residential provider has rendered during the 24-hour period. The residential provider may bill for 15-minute unit Supplemental Habilitation services rendered when the participant is admitted to an acute care hospital.

   When the individual is discharged from a hospital the residential provider may bill for Residential Habilitation, Life Sharing, or Supported Living on the discharge day of service regardless of how many hours of care the residential provider has rendered during the 24-hour period.

   - NOTE: Residential Habilitation, Life Sharing, Supported Living, or Supplemental Habilitation services may not be billed on the day of admission or the day of discharge when an individual is admitted to a **nursing or rehabilitation facility.** The provider may begin to bill *one day after* the day the individual is discharged.

Under these circumstances, PROMISe will deny the claim if the provider attempts to bill on the day of admission or discharge.

2. When an individual is receiving residential services from one provider and is transitioning from that provider to a new residential services provider, only the current residential provider that the individual is transitioning away from can bill for the day that the transition occurs regardless of the number of hours of service rendered by either provider. The reason for this is because two day units of service may not be billed on the same day.

Remote Supports as a Method of Residential Habilitation, Life Sharing, and Supported Living

Remote supports involve the use of technology that uses two-way real time communication in the individual's home and/or community that allows someone from off-site to monitor and respond to the individual's health and safety needs. Remote supports are an optional method of service delivery rendered as part of Residential Habilitation, Life Sharing or Supported Living services that must enhance or increase the individual's independence, reduce the individual's need for direct support, and comply with 42 CFR 441.301(c)(4)(vi)(A) through (D) related to privacy, control of schedule and activities and access to visitors.

Individuals must have an informed choice (understanding all the options available to them, including the benefits and the possible risks) to receive remote supports as a method of service delivery. This method of service delivery may only occur when the individual and the ISP team determines that remote supports is the most appropriate service delivery method to meet the participant's needs (including health and safety needs) and goals.

Prior to implementing remote supports as a method of residential service delivery, the residential provider must discuss the following with the individual and the ISP team to determine the appropriateness of this service delivery method:

- An evaluation plan that, at a minimum, includes:
    - The need(s) of the individual that will be met by the remote supports;
    - The equipment and/or devices that will be used and the individual's control over the equipment and/or devices. The individual's control over the equipment will be determined on a case-by-case basis depending on the device(s)/equipment used and the individual's needs;
    - How the remote supports will ensure the individual's health, welfare and independence; and
    - The training needed to successfully utilize the technology.
        - This includes training the individual and staff on the equipment and/or devices that will be used.
- An outcome monitoring plan.
- The back-up plan that will be implemented should there be a problem with the remote supports, including the equipment and/or devices used.
    - The back-up plan must be developed in accordance with guidance in Appendix D- 1-e to ensure that the health and safety needs of each individual will be met.
- The impact the remote supports will have on the individual's privacy, including whether devices and/or equipment used to facilitate each individual's right to privacy of person and possessions.

If an individual uses technology and/or equipment to receive remote support as part of the residential service, the SC may add the Remote Supports Equipment and Technology procedure code (W6087) to the individual's ISP. The residential provider must be the provider listed for procedure code W6087. The technology/equipment billed under W6087 must be specific to the individual and not shared with any other individuals in the home. (Technology and equipment used by multiple individuals in the home is covered under the residential rate.) If the individual moves into another home, and that equipment and/or technology was purchased (not leased), that equipment and/or technology must move with the individual into their new home.

In addition, please refer to ODP Announcement 24-015: Implementing Changes To Remote Supports And Assistive Technology In The November Waiver Amendments, for guidance for implementing changes to assistive technology and remote supports in the November 2023 amendments to the Consolidated, Community Living, and Person/Family Directed Support (P/FDS) Waivers.

As part of the Evaluation Plan, the following is not allowed because it infringes upon an individual's right to privacy:

- Recording of live interactions with the individual via audio or video. This means that images and sounds cannot be recorded and stored to be reviewed at a later time.

- The use of video monitoring equipment (equipment used to observe or watch) in bedrooms and bathrooms.

As part of the Evaluation Plan, the following may be allowed:

- Staff can provide live audio/verbal prompts or guidance (where no video is used) in bathrooms and bedrooms as part of this method of service delivery when needed by the individual.
    - The individual must be alerted prior to the activation of any audio communication device unless the individual turns on the audio communication device themselves.

- Live video or audio transmission is only allowable to persons designated by the individual and designated staff employed by the provider responsible for direct service delivery. The residential provider must ensure that the *communications platform* (ie. multiple devices in different locations that transmit live video and audio) used are not live streamed publicly or to any persons not designated by the individual and staff responsible for direct service delivery.
- Live real-time video communication between the individual and a staff person may only occur in the individual's bedroom when all of the following are met:
    - The individual has chosen to receive services in their bedroom due to a medical condition which makes it difficult or impossible for them to leave their bedroom to receive services in another room in the house or the individual would like privacy from others in the home (staff, family, housemates, etc.) during the receipt of services;
    - The individual turns the video communication device on and off themselves or requests assistance in turning the video communication device on and off;
    - The individual does not share a bedroom with others; and

  - Service delivery via video communication will not be performed as part of any activity during which privacy would generally be expected (while an individual is in a state of undress, during sexual activities, etc.).
- All audio and video devices that are used to render remote supports in any location in the home or community must include indicators that let the individual know that the devices are on and operating in audio or video mode.
- The use of sensors and other non-audio/video devices in bedrooms and bathrooms as part of the ISP.

SC Documentation:

- Remote supports must be documented in the ISP and fully integrated into the individual's overall system of support using person-centered planning.
- An outcome statement must be created specifically for remote supports as a method of residential service delivery.
  - The SC should indicate this phrase in the ISP: *The use of Remote Supports will be used to increase independence and reduce dependence on staff.*
  - The Residential Habilitation, Life Sharing or Supported Living provider must be listed as the provider for this outcome.
  - In the section titled "Relevant Assessments Linked to Outcome" a reference to the Evaluation Plan must be included.
  - Relevant information about the Evaluation Plan must also be included in the "Other Non-Medical Evaluations" section of the ISP.

Intensive Staffing, Supplemental Habilitation
In emergency situations or to meet an individual's temporary medical or behavioral needs, individuals authorized to receive residential services may also be authorized to receive Supplemental Habilitation.

Supplemental Habilitation may be delivered in an acute care hospital in accordance with ODP Bulletin 00-23-01.

Determining the need for Supplemental Habilitation Services:

- Supplemental Habilitation staffing should only be authorized for temporary medical or behavioral needs that cannot be met as part of the usual residential staffing pattern.

Service Limits:

- Supplemental Habilitation must be authorized separately by the AE.
- Supplemental Habilitation can be extended beyond 90 days for the following reasons:
  - Injury or illness that requires a more extended period of staff support than expected but projected to be less than an additional 90 days.
  - Mental health, behavioral or medical support needs have diminished but not eliminated the need for some additional staff support.
  - During the initial 90-day period, the person has experienced a change in status such as an injury, illness or an increase in dangerous behaviors or a criminal justice system imposed requirement.

- Acute condition or support need has persisted, is not expected to reduce through the temporary addition of support, and a new SIS has now been requested.

For an extension of Supplemental Habilitation, the following conditions must be met:

- The provider has a formal plan for discontinuance of Supplemental Habilitation.
- Current documentation is available from a healthcare provider outlining the mental health, behavioral or medical support condition and related support needs.

SC documentation requirements

- Supplemental Habilitation is used to temporarily meet the ***short-term*** unique *behavioral* or *medical* needs of an individual who receives licensed Residential Habilitation, Life Sharing or Supported Living services funded through the Consolidated or Community Living Waiver.
  - Supplemental Habilitation generally is not allowed when an individual lives in an unlicensed Life Sharing home due to the individual needing a yearly average of 30 hours or less of direct training and assistance per week.
- The individual's ISP must include a Consolidated or Community Living Waiver-Funded residential service procedure code and a Supplemental Habilitation procedure code.

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; **524,** Unlicensed

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated and Community Living Waivers: 0-120 years
Base Funding: 0-120 years old
Allowable Place of Service: 12-Home; 21- Inpatient Hospital (🩺); 99-Other (Community)

(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope (🩺) when an individual is in the hospital.)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W7070 🩺		Supplemental Habilitation	The provision of 1:1 staffing for habilitation to supplement the basic licensed Residential Habilitation, licensed Life Sharing or Supported Living service to meet the short-term unique behavioral or medical assessed needs of the individual. Supplemental Habilitation 1:1 - 15 min
W7084 🩺		Supplemental Habilitation	The provision of 2:1 staffing for habilitation to supplement the basic licensed Residential Habilitation, licensed Life Sharing or Supported

			Living service to meet the short-term unique behavioral or medical assessed needs of the individual. Supplemental Habilitation 2:1 - 15 min
	U1		Enhanced Communication Service – This modifier can be utilized with all of the Waiver Procedure Codes in this table for the direct provision of this service. 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.

Life Sharing

Life Sharing services are direct and indirect, provider agency managed services that occur in one of the following locations:

- *Private home of a host family/life sharer.*
    - The host family/life sharer may be the individual's relative(s) (see definition below of relative), legal guardian, or persons who are not related to the individual.

- *Private home of the individual where a host family/life sharer.*
    - who is not related to the individual moves into the individual's home and shares the individual's home as their primary residence.

For the purposes of Life Sharing the following definitions apply:

Relative - All relatives may provide Life Sharing services. In accordance with 55 Pa. Code § 6500.4, a host home that is owned, rented, or leased by a parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece or nephew does not need to be licensed. Relatives whose relationship to the individual are not specified in this list may require licensure based on the amount of care the individual requires as specified at 55 Pa. Code § 6500.3(f)(5).

If the individual who is receiving Life Sharing is younger than 18 and the person that is providing the service is a relative, that relative may only provide Life Sharing if it is considered extraordinary care. A relative is responsible to meet the needs of an individual who is younger than 18 years of age, including the need for assistance and supervision typically required for children at various stages of growth and development. A relative can, however, receive payment for Life Sharing services when this support goes beyond what would be expected to be performed in the usual course of parenting, and when needed support exceeds what is typically required for a child of the same age.

Life Sharing may also be provided to individuals who may be under the age of 21 with a diagnosis of a medically complex condition (please see the section "*Expanding Services for Individuals with a Medically Complex Condition"* for more information.

Further, the provider agency must develop a pre-service agreement with relatives that states the Life Sharing program requirements that the relative(s) must comply with to be a host family/life sharer and the conditions that will result in termination of the relative(s) as a host family/life sharer from the Life Sharing program.

Private home - A home that is owned, rented or leased by the individual or the host family/life sharer. Homes owned, rented or leased by a provider are not private homes. Homes owned, rented or leased by a provider and subsequently leased to an individual or the individual's relatives are also not private homes.

Host family/life sharer- One or more persons with whom the individual lives in a private home, such as the individual's relative(s), legal guardian, or persons who are not related to the individual. They also share daily life experience with the individual, providing service and support as needed in both the home and the community. The host family/life sharer is

responsible for, and actively involved in, providing care and support to the individual in accordance with the ISP.

This service is built on the principle that every individual has the capacity to engage in lifelong learning. As such, through the provision of this service, individuals will acquire, maintain, or improve skills necessary to live in the community, to live more independently, and to participate meaningfully in community life. To the extent that Life Sharing is provided in community settings outside of the residence, the settings must be inclusive rather than segregated.

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

Life Sharing services may be provided up to 24 hours a day based on the needs of the individual receiving services. The type and amount of assistance, support and guidance are informed by the assessed need for physical, psychological, medical, or emotional assistance established through an assessment or screening (including the Health Risk Screening Tool) and person-centered planning processes. The type and amount of assistance are delivered to enhance the autonomy of the individual, in line with their personal preference and to achieve their desired outcomes.

Life Sharing services are often the primary residence of the individual and as such, it is their home. Respect for personal routines, rhythms, rights, independence, privacy and personalization are intrinsic to the service as is access to experiences and opportunities for personal growth.

The Life Sharing provider must provide the level of services necessary to enable the individual to meet habilitation outcomes. This includes ensuring assistance, support and guidance (prompting, instruction, modeling, positive reinforcement) will be provided as needed to enable the individual to:

- Carry out activities of daily living such as personal grooming and hygiene, dressing, making meals and maintaining a clean environment.
- Learn and develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying through prescribed therapies and exercises, awareness and avoidance of risk including environmental risks, exploitation or abuse; responding to emergencies in the home and community such as fire or injury; knowing how and when to seek assistance.
- Manage or participate in the management of their medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, ensuring that there is a sufficient amount of medical supplies so the individual will not be at risk of not having the supplies, and keeping health logs and records.
- Manage their mental health diagnosis and emotional wellness including self-management of emotions such as disappointment, frustration, anxiety, anger, and depression; applying trauma informed care principles and practices; and accessing mental health services. The service should include: a comprehensive behavior

assessment; design, development and updates to a behavior support plan that includes positive practices and least restrictive interventions; development of a Crisis Intervention Plan; and implementation of the behavior support plan, Crisis Intervention Plan and/or the skill building plan which involve collecting and recording the data necessary to evaluate progress and the need for plan revisions.

- Participate in the development and implementation of the service plan and direct the person-centered planning process including identifying who should attend and what the desired outcomes are.
- Make decisions in identifying options/choices and evaluating options/choices against a set of personal preferences and desired outcomes. This includes assistance with identifying supports available within the community.
- Manage their home; including arranging for utility services, paying bills, home maintenance, and home safety.
- Achieve financial stability through managing personal resources, general banking and balancing accounts, record keeping and managing savings accounts and utilizing programs such as ABLE accounts.
- Communicate with providers, caregivers, family members, friends and others face-to-face and through the use of the telephone, correspondence, the internet, and social media. The service may require knowledge and use of sign language or interpretation for individuals whose primary language is not English.
- Use a range of transportation options including buses, trains, cab services, driving, and joining carpools, etc. Life Sharing providers are responsible to provide transportation to activities related to health, community involvement and the individual's ISP. The Life Sharing provider is not responsible for transportation for which another provider is responsible.
- Develop and manage relationships with individuals residing in the same home as appropriate, share responsibilities for shared routines such as preparing meals, eating together, carrying out routine home maintenance such as light cleaning, planning and scheduling shared recreational activities and other typical household routines, resolving differences and negotiating solutions.
- Develop and maintain relationships with members of the broader community and to manage problematic relationships.
- Exercise rights as a citizen and fulfill their civic responsibilities such as voting and serving on juries; attending public community meetings; to participate in community projects and events with volunteer associations and groups; to serve on public and private boards, advisory groups, and commissions, as well as develop confidence and skills to enhance their contributions to the community.
- Develop personal interests, such as hobbies, appreciation of music, and other experiences the individual enjoys or may wish to discover.
- Participate in preferred activities of community life such as shopping, going to restaurants, museums, movies, concerts, dances and faith-based services.

The Life Sharing provider is responsible for identification of risks to the individual and the implementation of actions such as reporting incidents as required by ODP, the Older Adults Protective Services Act, the Adult Protective Services Act and the Child Protective Services Law, and/or calling emergency officials for immediate assistance. The Life Sharing provider is

also responsible for providing physical health maintenance services including those required by a licensed nurse when required to assure health and wellness or as required in the ISP.

Life Sharing services include the support of a Life Sharing specialist for each individual with overall responsibility for supporting the individual and the host family/life sharer in the life sharing relationship. The Life Sharing specialist provides oversight and monitoring of the habilitative outcomes, health and wellness activities, ongoing assessment of supports and needs of the individual as identified in the service plan, as well as coordination of support services, such as relief, for the host family/life sharer.

When an individual's rights as specified in 55 Pa. Code §§ 6100.182 and 6100.183 are modified, the modification must be supported by a specific assessed need, agreed upon by the ISP team and justified in the ISP. When any individual rights are modified due to requirements in a court order, the modification must still be included in the ISP and the plan must be implemented. Because the origin of the rights modification is a court order, ISP team agreement is not a requirement for implementation of the modification.

Additional Service Definition Clarification:

The Respite limitations outlined in the Consolidated and Community Living Waivers apply to individuals in Life Sharing. An individual in licensed Life Sharing does not have to receive Respite in a licensed home. The individual can use any type of Respite that meets their needs and is agreed upon by the ISP team. If the Respite is being provided in a Life Sharing home (licensed or unlicensed), then the appropriate service to authorize is Respite-Life Sharing-Day procedure codes (W6100-W6104).

Determining the need for services:

- Is the individual interested in sharing their life with a host family/life sharer either in the private home of the individual or the home of the host family/life sharer?
- Could the individual's needs best be met through the flexibility and agency support (including life sharing specialists) offered through Life Sharing?
- Does the individual have behavioral support needs or nursing needs?
    - If yes, is the Life Sharing provider meeting those needs?

Service limits:

- Life Sharing services must be delivered in Pennsylvania. During temporary travel, however, this service may be provided at other locations per the ODP travel policy.
- No more than 4 people unrelated to the host family/life sharer can reside in the private home where Life Sharing services are provided.
- No more than 2 people may receive Life Sharing services in a private home.
- This service is billed as a day unit and may be provided at the following levels (Consolidated and Community Living waivers, unless otherwise noted):
    - Needs Group 1
    - Needs Group 2
    - Needs Group 3

- Needs Group 4

- The following Residential Enhanced Staffing add-on may be utilized for individuals receiving licensed Life Sharing services:
    - The provision of Supplemental Habilitation staffing in emergency situations or to meet an individual's temporary medical or behavioral needs.
  - Life Sharing may not be provided when the host family/life sharer is also a foster home for the individual.

HCBS Settings

All private homes in which Life Sharing are provided must be integrated and dispersed in the community in noncontiguous locations and may not be located on campus settings. To meet this requirement, the location of each home in which Life Sharing is provided must be separate from any other ODP-funded residential setting and must be dispersed in the community and not surrounded by other ODP-funded residential settings. Homes that share only one common party wall are not considered contiguous. Any home in which Life Sharing is provided should be located in the community and surrounded by the general public. New homes where Life Sharing will be provided or changes to existing homes where Life Sharing will be provided must be approved by ODP or its designee utilizing the ODP residential setting criteria.

Life Sharing may not be provided in a home enrolled on or after February 1, 2020, that is adjacent to any of the following regardless of the funding source of the individuals served:

- Licensed public and private (ICF/ID) (55 Pa. Code Chapter 6600) or ICF/ORC.
- Licensed Personal Care Homes (55 Pa. Code Chapter 2600).
- Licensed Assisted Living Residences (55 pa. Code Chapter 2800).
- Licensed Adult Training Facilities (55 Pa. Code Chapter 2380).
- Licensed Vocational Facilities (55 Pa. Code Chapter 2390).
- Licensed Older Adult Daily Living Centers (6 Pa. Code Chapter 11).

Exceptions are allowed for residential service locations to share one common party wall with one other Residential Service location funded through ODP's waivers in the form of a duplex, two bilevel units, and two side-by-side apartments.

Any home that begins to provide Life Sharing services on or after February 1, 2020 shall not be located in any development or building where more than 25% of the apartments, condominiums or townhouses have waiver funded Residential Habilitation, Life Sharing or Supported Living being provided.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

SC documentation requirements:

- 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 life sharing 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.

- SCs need to document the need for behavioral or nursing services that the Life Sharing provider is providing.
- If restrictive procedures are being used the SC must check the "Restrictive Procedure" box in Behavioral Support Plan screen.
- If any of an individual's rights are modified, the guidance in Section 7 of this manual must be followed. Decisions made in the provision of Life Sharing services to individuals under the age of 18 that mimic typical parental decisions, such as bedtime, nutrition, etc. do not rise to the level of a modification based on an assessed need, and do not need to be documented in the ISP.

The procedure code and service unit for Life Sharing – 30 hours per week or more on average:

Provider Type **52 –** Community Residential Rehabilitation
Specialty **524** – Unlicensed; **522** – Family Living Homes – 6500

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

Procedure Code	Allowable Modifiers	Needs Group	Service Description HCSIS Description
W8593	U5, SE	Needs Group 1	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a one-person home. Life Sharing-1 person-Elig-NG 1 > 30 Hrs
W8595	U5, SE	Needs Group 1	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a two-person home. Life Sharing-2 person-Elig-NG 1 > 30 Hrs
W8593	U6, SE	Needs Group 2	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a one-person home. Life Sharing-1 person-Elig-NG 2 > 30 Hrs
W8595	U6, SE	Needs Group 2	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a two-person home. Life Sharing-2 person-Elig-NG 2 > 30 Hrs
W8593	U7, SE	Needs Group 3	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a one-person home. Life Sharing-1 person-Elig-NG 3 > 30 Hrs

W8595	U7, SE	Needs Group 3	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a two-person home. Life Sharing-2 person-Elig-NG 3 > 30 Hrs
W8593	U8, SE	Needs Group 4	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a one-person home. Life Sharing-1 person-Elig-NG 4 > 30 Hrs
W8595	U8, SE	Needs Group 4	The provision of the eligible components of Life Sharing where the individual receives 30 hours or more per week of services in a two-person home. Life Sharing-2 person-Elig-NG 4 > 30 Hrs
	U1		Enhanced Communication Service - This modifier can be utilized with all the Waiver Eligible Procedure Codes in this table for the direct provision of this service. 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.

Modifiers U5, U6, U7 and U8 are Support Intensity Scale (SIS) Needs Group Modifiers.
Modifier SE - Must be used when the Life Sharing service is provided by a relative of the individual.

The procedure code and service unit for Life Sharing – under 30 hours per week on average:

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

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

Procedure Code	**Allowable Modifiers**	**Service Description** **HCSIS Description**
W7037	SE, TD, TE	The provision of the eligible components of Life Sharing where the individual receives under 30 hours per week of services on average in a one-person home. Life Sharing-1 per-Elig-Unlic < 30 Hrs
W7039	SE, TD, TE	The provision of the eligible components of Life Sharing where the individual receives under 30 hours per week of services on average in a two-person home. Life Sharing-2 per-Elig-Unlic < 30 Hrs

	U1	Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the direct provision of this service. 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.

Modifier TD – Must be used to identify services rendered by a Registered Nurse (RN).
Modifier TE – Must be used to identify services rendered by a Licensed Practical Nurse (LPN).
Modifier SE – Must be used when the Life Sharing service is provided by a relative of the individual.

◊ **The procedure code and service unit for Medically Complex Life Sharing (Needs Group 4):**

Provider Type **52 –** Community Residential Rehabilitation
Specialty **584** - Medically Complex

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

Procedure Code	**Allowable Modifiers**	**Needs Group**	**Service Description** **HCSIS Description**
W0062	U8, SE	Needs Group 4	The provision of the eligible components of Life Sharing for a person with a developmental disability due to a medically complex condition in a one-person home.
W0063	U8, SE	Needs Group 4	The provision of the eligible components of Life Sharing for a person with a developmental disability due to a medically complex condition in a two-person home.
	U1		Enhanced Communication Service - This modifier can be utilized with all the Waiver Eligible Procedure Codes in this table for the direct provision of this service. 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.

Modifier U8 is the Support Intensity Scale (SIS) Needs Group Modifier.

Modifier SE – Must be used when the Life Sharing service is provided by a relative of the individual.

Residential Habilitation

Residential Habilitation services are direct and indirect services provided to individuals who live in licensed and unlicensed provider owned, rented or leased residential settings. This service is built on the principle that every individual has the capacity to engage in lifelong learning. As such, through the provision of this service, individuals will acquire, maintain, or improve skills necessary to live in the community, to live more independently, and to participate meaningfully in community life. To the extent that Residential Habilitation is provided in community settings outside of the residence, the settings must be inclusive rather than segregated.

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

The type and amount of assistance, support and guidance are informed by the assessed need for physical, psychological and emotional assistance established through the assessment (including the Health Risk Screening Tool) and person-centered planning processes. The type and amount of assistance are delivered to enhance the autonomy of the individual, in line with their personal preferences and to achieve their desired outcomes. Residential Habilitation services are often the primary residence of the individual and as such, it is their home. Respect for personal routines, rhythms, rights, independence, privacy and personalization are intrinsic to the service as is access to experiences and opportunities for personal growth.

The Residential Habilitation provider must provide the level of services necessary to enable the individual to meet habilitation outcomes. This includes ensuring assistance, support and guidance (which includes prompting, instruction, modeling and reinforcement) will be provided as needed to enable the individual to:

- Carry out activities of daily living such as personal grooming and hygiene, dressing, making meals and maintaining a clean environment.
- Develop and maintain positive interactions and relationships with residents of one home and share meals and activities, as appropriate.
- Learn and develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying through prescribed therapies and exercises, awareness and avoidance of risk including environmental risks, exploitation or abuse; responding to emergencies in the home and community such as fire or injury; knowing how and when to seek assistance.
- Manage or participate in the management of their medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, and keeping health logs and records.
- Manage their mental health diagnosis and emotional wellness including self-management of emotions; applying trauma informed care principles and practices and accessing mental health services. The service should include: a comprehensive behavior assessment; design, development and updates to a behavior support plan that includes positive practices and least restrictive interventions; development of a Crisis Intervention Plan; and implementation of the behavior support plan, Crisis Intervention

Plan and/or the skill building plan which involve collecting and recording the data necessary to evaluate progress and the need for plan revisions.

- Participate in the development and implementation of the ISP and direct the person-centered planning process including identifying who should attend and what the desired outcomes are.
- Make decisions including identifying options/choices and evaluating options/choices against a set of personal preferences and desired outcomes. This includes assistance with identifying supports available within the community.
- Achieve financial stability through managing personal resources, general banking and balancing accounts, record keeping and managing savings accounts and programs such as ABLE accounts.
- Communicate with providers, caregivers, family members, friends and others face-to-face and through the use of the telephone, correspondence, the internet, and social media. The service may require knowledge and use of sign language or interpretation for individuals whose primary language is not English.
- Use a range of transportation options including buses, trains, cab services, driving, and joining carpools, etc. The Residential Habilitation provider is responsible for providing transportation to activities related to health, community involvement and the service plan. The Residential Habilitation provider is not responsible for transportation for which another provider is responsible.
- Reside in the same home to develop and manage relationships as appropriate, share responsibilities for routines such as preparing meals, eating together, carrying out routine home maintenance such as light cleaning, planning and scheduling shared recreational activities and other typical household routines, resolving differences and negotiating solutions.
- Develop and maintain relationships with members of the broader community and to manage problematic relationships.
- Exercise rights as a citizen and fulfill their civic responsibilities such as voting and serving on juries; attending public community meetings; to participate in community projects and events with volunteer associations and groups; to serve on public and private boards, advisory groups, and commissions, as well as develop confidence and skills to enhance their contributions to the community.
- Develop personal interests, such as hobbies, appreciation of music, and other experiences the individual enjoys or may wish to discover.
- Participate in preferred activities of community life such as shopping, going to restaurants, museums, movies, concerts, dances and faith-based services.

The Residential Habilitation provider is also responsible for providing physical health maintenance services including those required by a licensed nurse when required to assure health and wellness or as required in the ISP.

When an individual's rights as specified in 55 Pa. Code §§ 6100.182 and 6100.183 are modified, the modification must be supported by a specific assessed need, agreed upon by the ISP team and justified in the ISP. When any individual rights are modified due to requirements in a court order, the modification must still be included in the ISP and the plan must be implemented. Because the origin of the rights modification is a court order, ISP team agreement is not a requirement for implementation of the modification.

Any use of remote supports must comply with 42 CFR 441.301(c)(4)(vi)(A) through (D) related to privacy, control of schedule and activities and access to visitors.

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

1. Child Residential Services (the residential section of 55 Pa. Code Chapter 3800): The 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.
2. 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 individuals with intellectual disability and mental illness. Full-care CRRS is a program that provides living accommodations for individuals who are psychiatrically disabled and display severe community adjustment problems. A full range of personal assistance and psychological rehabilitation is provided for individuals in a structured living environment. Host homes as defined in section 5310.6 are excluded.
3. Community Homes for Individuals with an Intellectual Disability or Autism (55 Pa. Code Chapter 6400): A licensed Community Home is a home where services are provided to individuals with an intellectual disability or autism. 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 an intellectual disability or autism". In licensed Community Homes, services may be provided up to the approved program capacity of the home. Approved program capacity is established by ODP for each licensed 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 services up to the approved program capacity.
4. Unlicensed Residential Habilitation: Residential Habilitation may be provided to individuals who live in unlicensed provider-owned, rented or leased settings. The 55 Pa. Code §6400.3(f)(7) licensing regulations exclude community homes that serve 3 or fewer individuals with an intellectual disability or autism 18 years of age or older who need a yearly average of 30 hours or less of direct staff contact per week per home.

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

Additional Service Definition Clarification:

“Without Day”: “Licensed Residential Habilitation Without Day” (Modifier HI) is any day in which one of the following occurs:

- An individual solely receives services that are part of the Residential Habilitation service; or

- An individual receives fewer than 5 hours of services and/or unpaid supports that are not included in the Residential Habilitation service.

"With Day": "Licensed Residential Habilitation With Day" is any day in which an individual receives five (5) or more hours of services and/or unpaid supports that are not included in the Residential Habilitation service. When the individual is independent in the home or community for five or more hours in a day and does not receive direct services from the Residential Habilitation provider during that time, this would also be considered "Licensed Residential Habilitation With Day."

Residential Habilitation is authorized as day units either "with" or "without day" as described above.

To minimize critical revisions related to calculations of "with' and "without day," SCs may include units beyond 365 day units annually up to a maximum of 400 units total.

In situations where it is unclear how many days the individual will use "with" or "without" day, the default allocation of day units should be the following:

4 DAYS/WEEK WITH DAY
3 DAYS/WEEK WITHOUT DAY

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

- Provide transportation by use of agency staff and agency vehicles.
- Subcontract with the transportation entity that meets the transportation qualification criteria.
- 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, have access to those services.
- Explore the use of other generic public transportation services with the cost paid by the Residential Habilitation service provider.
- Explore resources and opportunities available through family and the community.
- For transportation to or from a job that meets the definition of competitive integrated employment and that need is documented in the service plan, the residential provider may provide the service and bill discretely or an arrangement with another transportation provider can be made.

Decisions made in the provision of Residential Habilitation services to individuals under the age of 18 that mimic typical parental decisions, such as bedtime, nutrition, etc., do not rise to the level of a modification based on an assessed need, and do not need to be documented in the ISP.

Determining the need for the service:

- Have all living options (private home, life sharing and supported living) been explored with the individual and the individual has expressed preference for a Residential Habilitation setting?

- Does the individual have behavioral support needs or nursing needs?
  - If yes, is the Residential Habilitation provider meeting those needs?

Service limits:

- The following Residential Enhanced Staffing add-on may be utilized for individuals receiving licensed Residential Habilitation services:
  - Supplemental Habilitation staffing in emergency situations or to meet a individual's temporary medical or behavioral needs.
- A setting enrolled to provide waiver services prior to July 1, 2017, shall not exceed a program capacity of 8. With ODP's written approval, a residential habilitation setting with a program capacity of 5 to 8 may move to a new location and retain the program capacity of 5 to 8. A setting enrolled to provide waiver services on July 1, 2017, or later shall not exceed a program capacity of 4. A setting that is a duplex, two bilevel units and two side-by-side apartments enrolled to provide waiver services on or after February 1, 2020, shall not exceed a program capacity of 4 in both units. With ODP's written approval, an ICF/ID licensed in accordance with 55 Pa. Code Chapter 6600 with a licensed capacity of 5 to 8 individuals may convert to a residential habilitation setting exceeding the program capacity of 4.
- Residential Habilitation services may not be provided in licensed Personal Care Homes or Assisted Living Residences and may only be provided in Domiciliary Care Homes if the home is licensed by the Department under 55 Pa. Code 6400, 5310 or 3800 and certified by the local Area Agency on Aging (6 Pa. Code Chapter 21).

HCBS Settings:

- All settings must be integrated and dispersed in the community in noncontiguous locations and may not be located on campus settings. To meet this requirement, the location of each setting must be separate from any other ODP-funded residential setting and must be dispersed in the community and not surrounded by other ODP-funded residential settings. Settings that share only one common party wall are not considered contiguous. Settings should be located in the community and surrounded by the general public. New settings or changes to existing settings must be approved by ODP or its designee utilizing ODP's criteria.

- Residential Habilitation may not be provided in a home enrolled on or after February 1, 2020, that is adjacent to any of the following regardless of the funding source of the individuals served:

  - Licensed public and private (ICF/ID) (55 Pa. Code Chapter 6600) or ICF/ORC.
  - Licensed Personal Care Homes (55 Pa. Code Chapter 2600).
  - Licensed Assisted Living Residences (55 pa. Code Chapter 2800).
  - Licensed Adult Training Facilities (55 Pa. Code Chapter 2380).
  - Licensed Vocational Facilities (55 Pa. Code Chapter 2390).
  - Licensed Older Adult Daily Living Centers (6 Pa. Code Chapter 11).
  - Exceptions are allowed for Residential Service locations to share one common party wall with one other Residential Service location funded through ODP's waivers in the form of a duplex, two bilevel units, and two side-by-side apartments. This exception does not extend to Residential Service locations that are not funded through ODP's waivers.

- Settings enrolled on or after February 1, 2020, shall not be located in any development or building where more than 25% of the apartments, condominiums or townhouses have waiver funded Residential Habilitation, Life Sharing or Supported Living being provided.

SC documentation requirements:

- 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.
- SCs will need to document the need for behavioral or nursing services that the residential provider is providing.
- If restrictive procedures are being used the SC must check the "Restrictive Procedure" box on the Behavioral Support Plan screen of the ISP in HCSIS.
- If any of an individual's rights are modified, Section 7 of this manual must be followed. Decisions made in the provision of Residential Habilitation services to individuals under the age of 18 that mimic typical parental decisions, such as bedtime, nutrition, etc., do not rise to the level of a modification based on an assessed need, and do not need to be documented in the service plan.

Licensed Residential Habilitation with Day

The procedure codes and service units for Licensed Residential Habilitation with Waiver-Funded Service during the day:

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

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

Procedure Code	Allowable Modifiers	Needs Group	Service Description HCSIS Description
W9000	U5	1	The provision of the eligible components of Residential Habilitation With Day in a licensed one person residence. Res Hab-1 Person-NG 1-Elig-w/Day Supports

W9029	U5	1	The provision of the eligible components of Residential Habilitation With Day in a licensed two person residence. Res Hab-2 Person-NG 1-Elig-w/Day Supports
W9045	U5	1	The provision of the eligible components of Residential Habilitation With Day in a licensed three person residence. Res Hab-3 Person-NG 1-Elig-w/Day Supports
W9047	U5	1	The provision of the eligible components of Residential Habilitation With Day in a licensed four person residence. Res Hab-4 Person-NG 1-Elig-w/Day Supports
W9064	U5	1	The provision of the eligible components of Residential Habilitation With Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 1-Elig-w/Day Supports
W9000	U6	2	The provision of the eligible components of Residential Habilitation With Day in a licensed one person residence. Res Hab-1 Person-NG 2-Elig-w/Day Supports
W9029	U6	2	The provision of the eligible components of Residential Habilitation With Day in a licensed two person residence. Res Hab-2 Person-NG 2-Elig-w/Day Supports
W9045	U6	2	The provision of the eligible components of Residential Habilitation With Day in a licensed three person residence. Res Hab-3 Person-NG 2-Elig-w/Day Supports
W9047	U6	2	The provision of the eligible components of Residential Habilitation With Day in a licensed four person residence. Res Hab-4 Person-NG 2-Elig-w/Day Supports
W9064	U6	2	The provision of the eligible components of Residential Habilitation With Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 2-Elig-w/Day Supports
W9000	U7	3	The provision of the eligible components of Residential Habilitation With Day in a licensed one person residence. Res Hab-1 Person-NG 3-Elig-w/Day Supports
W9029	U7	3	The provision of the eligible components of Residential Habilitation With Day in a licensed two person residence. Res Hab-2 Person-NG 3-Elig-w/Day Supports

W9045	U7	3	The provision of the eligible components of Residential Habilitation With Day in a licensed three person residence. Res Hab-3 Person-NG 3-Elig-w/Day Supports
W9047	U7	3	The provision of the eligible components of Residential Habilitation With Day in a licensed four person residence. Res Hab-4 Person-NG 3-Elig-w/Day Supports
W9064	U7	3	The provision of the eligible components of Residential Habilitation With Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 3-Elig-w/Day Supports
W9000	U8	4	The provision of the eligible components of Residential Habilitation With Day in a licensed one person residence. Res Hab-1 Person-NG 4-Elig-w/Day Supports
W9029	U8	4	The provision of the eligible components of Residential Habilitation With Day in a licensed two person residence. Res Hab-2 Person-NG 4-Elig-w/Day Supports
W9045	U8	4	The provision of the eligible components of Residential Habilitation With Day in a licensed three person residence. Res Hab-3 Person-NG 4-Elig-w/Day Supports
W9047	U8	4	The provision of the eligible components of Residential Habilitation With Day in a licensed four person residence. Res Hab-4 Person-NG 4-Elig-w/Day Supports
W9064	U8	4	The provision of the eligible components of Residential Habilitation With Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 4-Elig-w/Day Supports
W9000	U9	5	The provision of the eligible components of Residential Habilitation With Day in a licensed one person residence. Res Hab-1 Person-NG 5-Elig-w/Day Supports
W9029	U9	5	The provision of the eligible components of Residential Habilitation With Day in a licensed two person residence. Res Hab-2 Person-NG 5-Elig-w/Day Supports
W9045	U9	5	The provision of the eligible components of Residential Habilitation With Day in a licensed three person residence. Res Hab-3 Person-NG 5-Elig-w/Day Supports

W9047	U9	5	The provision of the eligible components of Residential Habilitation With Day in a licensed four person residence. Res Hab-4 Person-NG 5-Elig-w/Day Supports
W9064	U9	5	The provision of the eligible components of Residential Habilitation With Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 5-Elig-w/Day Supports
	U1		Enhanced Communication Service - This modifier can be utilized with all the Waiver Eligible Procedure Codes in this table for the direct provision of this service. 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.

Modifiers U5, U6, U7, U8 and U9 are Support Intensity Scale (SIS) Needs Group Modifiers.

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 – U5, U6, U7 or U8
2nd - U1

Licensed Residential Habilitation without Day

The procedure codes and service units for Licensed Residential Habilitation without Waiver-Funded Service during the day:

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

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

Procedure Code	Allowable Modifiers	Needs Group	Service Description HCSIS Description
W9000	U5, HI	1	The provision of the eligible components of Residential Habilitation Without Day in a licensed one person residence. Res Hab-1 Person-NG 1-Elig
W9029	U5, HI	1	The provision of the eligible components of Residential Habilitation Without Day in a licensed two person residence. Res Hab-2 Person-NG 1-Elig
W9045	U5, HI	1	The provision of the eligible components of Residential Habilitation Without Day in a licensed three person residence. Res Hab-3 Person-NG 1-Elig
W9047	U5, HI	1	The provision of the eligible components of Residential Habilitation Without Day in a licensed four person residence. Res Hab-Lic-4 Person-Elig-NG 1
W9064	U5, HI	1	The provision of the eligible components of Residential Habilitation Without Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 1-Elig
W9000	U6, HI	2	The provision of the eligible components of Residential Habilitation Without Day in a licensed one person residence. Res Hab-1 Person-NG 2-Elig
W9029	U6, HI	2	The provision of the eligible components of Residential Habilitation Without Day in a licensed two person residence. Res Hab-2 Person-NG 2-Elig

W9045	U6, HI	2	The provision of the eligible components of Residential Habilitation Without Day in a licensed three person residence. Res Hab-3 Person-NG 2-Elig
W9047	U6, HI	2	The provision of the eligible components of Residential Habilitation Without Day in a licensed four person residence. Res Hab-Lic-4 Person-Elig-NG 2
W9064	U6, HI	2	The provision of the eligible components of Residential Habilitation Without Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 2-Elig
W9000	U7, HI	3	The provision of the eligible components of Residential Habilitation Without Day in a licensed one person residence. Res Hab-1 Person-NG 3-Elig
W9029	U7, HI	3	The provision of the eligible components of Residential Habilitation Without Day in a licensed two person residence. Res Hab-2 Person-NG 3-Elig
W9045	U7, HI	3	The provision of the eligible components of Residential Habilitation Without Day in a licensed three person residence. Res Hab-3 Person-NG 3-Elig
W9047	U7, HI	3	The provision of the eligible components of Residential Habilitation Without Day in a licensed four person residence. Res Hab-Lic-4 Person-Elig-NG 3
W9064	U7, HI	3	The provision of the eligible components of Residential Habilitation Without Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 3-Elig
W9000	U8, HI	4	The provision of the eligible components of Residential Habilitation Without Day in a licensed one person residence. Res Hab-1 Person-NG 4-Elig
W9029	U8, HI	4	The provision of the eligible components of Residential Habilitation Without Day in a licensed two person residence. Res Hab-2 Person-NG 4-Elig
W9045	U8, HI	4	The provision of the eligible components of Residential Habilitation Without Day in a licensed three person residence. Res Hab-3 Person-NG 4-Elig

W9047	U8, HI	4	The provision of the eligible components of Residential Habilitation Without Day in a licensed four person residence. Res Hab-Lic-4 Person-Elig-NG 4
W9064	U8, HI	4	The provision of the eligible components of Residential Habilitation Without Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 4-Elig
W9000	U9, HI		The provision of the eligible components of Residential Habilitation Without Day in a licensed one person residence. Res Hab-1 Person-NG 5-Elig
W9029	U9, HI		The provision of the eligible components of Residential Habilitation Without Day in a licensed two person residence. Res Hab-2 Person-NG 5-Elig
W9045	U9, HI		The provision of the eligible components of Residential Habilitation Without Day in a licensed three person residence. Res Hab-3 Person-NG 5-Elig
W9047	U9, HI		The provision of the eligible components of Residential Habilitation Without Day in a licensed four person residence. Res Hab-Lic-4 Person-Elig-NG 5
W9064	U9, HI		The provision of the eligible components of Residential Habilitation Without Day in a licensed five to eight person residence. Res Hab-5-8 Person-NG 5-Elig
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Eligible Procedure Codes in this table for the direct provision of this service. 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.

Modifiers U5, U6, U7, U8 and U9 are Support Intensity Scale (SIS) Needs Group Modifiers.
Modifier HI – Must be used for Residential Habilitation Without Day.

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 – U5, U6, U7 or U8
2nd - U1

OR

1st – U5, U6, U7 or U8
2nd – HI

When billing for three modifiers for this service they must be listed in the following order for the claim to process correctly:
1st – U5, U6, U7 or U8
2nd – HI
3rd – U1

Licensed Ineligible Residential Habilitation

The procedure codes and service units for Licensed Ineligible Residential Habilitation:

Provider Type **52** – Community Residential Habilitation
Specialties: **456 -** CRR-Adult; **520** - Child Residential Services – 3800; **521 -** Adult Residential-6400

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

Procedure Code	Service Level	Service Description HCSIS Description
W9001	Ineligible	The ineligible portion of Residential Habilitation in a licensed one person residence. Res Hab-Lic-1 Person-Inelig
W9030	Ineligible	The ineligible portion of Residential Habilitation in a licensed two person residence. Res Hab-Lic-2 Person-Inelig
W9046	Ineligible	The ineligible portion of Residential Habilitation in a licensed three person residence. Res Hab-Lic-3 Person-Inelig
W9048	Ineligible	The ineligible portion of Residential Habilitation in a licensed four person residence. Res Hab-Lic-4 Person-Inelig
W9065	ineligible	The ineligible portion of Residential Habilitation in a licensed five to eight person residence. Res Hab-Lic-5-8 Person-Inelig

Unlicensed Residential Habilitation

The procedure codes and service units for Unlicensed Residential Habilitation:

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

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

Procedure Code	Allowable Modifiers	Service Description HCSIS Description
W7078	TD, TE, U1	The provision of the eligible components of Residential Habilitation in an unlicensed one person residence. Resid Hab-Unlic 1-Indiv Home (Eligible)
W7080	TD, TE, U1	The provision of the eligible components of Residential Habilitation in an unlicensed two person residence. Resid Hab-Unlic 2-Indiv Home (Eligible)
W7082	TD, TE, U1	The provision of the eligible components of Residential Habilitation in an unlicensed three person residence. Resid Hab-Unlic 3-Indiv Home (Eligible)
	U1	Enhanced Communication Service – This modifier can be utilized with all the Waiver Procedure Codes in this table for the direct provision of this service. 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.

Modifier TD – Must be used when the service is provided by a Registered Nurse (RN).
Modifier TE – Must be used when the service is provided by a Licensed Practical Nurse (LPN).

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

Unlicensed Ineligible Residential Habilitation:

Provider Type 52 - Community Residential Rehabilitation
Specialty 524 - Unlicensed

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

Procedure Code	Allowable Modifiers	Service Description HCSIS Description
W7079		Resid Hab-Unlic 1-Indiv Home (Inelig))
W7081		Resid Hab-Unlic 2-Indiv Home (Inelig)

W7083		Resid Hab-Unlic 3-Indiv Home (Inelig)

Supported Living

These are direct and indirect services provided to individuals who live in a private home that is owned, leased or rented by the individual or provided for the individual's use via a Special or Supplemental Needs trust and located in Pennsylvania. Supported Living services are provided to protect the health and welfare of individuals by assisting them in the general areas of self-care, health maintenance, wellness activities, meal preparation, decision making, home management, managing personal resources, communication, mobility and transportation, relationship development and socialization, personal adjustment, participating in community functions and activities and use of community resources. Through the provision of this service individuals will be supported to live in their own home in the community and to acquire, maintain or improve skills necessary to live more independently and be more productive and participatory in community life.

This service is billed as a day unit and includes indirect support for periods of time that the individual does not need direct support in their home and community. The Supported Living provider, however, must ensure that direct support is provided as needed to achieve desired outcomes, facilitate participation in the community and mitigate risks. The Supported Living provider must also ensure that on-call staff are available to support the individual 24 hours a day. The type and degree of assistance, support and guidance are informed by the assessed need for physical, psychological and emotional assistance established through the assessment and person-centered planning processes.

The Supported Living provider must provide the level of services necessary to enable the individual to meet habilitation outcomes. This includes ensuring assistance, support and guidance (which includes prompting, instruction, modeling and reinforcement) will be provided as needed to enable the individual to:

1. Carry out activities of daily living such as personal grooming and hygiene, dressing, making meals and maintaining a clean environment.
2. Learn and develop practices that promote good health and wellness such as nutritious meal planning, regular exercise, carrying through prescribed therapies and exercises, awareness and avoidance of risk including environmental risks, exploitation or abuse; responding to emergencies in the home and community such as fire or injury; knowing how and when to seek assistance.
3. Manage or participate in the management of his or her medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, and keeping health logs and records. The staff providing this support may also administer medications in accordance with applicable regulatory guidance.
4. Manage his or her mental health diagnosis and emotional wellness including self-management of emotions; applying trauma informed care principles and practices; and accessing mental health services. The service should include: a comprehensive behavior assessment; design, development and updates to a behavior support plan that includes positive practices and least restrictive interventions; development of a Crisis Intervention Plan; and implementation of the behavior support plan, Crisis Intervention Plan and/or the skill building plan which involve collecting and recording the data necessary to evaluate progress and the need for plan revisions.

5. Participate in the development and implementation of the service plan and direct the person-centered planning process including identifying who should attend and what the desired outcomes are.
6. Make decisions including identifying options/choices and evaluating options/choices against a set of personal preferences and desired outcomes. This includes assistance with identifying supports available within the community.
7. Manage his or her home including arranging for utility services, paying bills, home maintenance, and home safety.
8. Achieve financial stability through managing personal resources, general banking and balancing accounts, record keeping and managing savings accounts and programs such as ABLE accounts.
9. Communicate with providers, caregivers, family members, friends and others face-to-face and through the use of the telephone, correspondence, the internet, and social media. The service may require knowledge and use of sign language or interpretation for individuals whose primary language is not English.
10. Use a range of transportation options including buses, trains, cab services, driving, and joining carpools, etc. The Supported Living provider is responsible to provide transportation to activities related to health, community involvement and the individual's service plan. The Supported Living provider is not responsible for transportation for which another provider is responsible.
11. Develop and manage relationships with roommates as appropriate, share responsibilities for shared routines such as preparing meals, eating together, carrying out routine home maintenance such as light cleaning, planning and scheduling shared recreational activities and other typical household routines, resolving differences and negotiating solutions.
12. Develop and maintain relationships with members of the broader community (examples include but are not limited to: neighbors, coworkers, friends and family) and to manage problematic relationships.
13. Exercise rights as a citizen and fulfill his or her civic responsibilities such as voting and serving on juries; attend public community meetings; participate in community projects and events with volunteer associations and groups; serve on public and private boards, advisory groups, and commissions, as well as develop confidence and skills to enhance his or her contributions to the community.
14. Develop personal interests; such as hobbies, appreciation of music, and other experiences the individual enjoys or may wish to discover.
15. Participate in preferred activities of community life such as shopping, going to restaurants, museums, movies, concerts, dances and faith-based services.

The supported living provider is responsible for the identification of risk to the individual and the implementation of actions such as reporting incidents as required by ODP, the Older Adults Protective Services Act, the Adult Protective Services Act and the Child Protective Services Law, and/or calling emergency officials for immediate assistance. The Supported Living provider is also responsible for the provision of physical health maintenance services including those required by a licensed nurse when required to assure health and wellness or as required in the service plan.

This service is billed as a day unit and may be provided at the following levels:

- Needs Group 1

- Needs Group 2
- Needs Group 3
- Needs Group 4

Supported Living services include the support of a supported living specialist for each individual with overall responsibility to provide oversight and monitoring of the habilitative outcomes, health and wellness activities, ongoing assessment of supports and needs of the individual as identified in his or her service plan, as well as coordination of support services, both direct and indirect related to the Supported Living service.

In emergency situations or to meet an individual's temporary medical or behavioral needs, individuals authorized to receive Supported Living may also be authorized to receive Supplemental Habilitation for no more than 90 calendar days unless a variance is granted by the AE.

Supported Living services must be delivered in a private home located in Pennsylvania or other community settings. During temporary travel, however, this service may be provided in Pennsylvania or other locations per the ODP travel policy.

Determining the need for services:

- Could the individual's needs best be met through the flexibility and agency support (including supported living specialists) offered through Supported Living?
- Does the individual have behavioral support needs or nursing needs?
  - If yes, is the Supported Living provider meeting those needs?

Service Limits:

- Supported Living services may not be provided in licensed or unlicensed residential habilitation settings, licensed or unlicensed Life Sharing homes, Adult Training Facilities (55 Pa. Code Chapter 2380) or Vocational Facilities (55 Pa Code Chapter 2390).

HCBS Settings:

- Settings enrolled on or after February 1, 2020, shall not be located in any development or building where more than 25% of the apartments, condominiums or townhouses have ODP-funded Residential Habilitation, Life Sharing or Supported Living being provided.

The procedure code and service units for Supported Living Services:

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

Service Unit: Day
Age Limits & Funding:
Consolidated and Community Living Waivers: 18-120 years old
Base Funding: 18-120 years old

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

Procedure Code	Allowable Modifiers	Needs Group	Service Description HCSIS Description
W9872	U5	1	The provision of Supported Living in a one person home. Supported Living-1 Person-NG1
W9873	U5	1	The provision of Supported Living in a two person home. Supported Living-2 Person-NG1
W9874	U5	1	The provision of Supported Living in a three person home. Supported Living-3 Person-NG1
W9872	U6	2	The provision of Supported Living in a one person home. Supported Living-1 Person-NG2
W9873	U6	2	The provision of Supported Living in a two person home. Supported Living-2 Person-NG2
W9874	U6	2	The provision of Supported Living in a three person home. Supported Living-3 Person-NG2
W9872	U7	3	The provision of Supported Living in a one person home. Supported Living-1 Person-NG3
W9873	U7	3	The provision of Supported Living in a two person home. Supported Living-2 Person-NG3
W9874	U7	3	The provision of Supported Living in a three person home. Supported Living-3 Person-NG3
W9872	U8	4	The provision of Supported Living in a one person home. Supported Living-1 Person-NG4
W9873	U8	4	The provision of Supported Living in a two person home. Supported Living-2 Person-NG4
W9874	U8	4	The provision of Supported Living in a three person home. Supported Living-3 Person-NG4
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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.

Modifiers U5, U6, U7 and U8 are Support Intensity Scale (SIS) Needs Group Modifiers.

Section 14.20: Respite

Respite services are direct services that are provided to supervise and support individuals living in private homes (for definitions of key terms, see Section 20) on a short-term basis for planned or emergency situations, giving the person(s) normally providing care a period of relief.

- 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.

In emergency situations, Respite services may be provided in:

- A licensed Residential Habilitation home, Child Residential and Day Treatment Facility, or Community Residential Rehabilitation Services home (under 55 Pa. Code Chapters 6400, 3800, or 5310) beyond the number of people who are allowed to be provided services in the home (approved program capacity), but not beyond the home's licensed capacity;
    - When Respite is provided in a Residential Habilitation or Life Sharing home, the home must be integrated and dispersed in the community in noncontiguous (not adjacent to, attached to, or located in the same building) locations, and may not be located on campus settings. Settings that only share one common party wall are considered noncontiguous.
- A non-waiver funded licensed residential setting or in a hotel when approved by ODP.
    - Settings considered non-waiver funded licensed residential settings include residential settings located on a campus or that are contiguous (adjacent to, attached to, or located in the same building) to other ODP-funded residential settings (settings that share one common party wall are not considered contiguous).
    - This will also include settings enrolled on or after the effective date of 55 Pa. Code Chapter 6100 regulations, that are located in any development or building where more than 25% of the apartments, condominiums or townhouses have waiver funded Residential Habilitation, Life Sharing or Supported Living services being provided.

An emergency circumstance is defined as a situation where:

- An individual's health and welfare is at immediate risk;
- An individual experiences the sudden loss of his or her home (for example from a fire or natural disaster).
    - This is not intended to replace a residential provider's responsibility to secure an alternative if there is a need for an emergency location;
- An individual loses the care of a relative or unrelated caregiver, without advance warning or planning; or
- There is an imminent risk of institutionalization.

To the degree possible, the respite provider must maintain the individual's schedule of activities including activities that allow participation in the community. This service also includes implementation of an individual's Behavioral Support Plan or Crisis Intervention Plan as applicable.

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

- Individual's private home located in Pennsylvania.
- Unlicensed private home that is located in Pennsylvania, Washington DC, or Virginia or a state contiguous to Pennsylvania.

- Other private homes, hotels, or rentals during temporary travel in accordance with ODP's travel policy.
- Unlicensed and Licensed Life Sharing home (55 Pa. Code Chapter 6500) located in Pennsylvania.
- Licensed Residential Habilitation home (55 Pa. Code Chapter 6400) located in Pennsylvania within the home's approved program capacity of 1 to 4.
- 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.
- Respite Camp settings that meet applicable state or local codes.
- Community settings that maintain the individual's schedule of activities.

Additional Service Definition Clarification:

Variances:

A variance for Respite services in the following settings may be requested when the individual has a Needs Group 3 or higher that indicates medical or behavioral needs and the individual is unable to locate a respite provider to render services in a community setting:

- Licensed Intermediate Care Facilities for individuals with an Intellectual Disability (55 Pa. Code 6600) that are owned and operated by private agencies.
- Licensed Nursing Homes (28 Pa. Code Chapters 201, 203, 205, 207, 209 and 211).
- Licensed Community Homes (55 Pa. Code Chapter 6400, 3800 or 5310) located in Pennsylvania within the home's approved program capacity of 5 to 8.

Please note: A variance does not need to be completed for Respite provided in a Life Sharing home. For Life Sharing service locations that have an approved program capacity of 1, the approved program capacity can be exceeded to provide Respite to a second person.

Respite should not be used to provide relief to direct service professionals. It is the responsibility of the employer to ensure that direct service professionals receive relief. Respite should not be included as the back-up plan for a paid service.

Respite for children by a nurse:

Children (under age 21) who have medical needs that require Respite by a nurse can request a variance when the following criteria are met:

- The child is authorized to receive less than 24 hours a day of nursing through private insurance or Medical Assistance;

And one of the following:

- The child requires administration of intravenous fluid or medication, which is specified in a written order by a licensed doctor of the healing arts; or
- The child uses monitoring, defibrillating or resuscitating equipment, or a combination of the three; or
- The child requires other skilled activities that must be provided by a nurse. A list of non-skilled activities that can be performed by professionals other than a nurse is available at https://www.dhs.pa.gov/about/DHS-Information/Documents/InformationforAdvocatesandStakeholders/Long-Term_Services_and_Supports_Subcommittee/LTSSMeetingMinutes/LTSSMeetingMinutes/c_272151.pdf and https://sais.health.pa.gov/CommonPOC/content/FacilityWeb/attachment.asp?messageid

=3302&filename=DOH+Home+Care+Agency+Guidance+Final%2Epdf&attachmentnumber=1

A request for a variance to this limit may not be approved for Respite provided by a nurse unless there is an emergency circumstance involving a child with medical needs who meets the criteria described above. Ongoing nursing needs for children with medical needs are addressed through Medical Assistance Fee-for-Service or Physical Health Managed Care Organizations.

Determining the need for services:
The team must address the following additional questions when determining which Respite is necessary:

- What are the specific supports the individual needs during respite?
- 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?
- Is there availability of natural supports?
  To determine the ability for an individual to receive enhanced and non-enhanced 2:1 levels of Respite, where the direct service professional does not have a degree, the following decision tree shall be applied:

Question 1 - Does the individual have a medical or behavioral support need?

- If NO - STOP. Enhanced and 2:1 levels of service are not supported for the individual
- If YES - Proceed to Question 2 for 2:1 levels of service. Proceed to Question 3 for the 1:1 enhanced level of service.

Question 2 (applies to 2:1 levels of service only) - Is the individual's medical or behavioral need of a nature that 2 staff are required to provide the service?

- If NO – STOP. 2:1 levels of service (enhanced or non-enhanced) are not supported for the individual.
- If YES – Add the non-enhanced 2:1 levels of service to the ISP. Proceed to Question 3 for the enhanced 2:1 levels of service.

Question 3 (applies to Enhanced levels of service only) - Is the individual's medical or behavioral need:

1) Severe enough that it cannot be met through the service definition as written, i.e. requires specific behavioral or medical support to access the service as written in the service definition specifications?

AND / OR

2) Of a nature that it must be met by someone with one of the licenses, certificates, or degrees specified in the qualifications?

- If NO – STOP. Enhanced levels of service are not supported for the individual.
- If YES - Add enhanced levels of service to the ISP.

Any individual age 21 or older who needs nursing services can receive this type of support through the Shift Nursing service.

Service limits:

- Respite services are limited to:
  - 30 units of day respite per individual in a period of one fiscal year, and
  - 480 units of 15-minute unit respite per individual in a period of one fiscal year (Consolidated Waiver).
  - 1440 units of 15-minute unit respite per individual in a period of one fiscal year (Community Living or P/FDS Waiver).
- Requests for a variance to this limit may be made for individuals who have behavioral or medical support needs or for emergency circumstances using the standard ODP variance process.
- Individuals authorized to receive **15-minute unit** Respite services may not receive the direct portion of the following services at the same time: Community Participation Support; Small Group Employment; Supported Employment; Advanced Supported

Employment; Education Support; Music, Art and Equine Assisted Therapy and Consultative Nutritional Services.

- Individuals authorized to receive Respite services **(15-minute or Day)** may not receive the following services at the same time: Companion, In-Home and Community Supports, and Shift Nursing.
- Respite services may not be provided in hospitals, Personal Care Homes or public ICFs/ID (ICFs/ID that are owned and operated by any state).

Authorizing Units on ISP:

Individuals may be authorized on the ISP to receive two categories of Respite services:

- Day respite: must be provided for periods of more than 16 hours, and is billed using a daily unit;
  - Day respite is the only type of Respite allowable to be provided in Residential Habilitation, Life Sharing, private ICFs/ID, or licensed nursing homes.
    - Day respite authorized in these settings must be provided for periods of at least 8 non-continuous care hours within a 24-hour period.
    - Day respite authorized to be provided in private homes will be billed as a day unit when a period of more than 16 hours of support is provided.
  - As of January 1st, 2021, respite provided in a Licensed or Unlicensed Life Sharing home must be authorized and billed using the "24-hour Respite in a Life Sharing setting" procedure codes which in HCSIS reads as "Respite-Life Sharing-Day" (W6100-W6104).
  - The day unit is tied to where Respite is delivered; when Respite is provided by anyone in a licensed or unlicensed Life Sharing or Residential Habilitation setting, only Day Respite can be authorized and billed.
- 15-minute respite must be provided for periods of 16 hours or less and is billed using a 15-minute unit.
  - Individuals may not be authorized for 15-minute unit respite provided in Residential Habilitation settings, Life Sharing settings, private ICFs/ID, or licensed nursing homes.

Please Note:

- Individuals who receive Residential Habilitation or Supported Living Services may not bill Day Respite or 15-Minute Unit respite during the same time period.
- If the Respite occurs in a private home, that is not a Life Sharing home, and is located in Pennsylvania, Washington DC, or Virginia or a state contiguous to Pennsylvania as specified in the waiver (such as the private home of a friend, family member or neighbor), either 15-minute or day Respite may be approved and authorized (which is dependent on the number of hours of Respite provided as specified in the Respite service definition).
- In Life Sharing, if the "respite" is provided informally by another member of the host family who is not the primary caregiver, a neighbor or another person with whom the Life Sharing provider, host family and individual have a relationship, it may not be billed as a discrete Respite service. However, nothing precludes Life Sharing providers and host families from continuing to engage in informal "substitute care" arrangements. When this occurs, billing should be the day rate for Life Sharing (see ODP Communication 028-18, *Now Available: Life Sharing and Respite Question and Answer Document)*.

Room and board costs are included in the fee schedule rate solely for Respite provided in a licensed residential setting. For this reason, there may not be a charge for room and board to

the individual for Respite that is provided in a licensed residential setting. There may not be a charge to the individual for room and board in respite camp settings that are licensed or accredited. The waiver will reimburse the room and board fee charged to the general public if the camp is licensed or accredited. The camp should provide separate documentation of the service cost and the room and board component based on the accreditation or certification standard for the camp.

SC documentation requirements:

- Documentation of the purpose of the Respite service must be documented in the ISP (emergency, relief of the caregiver, break for the individual, etc.).
- For 2:1 staffing (both enhanced and non-enhanced), the individual's behavioral or medical need for this level of staffing, as well as the license(s), certificate(s) or degree(s) that the direct service professionals possess to provide the enhanced level(s) of service must be documented in the ISP.

The procedure codes, modifiers, and service units for 24-Hour Respite – Unlicensed Out-of-Home and In-Home (excluding Life Sharing):
These codes would be used for Respite in the individual's unlicensed private home (located in Pennsylvania), an unlicensed private home of a family member, friend or other respite provider (located in Pennsylvania, Washington DC, or Virginia or a state contiguous to Pennsylvania), other private homes, hotels, or rentals during temporary travel in accordance with ODP's travel policy and community settings that maintain the individual's schedule of activities.

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

Service Unit: Day
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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 HCSIS Description
W9795		Basic Staff Support	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-Day (Basic 1:4) Out-of-Home Respite-Unlic-Day (Basic 1:4) In-Home Staff Ratio 1:4
W9796		Staff Support Level 1	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting.

			Respite-Unlic-Day (Level 1, 1:3) Out-of-Home Respite-Unlic-Day (Level 1, 1:3) In-Home Staff Ratio 1:3
W9797		Staff Support Level 2	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-Day (Level 2, 1:2) Out-of-Home Respite-Unlic-Day (Level 2, 1:2) In-Home Staff Ratio 1:2
W9798*		Staff Support Level 3	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-Day (Level 3, 1:1) Out-of-Home Respite-Unlic-Day (Level 3, 1:1) In-Home Staff Ratio 1:1
W9799*	**TD or TE**	Staff Support Level 3 Enhanced	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-Day (Level 3, 1:1 Enh) Out-of-Home Respite-Unlic-Day (Level 3, 1:1 Enh) In-Home Staff Ratio 1:1 with a licensed nurse (only for children with medical needs) or a certified staff member
W9800*		Staff Support Level 4	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-Day (Level 4, 2:1) Out-of-Home Respite-Unlic-Day (Level 4, 2:1) In-Home Staff Ratio 2:1
W9801*	**TD or TE**	Staff Support Level 4 Enhanced	The provision of day respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-Day(Level 4, 2:1 Enhcd) Out-of-Home Respite-Unlic-Day (Level 4, 2:1 Enhcd) In-Home Staff Ratio 2:1 with one licensed nurse (only available to children with medical needs) or one certified staff member and one staff member with at least a high school diploma

Service Unit: Day
Provider Type **54** - Intermediate Service Organization
Specialty **540** - ISO-Agency With Choice

Allowable Modifiers	Service Level	Service Description
U4*	No benefit allowance	This modifier is to be used with the noted procedure codes and modifiers (as appropriate) by the Agency With Choice Financial

Only used with W9798 W9799 W9800 W9801		Management Service when no benefit allowance is paid to the support service professional as part of the wage.
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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 or more modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE
2st – U4
3nd – U1

The procedure codes, modifiers, and service units for 24-Hour Respite – Licensed and Unlicensed Life Sharing setting:

These codes would be used for Respite in an unlicensed or licensed Life Sharing home located in Pennsylvania.
Provider Type **51 -** Home & Community Habilitation
Specialty **512 -** Respite Care Home-Based; **513** - Respite Care-Out of Home

Service Unit: Day
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 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** **HCSIS Description**
W6100	**U1**	Staff Support Level 2	The provision of day respite in an unlicensed or licensed, out-of-home or in-home Life Sharing setting. Respite-Life Sharing-Day (Level 2, 1:2)Out-of-Home Respite-Life Sharing-Day (Level 2, 1:2) In-Home Staff Ratio 1:2
W6101	**U1**	Staff Support Level 3	The provision of day respite in an unlicensed or licensed, out-of-home or in-home Life Sharing setting. Respite-Life Sharing-Day (Level 3, 1:1)Out-of-Home Respite-Life Sharing-Day (Level 3, 1:1) In-Home Staff Ratio 1:1
W6102	**TD or TE, U1**	Staff Support Level 3 Enhanced	The provision of day respite in an unlicensed or licensed, out-of-home or in-home Life Sharing setting.

			Respite-Life Sharing-Day(Lvl 3,1:1 Enh)Out-of-Home Respite-Life Sharing-Day (Level 3,1:1 Enh) In-Home Staff Ratio 1:1 with a licensed nurse (only for children with medical needs) or a certified staff member
W6103	**U1**	Staff Support Level 4	The provision of day respite in an unlicensed or licensed, out-of-home or in-home Life Sharing setting. Respite-Life Sharing-Day (Level 4, 2:1)Out-of-Home Respite-Life Sharing-Day(Level 4, 2:1)In-Home Staff Ratio 2:1
W6104	**TD or TE, U1**	Staff Support Level 4 Enhanced	The provision of day respite in an unlicensed or licensed, out-of-home or in-home Life Sharing setting. Respite-Life Sharing-Day(Lvl 4,2:1 Enh)Out-of-Home Respite-Life Sharing-Day (Level 4, 2:1 Enh)In-Home Staff Ratio 2:1 with one licensed nurse (only available to children with medical needs) or one certified staff member and one staff member with at least a high school diploma

Allowable Modifiers	Service Level	Service Description
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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 or more modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE
2st – U1

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

These codes would be used for Respite in the individual's unlicensed private home that is not a Life Sharing home (located in Pennsylvania), an unlicensed private home of a family member, friend or other respite provider that is not a Life Sharing home (located in Pennsylvania, Washington DC, or Virginia or a state contiguous to Pennsylvania), other private homes, hotels, or rentals during temporary travel in accordance with ODP's travel policy and community settings that maintain the individual's schedule of activities.

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Base Funding: 0-120 years old
Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W8096		Basic Staff Support	The provision of 15-minute unit respite in an unlicensed out-of-home or in-home setting. Respite-Unlic- 15-min (Basic 1:4) Staff Ratio 1:4
W9860		Staff Support Level 1	The provision of 15-minute unit respite in an unlicensed out-of-home or in-home setting. Respite-Unlic-15-min(Level 1, 1:3) Out-of-Home Respite-Unlic-15-min(Level 1, 1:3) In-Home Staff Ratio 1:3
W9861		Staff Support Level 2	The provision of 15-minute unit respite in an unlicensed out-of-home or in-home setting. Respite-Unlic-15-min(Level 2, 1:2)Out-of-Home Respite-Unlic-15-min(Level 2, 1:2)In-Home Staff Ratio 1:2
W9862*		Staff Support Level 3	The provision of 15-minute unit respite in an unlicensed out-of-home or in-home setting. Respite-Unlic-15-min(Level 3, 1:1)Out-of-Home Respite-Unlic-15-min(Level 3, 1:1)In-Home Staff Ratio 1:1
W9863*	**TD or TE**	Staff Support Level 3 Enhanced	The provision of 15-minute unit respite in an unlicensed out-of-home or in-home setting. Respite-Unlic- 15-min(Level 3, 1:1 Enhcd) Staff Ratio 1:1 with a licensed nurse (only for children with medical needs) or a certified staff member
W9864*		Staff Support Level 4	The provision of 15-minute unit respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-15min(Lvl 4,2:1) Out of Home Respite-Unlic-15-min(Lvl 4, 2:1) In-Home

			Staff Ratio 2:1
W8095*	**TD or TE**	Staff Support Level 4 Enhanced	The provision of 15-minute respite in an unlicensed out-of-home or unlicensed in-home setting. Respite-Unlic-15-min(Level 4, 2:1 Enhanced) Staff Ratio 2:1 with one licensed nurse (only for children with medical needs) or one certified direct service professional and one staff member with at least a high school diploma

Service Unit: 15 minutes
Provider Type **54** - Intermediate Service Organization
Specialty **540** - ISO-Agency With Choice

Allowable Modifiers	**Service Level**	**Service Description**
U4* Only used with W9862 W9863 W9864 W8095	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 professional as part of the wage.
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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 or more modifiers for this service they must be listed in the following order for the claim to process correctly:

1st – TD or TE
2st – U4
3nd – U1

The procedure codes, modifiers, and service units for 24-Hour Respite — Licensed Out-Of-Home:
These codes would be used for Respite provided in a Licensed Community Home (55 Pa. Code Chapter 6400) located in Pennsylvania, a Licensed Child Residential Service Home (55 Pa. Code Chapter 3800) located in Pennsylvania, or a Licensed Community Residential Rehabilitation Services for the Mentally Ill Home (55 Pa. Code Chapter 5310) located in Pennsylvania.

Please Note: Modifiers will be used to represent the Needs Group associated with the individual. These modifiers will be attached to the licensed Respite-day procedure codes and should be used when billing services that use a Needs Group. The modifiers will be visible on the Service Detail screen in HCSIS.

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

Specialty **513** - Respite Care-Out of Home

Service Unit: Day
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Base Funding: 0-120 years old
Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Needs Group	Service Description HCSIS Description
W9791	**U5**	1	The provision of day respite in a licensed out-of-home setting that serves 2 persons. Respite-Lic-Day-2 person-NG 1
W9792	**U5**	1	The provision of day respite in a licensed out-of-home setting that serves 3 persons. Respite-Lic-Day-3 person-NG 1
W9793	**U5**	1	The provision of day respite in a licensed out-of-home setting that serves 4 persons. Respite-Lic-Day-4 person-NG 1
W9791	**U6**	2	The provision of day respite in a licensed out-of-home setting that serves 2 persons. Respite-Lic-Day-2 person-NG 2
W9792	**U6**	2	The provision of day respite in a licensed out-of-home setting that serves 3 persons. Respite-Lic-Day-3 person-NG 2
W9793	**U6**	2	The provision of day respite in a licensed out-of-home setting that serves 4 persons. Respite-Lic-Day-4 person-NG 2
W9790	**U7**	3	The provision of day respite in a licensed out-of-home setting that serves 1 person. Respite-Lic-Day-1 person-NG 3
W9791	**U7**	3	The provision of day respite in a licensed out-of-home setting that serves 2 persons. Respite-Lic-Day-2 person-NG 3
W9792	**U7**	3	The provision of day respite in a licensed out-of-home setting that serves 3 persons. Respite-Lic-Day-3 person-NG 3
W9793	**U7**	3	The provision of day respite in a licensed out-of-home setting that serves 4 persons. Respite-Lic-Day-4 person-NG 3
W9790	**U8**	4	The provision of day respite in a licensed out-of-home setting that serves 1 person. Respite-Lic-Day-1 person-NG 4

W9791	**U8**	4	The provision of day respite in a licensed out-of-home setting that serves 2 persons. Respite-Lic-Day-2 person-NG 4
W9792	**U8**	4	The provision of day respite in a licensed out-of-home setting that serves 3 persons. Respite-Lic-Day-3 person-NG 4
W9793	**U8**	4	The provision of day respite in a licensed out-of-home setting that serves 4 persons. Respite-Lic-Day-4 person-NG 4
W9790	**U9**	5	The provision of day respite in a licensed out-of-home setting that serves 1 person. Respite-Lic-Day-1 person-NG 5
W9791	**U9**	5	The provision of day respite in a licensed out-of-home setting that serves 2 persons. Respite-Lic-Day-2 person-NG 5
W9792	**U9**	5	The provision of day respite in a licensed out-of-home setting that serves 3 persons. Respite-Lic-Day-3 person-NG 5
W9793	**U9**	5	The provision of day respite in a licensed out-of-home setting that serves 4 persons. Respite-Lic-Day-4 person-NG 5
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the direct provision of this service. 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.
	U2		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

Modifiers U5, U6, U7, U8, and U9 are Support Intensity Scale (SIS) Needs Group Modifiers.
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 – U5, U6, U7, U8 or U9
2nd - U1

OR

1st – U5, U6, U7, U8 or U9
2nd – U2

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

1st – U5, U6, U7, U8, or U9
2nd – U2

3rd – U1

The procedure codes, modifiers, and service units for 24-Hour Respite – Respite Only Homes:
These codes would be used for a home that is licensed under 55 Pa. Code Chapter 6400 that solely provides respite services in the home.

Provider Type **52 -** Community Residential Habilitation
Specialty **513** - Respite Care-Out of Home

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

Procedure Code	Allowable Modifiers	Needs Group	Service Description HCSIS Description
W9865	**U5**	1	The provision of day respite in a respite only home with an approved program capacity of 2 persons. Respite Only Home-2 People-Lic-Day-NG 1
W9866	**U5**	1	The provision of day respite in a respite only home with an approved program capacity of 3 persons. Respite Only Home-3 People-Lic-Day-NG 1
W9871	**U5**	1	The provision of day respite in a respite only home with an approved program capacity of 4 persons. Respite Only Home-4 People-Lic-Day-NG 1
W9865	**U6**	2	The provision of day respite in a respite only home with an approved program capacity of 2 persons. Respite Only Home-2 People-Lic-Day-NG 2
W9866	**U6**	2	The provision of day respite in a respite only home with an approved program capacity of 3 persons. Respite Only Home-3 People-Lic-Day-NG 2
W9871	**U6**	2	The provision of day respite in a respite only home with an approved program capacity of 4 persons. Respite Only Home-4 People-Lic-Day-NG 2
W9865	**U7**	3	The provision of day respite in a respite only home with an approved program capacity of 2 persons. Respite Only Home-2 People-Lic-Day-NG 3
W9866	**U7**	3	The provision of day respite in a respite only home with an approved program capacity of 3 persons. Respite Only Home-3 People-Lic-Day-NG 3
W9871	**U7**	3	The provision of day respite in a respite only home with an approved program capacity of 4 persons. Respite Only Home-4 People-Lic-Day-NG 3

W9865	**U8**	4	The provision of day respite in a respite only home with an approved program capacity of 2 persons. Respite Only Home-2 People-Lic-Day-NG 4
W9866	**U8**	4	The provision of day respite in a respite only home with an approved program capacity of 3 persons. Respite Only Home-3 People-Lic-Day-NG 4
W9871	**U8**	4	The provision of day respite in a respite only home with an approved program capacity of 4 persons. Respite Only Home-4 People-Lic-Day-NG 4
W9865	**U9**	5	The provision of day respite in a respite only home with an approved program capacity of 2 persons. Respite Only Home-2 People-Lic-Day-NG 5
W9866	**U9**	5	The provision of day respite in a respite only home with an approved program capacity of 3 persons. Respite Only Home-3 People-Lic-Day-NG 5
W9871	**U9**	5	The provision of day respite in a respite only home with an approved program capacity of 4 persons. Respite Only Home-4 People-Lic-Day-NG 5
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the direct provision of this service. 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.

Modifiers U5, U6, U7, U8 and U9 are Support Intensity Scale (SIS) Needs Group Modifiers.

The procedure codes, modifiers, and service units for Exceptional Day Respite:
These codes would be used for day respite provided in the following enrolled and qualified settings when the individual has a Needs Group 3 or higher that indicates medical or behavioral needs, and the individual is unable to locate a respite provider to render services in a community setting. (NOTE: Before these services can be provided, a Variance Form (DP 1086) must be completed. Consult Bulletin 00-18-06, *Variance Form and Process*, or its successor for instructions.)

- Licensed intermediate care facilities for individuals with an intellectual disability (55 Pa. Code Chapter 6600) that are owned and operated by private agencies.
- Licensed Nursing Homes (28 Pa. Code Chapters 201, 203, 205, 207, 209 and 211).
- Homes Licensed under 55 Pa. Code Chapter 6400, 3800 or 5310 located in Pennsylvania within the home's approved program capacity of 5 to 8.

These codes should also be used for day respite provided in a private licensed facility or a non-waiver licensed facility in an emergency circumstance.

The rate for Exceptional Day Respite provided in a home licensed under 55 Pa. Code Chapter 6400, 3800 or 5310 must be the fee schedule rate developed for Residential Habilitation

services provided. The rate entered for Respite in one of the other locations listed must be the same as the rate charged for any other person receiving services in that location.

Provider Type **52 -** Community Residential Habilitation
Specialties **456** - CRR-Adult; **513** - Respite Care - Out of Home; **520** - Child Residential Services-3800; **521** - Adult Residential-6400

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

Procedure Code	**Allowable Modifiers**	**Needs Group**	**Service Description** **HCSIS Description**
H0045	**U5**	1	The provision of exceptional day respite. Respite, Non-Waiver Setting/PLF, NG 1
H0045	**U6**	2	The provision of exceptional day respite. Respite, Non-Waiver Setting/PLF, NG 2
H0045	**U7**	3	The provision of exceptional day respite. Respite, Non-Waiver Setting/PLF, NG 3
H0045	**U8**	4	The provision of exceptional day respite. Respite, Non-Waiver Setting/PLF, NG 4
H0045	**U9**	5	The provision of exceptional day respite. Respite, Non-Waiver Setting/PLF, NG 5
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the direct provision of this service. 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.
	HE		This modifier must be used as it denotes ODP specific code

The procedure codes and service units for Waiver Respite Camp, 24 hours and 15 minute Services:
Provider Type **55** - Vendor
Specialty **554** - Respite, Overnight Camp (24-hour); **555** - Respite, Day Camp (15 minute unit)

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, Community Living and P/FDS Waivers: 0 - 120 years old
Base Funding: 0-120 years old
Allowable Place of Service: 99-Community

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description	Service Unit
W7285*	**U1**	**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. Respite Camp, 24 Hours, Eligible-Day	Day
W7286*	**U1**	**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. Respite Day Camp, 15 Mins, Eligible-15 Mins-	15 minutes

U1 - Utilized with the appropriate procedure code to allow providers, who are approved by the Department, to receive the Enhanced Communication Services Rate.

Section 14.21: Shift Nursing

Shift Nursing is a direct service that can be provided either part-time or full-time in accordance with 49 Pa. Code Chapter 21 (State Board of Nursing) which 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."

Shift Nursing services can only be provided to adult individuals (age 21 and older). All medically necessary shift nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Shift Nursing services may only be funded for adult individuals through the Waiver if documentation is secured by the Supports Coordinator that shows the service is medically necessary and not covered by the individual's insurance (Medical Assistance (MA), Medicare and/or private insurance) or insurance limitations have been reached.

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:

- 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. Home Biphasic Intermittent Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP) do not require nursing presence. Many medications can be administered by direct service professionals who are not nurses. For more information please refer to the Pennsylvania Department of Health's guidance regarding non-skilled services/activities that can be performed by direct care workers at
- https://www.dhs.pa.gov/about/DHS-Information/Documents/InformationforAdvocatesandStakeholders/Long-Term_Services_and_Supports_Subcommittee/LTSSMeetingMinutes/LTSSMeetingMinutes/c_272151.pdf and and https://sais.health.pa.gov/CommonPOC/content/FacilityWeb/attachment.asp?messageid=3302&filename=DOH+Home+Care+Agency+Guidance+Final%2Epdf&attachmentnumber=1
- Children aging out of EPSDT (reaching their 21st birthday) and receiving home health service as well as children aging out of the school system (IDEA) and receiving nursing services must be assessed for their current service needs through the waivers. They will not automatically receive nursing services through ODP.

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

- Does this individual have an unstable airway that without immediate intervention could cause respiratory arrest (stop breathing)?
- Does this individual need clinical treatment that either requires the presence of a nurse or can the treatment be taught to someone such as the individual's staff with monitoring by a nurse?
- Does this individual have someone supporting him or her that can be taught treatment techniques and maintain management of equipment (including life-supporting equipment) and its function in his or her home?
- The need for the service must be evaluated on a periodic basis, at least annually, as part of the ISP process. This evaluation must review whether the individual continues to require the current level of authorized services and that the service continues to result in positive outcomes for the individual.

Service limits:

- The service must be provided by a licensed registered nurse (RN) or a licensed practical nurse (LPN).
- Individuals authorized to receive Shift Nursing services may not receive the following services at the same time as this service: Respite (15-minute or Day); Companion; In-Home and Community Supports; Community Participation Support; Therapies and Consultative Nutritional Services.
- Individuals who receive Residential Habilitation, Life Sharing, or Supported Living services may not receive Shift Nursing, except in the following circumstances:
  - Only for individuals who receive nursing supports daily, Shift Nursing can be authorized as a separate and discrete service, solely for the hours of a home visit and as deemed necessary in accordance with the Shift Nursing service definition (please view ODP waivers). Documentation must be included to show:
    - The residential provider is unable to provide nursing supports; and
    - The person(s) who the individual is visiting is unable to provide the nursing support during the visit.
  - In situations as described above, there should be a service plan team meeting to discuss with the residential provider about their ability and/or willingness to provide such supports.

✎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.
- Documentation, including the most recent nursing care plan, from the nursing service provider to confirm that nursing care continues to be appropriate.
- 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 individual's condition is present prior to the beginning of service.
- Document how Shift Nursing services support the individual's Outcome Statement in the Outcome Actions.
- Since Shift Nursing may only be funded for adults with documentation from the individual's insurance company (see above); ODP will also accept the following documentation when insurance carriers decline to provide written documentation:

- A copy of the policy or some other written statement documenting that the service, item or amount requested exceeds the allowable service limit or that the service is not covered.
- Adults are not entitled to private duty nursing/shift nursing through the Medical Assistance program's fee-for-service or managed care delivery systems. The Medical Assistance program's Adult Benefit Package Chart indicates that home health care is the only service available in the individual's home with a nursing and/or therapy component. This chart is available at the end of OMAP Bulletin 99-15-05 which can be accessed at https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/c_172249.pdf. This chart should be printed and kept in each individual's file as documentation that private duty nursing/shift nursing is not available for individuals 21 years of age and older.
- Written confirmation of information received verbally from an insurance carrier should the insurance carrier decline to send a denial letter is acceptable only when it: a) is sent to the insurance carrier, b) identifies the item or service in question, and c) requests that the insurance carrier advise the writer of any inaccuracy.

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

Nursing Services--RN

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

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
T2025	**TD**	Nursing Service – RN	This service consists of Nursing services within scope of practice. Nursing - (1:1) RN-15 minutes Staffing Ratio 1:1
T2025	**TD, UN**	Nursing Service – RN	This service consists of Nursing services within scope of practice. Nursing (1:2) RN Staffing Ratio 1:2
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code and modifiers above for the direct provision of this service. 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.

Modifier UN is used to identify shift nursing at the 1:2 ratio

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

1st – TD
2nd – UN
3rd – U1

Nursing Services--LPN

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

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

Service unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
T2025	**TE**	Nursing Service – LPN	This service consists of Nursing services within scope of practice. Nursing - (1:1) LPN-15 minutes Staffing ratio 1:1
T2025	**TE, UN**	Nursing Service – LPN	This service consists of Nursing services within scope of practice. Nursing (1:2) LPN Staffing ratio 1:2
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code and modifiers above for the direct provision of this service. 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.

Modifier UN is used to identify shift nursing at the 1:2 ratio

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

1st – TE
2nd – UN
3rd – U1

Section 14.22: Specialized Supplies

Specialized Supplies consist of personal protective equipment and incontinence supplies that are medically necessary and are not a covered service through the MA State Plan, Medicare or private insurance. Incontinence supplies are limited to diapers, incontinence pads, cleansing wipes, under pads, and vinyl or latex gloves.

Personal Protective Equipment for mitigation of the spread of infectious diseases includes the following for the individual and unpaid caregivers using any model of service delivery and Support Service Professionals in the Vendor/Fiscal Employer Agent participant directed services model:

- Gloves;
- Surgical masks, cloth masks, clear masks, and face shields;
- Gowns;
- Goggles;
- Alcohol based hand sanitizer; and
- Thermometers. No more than one thermometer shall be requested per individual. If an ear or oral thermometer that requires probe covers is requested, the probe covers are covered through Specialized Supplies.

If the individual is receiving home health services through the MA State Plan, all Personal Protective Equipment for the individual is covered through that service so Personal Protective Equipment cannot be covered for the individual through Specialized Supplies. Personal Protective Equipment can be covered for unpaid caregivers who will use the Personal Protective Equipment to maintain the health and welfare of the individual.

Specialized Supplies can only be provided to adults (individuals age 21 and older). All medically necessary Specialized Supplies for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Specialized Supplies may only be funded for adults if documentation is secured by the Supports Coordinator that shows the supplies are medically necessary and either not covered by the individual's insurance or insurance limitations have been reached. An individual's insurance includes Medical Assistance (MA), Medicare and/or private insurance.

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

Service limits:

- Individuals authorized to receive Specialized Supplies may not be authorized to receive Residential Habilitation, Life Sharing or Supported Living services. Please see section 14.19 for information about an exception on the day an individual transitions into or out of a residential home.
- This service is limited to $500 per individual per fiscal year.

SC documentation requirements:

- Specialized Supplies may only be funded for adults through the waivers if documentation is secured by the SC that shows the service is medically necessary and there is documentation of one of the following: the specialized supplies are not covered by the individual's insurance, the specialized supplies have been denied by the insurance carrier or insurance limitations for specialized supplies have been reached. While written documentation from insurance carriers of limitations, lack of coverage for services and denials must be requested; ODP will also accept the following documentation when insurance carriers decline to provide written documentation:
  - A copy of the policy or some other written statement documenting that the service, item or amount requested exceeds the allowable service limit or that the service is not covered.
  - Written confirmation of information received verbally from an insurance carrier should the insurance carrier decline to send a denial letter is acceptable only when it: a) is sent to the insurance carrier, b) identifies the item or service in question, and c) requests that the insurance carrier advise the writer of any inaccuracy.

The procedure code 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.

Service Unit: Vendor Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 12-Home; 99-Community

Procedure Code	Service Level	Service Description HCSIS Description
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. Specialized Supplies

New Service Effective 3/1/2024:

Section 14.23: Specialty Telehealth and Assessment Team

The goal of the Specialty Telehealth and Assessment Team service is to provide a right-on-time telehealth assessment when the individual's primary care physician is unavailable or unable to determine the best clinical course of action, often avoiding unnecessary emergency room visits. Specialty Telehealth and Assessment Team services are designed to coordinate individuals' care with local emergency departments, urgent care facilities, primary care physicians, and other healthcare providers to enable real time medical support, consultation and coordination on physical health issues and to assist individuals, families and providers to understand presenting health symptoms and to identify the most appropriate next steps. If a hospital visit is clinically necessary, this service allows the provider to communicate with the emergency department directly, ensuring advance preparation for the emergency department and potentially decreasing the need for inpatient admission. The Specialty Telehealth and Assessment Team provider is responsible for developing a one or two page summary of their role in service delivery to be shared with other health care professionals involved in the individual's care.

The service is consultative in nature related specifically to the presence of an intellectual disability, developmental disability, or autism and provides disability-specific guidance on when best to seek additional or in-person medical treatment for the individual. This is a supportive service that can occur while the individual is in their private or residential home to help assess their need for medical attention. Telehealth assessments may only be completed in bedrooms and bathrooms when the individual has chosen to have the assessment completed in these rooms for privacy or the individual has a medical condition which makes it difficult or impossible for the assessment to occur in another room in the house. The service serves as a conduit to, rather than a duplication of, medical services covered under the state plan.

The service also includes support and consultation to paid and unpaid caregivers otherwise unavailable in any other service and seeks to build the capacity of paid and unpaid caregivers to better understand the best approaches for supporting the individual based on their symptom presentation. Support to caregivers, which is informed by staff with strong expertise in intellectual disability, developmental disability, and autism, is an essential component that is not available elsewhere within the Medicaid state plan or other waiver services.

The Specialty Telehealth and Assessment Team service is available 24 hours a day, 7 days a week and includes immediate evaluations, video-assisted examinations, development of treatment plans, and discussion and coordination with individuals and/or caregivers.

The service includes follow-up consultations with the individual, family, and/or caregiver of the individual within 18 hours of the initial call. Specialty Telehealth and Assessment Team services are unique in both provider qualifications and coverage within Medicaid and does not duplicate (but complements and links to) those services available in the state plan. The combination of required medical experience AND extensive expertise with people with intellectual disabilities, developmental disabilities, or autism is not included in state plan services and the consultative nature of the service distinguishes this service from other state plan benefits. The service does not duplicate supports coordination. The care coordination facilitated by this service becomes a part of rather than duplicating the service plan. Furthermore, this service provides clinically informed, disability specific medical advice and counseling to caregivers that is entirely distinct from any information provided by or available to the Supports Coordinators.

The services are limited to additional services not otherwise covered under the state plan, including EPSDT, and must be consistent with waiver objectives of avoiding institutionalization.

Additional Service Definition Clarification:

This service is provided as a monthly service and billed in monthly units. Individuals who choose to use this service must be authorized for one unit of service per month (a maximum of 12 units of service may be authorized on an ISP for the plan year).

The same rate will be billed each month for the service regardless of how often the service is used, including when the service isn't used during a month. The provider may establish a limit for calls per month but there is no waiver limitation. This should be discussed with the provider prior to choosing to receive the service.

Individuals can choose to stop receiving the service at any time. When this occurs, the service will be billed for the full month. Example: During an ISP team, an individual chooses to stop receiving the STAT service on May 7th. The monthly rate will be billed for May but will stop being billed from June forward.

Service Limits:

- Individuals must have access to an electronic tablet or smart phone that has internet service via Wi-Fi or cellular data and is capable of audio and video transmission to utilize Specialty Telehealth and Assessment Team services.
    - Cellular data service and internet service cannot be covered through the waivers as they are considered room and board costs.
- This service will not duplicate any service available to the individual through the state plan.
- This service will not supplant care provided by specialists or a primary care physician, including in-person exams as needed.
- This service is provided as a monthly service and billed in monthly units.

SC documentation requirements:

- STAT provides an accessible, on demand, telehealth assessment for urgent medical evaluation. STAT will provide the individual timely medical evaluations by providers who specialize in triaging medical care for individuals with intellectual/developmental disabilities and Autism.

The procedure code and service unit for Specialty Telehealth and Assessment Team:

Provider Type **51 - Home and Community Habilitation**
Specialty **365**, -Specialty Telehealth and Assessment Team Service (STAT)

Service Unit: Outcome-based

Age Limits & Funding: Consolidated, Community Living & P/FDS Waivers: 0- 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** **HCSIS Description**
W7032	Specialty Telehealth and Assessment Team Service (STAT)	Specialty Telehealth and Assessment Team Service (STAT)

Section 14.24: Supports Broker Services

The Supports Broker service is a direct and indirect service available to individuals who elect to self-direct their own services utilizing one of the participant-directed options outlined in Appendix E-1 of the Waivers. The purpose of the Supports Broker service is to assist and support Common Law Employers (CLE) and Managing Employers (ME) to perform employer-related functions independently and to assist individuals to be as successful as possible in self-directing their services. The Supports Broker's ultimate goal is to maximize the CLE's or ME's knowledge of all functions of their role and minimize or eliminate the need for the Supports Broker service, when possible.

Supports Broker teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47.

Under no circumstances may Supports Brokers perform the Agency With Choice (AWC) or CLE functions specified in Appendix E-1-a of the Waivers or the CLE/ME duties specified in ODP bulletins relating to either participant-directed service delivery model.

Supports Broker Services may be provided by individual and agency providers that provide other Waiver, intellectual disability or autism 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 intellectual disability services when authorized to provide Support Broker services to the individual. In addition, Supports Broker providers may not provide administrative services such as Health Care Quality Unit or Administrative Entity functions. However, an IM4Q program may provide Supports Broker services to individuals who they are not responsible for interviewing.

This service is limited to the following list of activities:

- Educating and supporting the Managing Employer or Common Law Employer to complete employer-or managing employer responsibilities as outlined in the Common Law Employer Agreement or the Managing Employer Agreement form. This will assist the CLEs/MEs with performing such tasks independently and without ongoing assistance from the Supports Broker to the fullest possible extent.
- Assisting CLEs/MEs to understand and participate in orientation and trainings provided by the Vendor/Fiscal Employment Agency or the Agency with Choice.
- Providing education, guidance, and support in developing effective recruiting and hiring techniques so that CLEs/MEs can perform such tasks independently and without ongoing assistance from the Supports Broker to the fullest possible extent.
- Assisting CLEs and MEs to develop a process to determine pay rates for Support Service Professionals so that CLEs/MEs can perform such tasks independently and without ongoing assistance from the Support Broker to the fullest possible extent.
- Educating and supporting CLEs / MEs on managing service utilization such that overall expenditures do not exceed authorized units for services and assisting in the development of a method accomplish this on an ongoing basis.
- Assisting CLEs / MEs to develop a process and provide assistance to the extent necessary to recruit and retain Support Service Professionals and expanding and coordinating informal, unpaid resources and networks within the community to support meeting the individual's needs through participant-direction, which may include facilitating a support group that helps to meet the individual's self-direction needs.

These support groups are separate and apart from the service plan team meetings arranged and facilitated by the Supports Coordinator.

- Providing technical assistance and support to CLEs/MEs to develop training plans and track completion of training for Support Service Professionals.
- Providing technical assistance and support to CLEs/MEs to establish a process for creating work schedules that include both Support Service Professionals and (when applicable) unpaid supports, including developing, implementing, and modifying back-up plans for when a Support Service Professional or unpaid support is unable to work due to an emergency, acute illness, etc.
- Assist with Scheduling paid and unpaid supports.
- Providing technical assistance and guidance to support CLEs/MEs to develop a performance review process for Support Service Professionals, including but not limited to creating a performance review tool and review schedule.
- Providing or arranging for training that will aid the CLE/ME in developing their management skills, including but not limited to:
    - Conflict resolution
    - Effective communication
    - Workplace safety and injury prevention
    - Expanding and coordinating informal, unpaid resources and networks within the community to support success with participant directed services
    - Problem-solving
    - Decision-making
    - Achieving desired personal and assessed outcomes

- Identifying areas where the Supports Broker service can support an individual's desired goals and outcomes related to participant directed services; and propose modifications to participant directed services in the individual's service plan; share the information with the service plan team for inclusion in the service plan.
- Providing information, guidance, and support with responding to notices for corrective action from the FMS, SC, AE or ODP.
- Providing guidance and support with complying with the standards, regulations, policies and waiver requirements related to the participant direction of services.
- Assisting the individual to secure a new surrogate when necessary.
- Reviewing of workplace safety issues and strategies for effective management of workplace injury prevention.
- Identifying areas of support that will promote success with self-direction and independence and share the information with the team and Supports Coordinator for inclusion in the service plans.
- Advising in problem-solving, decision-making, and achieving desired personal and assessed outcomes related to the participant directed services.

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

Supports Brokers must work collaboratively with the individual's Supports Coordinator and service plan team but may not perform Supports Coordination functions or activities as listed in the Supports Coordination service in Appendix C1/C3 of the Waivers.

Specific Supports Broker activities may be completed while an individual is hospitalized in an acute care hospital in accordance with ODP Bulletin 00-23-01.

The VF/EA FMS is required to provide the VF/EA FMS administrative service and pay for all identified participant directed services authorized for an individual who is self-directing through the VF/EA FMS Intermediate Services Organization Provider Type. Self-directing individuals in the VF/EA FMS program may employ Supports Brokers through a Common-Law Employer relationship; when this occurs, Supports Brokers will be considered "Support Service Professionals" (SSP) for the purposes of this definition.

AWC FMS providers are required to provide AWC FMS administrative services in addition to all identified participant directed waiver services authorized for an individual who is self-directing through an AWC FMS provider. As such, the AWC FMS provider is able to provide both Supports Broker services and other participant directed waiver services to the same individual, but only as an AWC FMS Intermediate Services Organization Provider Type.

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

Additional Service Definition Clarification:

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

- Supports Broker services are excluded from the calculation of the P/FDS cap because the services are integral to ensuring the success of individuals in utilizing participant-directed service models.

- It is important to have a discussion with the individual and/or surrogate and Supports Broker about the expected frequency and duration of the service. The Supports Broker service is often more intensive when an individual first begins self-directing, during periods of transition and with staff turnover.

- It is allowable for Supports Broker services to be the first and only participant-directed service on an ISP for a period of time to assist common law employers or managing employers in activities such as recruiting, hiring, determining pay rates and scheduling support service professionals for other services that will be self-directed.

Determining the need for services:

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

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

Service Limits:

- Individuals authorized to receive Supports Broker services may not be authorized to receive Residential Habilitation Services, Life Sharing or Supported Living unless they are planning to transition to participant-directed services in a private home.
- This service is limited to a maximum of 1,040 (15-minute) units, which is equal to 260 hours, per individual per fiscal year.

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 procedure code and service unit for Supports Broker Services:

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

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

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 11-Office; 12-Home; 21- Inpatient Hospital (🩺); 99-Other (Community)

(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope (🩺) when an individual is in the hospital.)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
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.

			Supports Broker Services-15 Mins Staff Ratio 1:1
	U1		Enhanced Communication Service - This modifier should be utilized with the procedure code above for the direct provision of this service. 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.

Service Unit: 15 minutes
Provider Type **54** - Intermediate Service Organization
Specialty **540**, ISO-Agency With Choice

Allowable Modifiers	**Service Level**	**Service Description** **HCSIS Description**
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 professional as part of the wage. Supports Broker Services-15 Mins-U4
U1		Enhanced Communication Service - This modifier can be utilized with the Agency With Choice modifier in this table for the direct provision of this service. 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 14.25: Supports Coordination

Supports Coordination is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for individuals. This includes locating, coordinating and monitoring needed services and supports when an individual is admitted to a nursing home for less than 30 days or an acute care hospital for any duration of time.

The most important element of quality Supports Coordination is building relationships. When strong relationships are developed the quality of supports and services improves. Building relationships is not a separate and distinct activity; it is integral to each function the support coordinator performs.

Locating services and supports consists of assistance to the individual and his or her family in linking, arranging for, and obtaining services specified in the service plan, including resources in the community, competitive integrated employment, needed medical, social, habilitation, and participant direction opportunities.

Activities under the locating function include all of the following, as well as the documentation of the activities:

- Assist the individual in choosing people to be part of the service plan team;
- Assist the individual to invite other people of the individual's choice who may contribute valuable information during the planning process;
- Engage in meaningful conversations with the individual and his or her family, providers and others who provide support to develop, update, and implement the service plan;
- Link support needs of the individual and his or her family identified in the service plan with resources in the community;
- Research existing and identify new resources in the community;
- Gather and share information with which to identify needs and concerns and build partnerships in support of the individual and his or her family;
- Inform individuals, their families and other caregivers 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 service plan;
- Assist the individual and his or her family in identifying and choosing willing and qualified providers;
- Make referrals to providers (unpaid or paid) with information and follow-up support;
- Participate in the ODP standardized needs assessment process to inform development of the service plan, including any necessary service plan updates;
- Facilitate the completion of additional assessments, based on individuals' strengths, needs and preferences for planning purposes and service plan development;
- Provide individuals and their families with information on competitive integrated employment during the planning process and upon the individual's or family's request;
- Provide individuals and their families or other caregivers with information on participant direction opportunities, including the potential benefits, responsibilities and risks associated with directing services, during the planning process and upon request.
- Provide information to individuals and their families on fair hearing rights, explain what the fair hearing process entails, and assist with fair hearing requests when needed and upon request.

Coordinating consists of development and ongoing management of the service plan in cooperation with the individual, his or her family, and members of the service plan team. Activities 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 service plan to promote community integration and to meet the individual's needs in the least restrictive manner;
- Review and update the individual's service plan annually;
- Revise the individual's service plan when there is a change in need or at the request of the individual and their family;
- Work with the authorizing entity regarding the authorization of services on an ongoing basis and when issues are identified regarding requested services;
- Use information from the LifeCourse framework that helps lead to the good life that the individual and his or her family envision and assist with the development of the individual's service plan, including any updates to the service plan;
- Use information from the ODP standardized needs assessment, as well as any additional assessments completed to develop the service plan to ensure the service plan addresses all of the individual's needs;
- Periodic review of the service plan with the individual, his or her family, and/or members of the service plan team;
- Periodic review of the standardized needs assessment with the individual and his or her family, at least annually or more frequently based on changes in a individual's needs, to ensure the assessment is current;
- Coordinate service plan planning with providers of service and other entities, resources and programs as necessary to ensure all areas of the individual's needs are addressed;
- Collaborate with family, friends, and other community members to facilitate coordination of a relationship-based support network and develop supporting partnerships in order for the individual to pursue their vision of a good life;
- Coordinate meetings with individual and his or her family with other individuals and his or her family receiving services from the providers under consideration and who would be willing to give consent to share their experiences about those providers;
- Coordinate meetings between the individual and his or her family members and provider management staff to discuss provider practices in delivering services;
- Coordinate the resolution of barriers to service delivery and accomplishments of outcomes in the service plan;
- Distribute information to individuals, his or her family and others who are responsible for planning and implementation of services and support; and
- 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.

Monitoring consists of ongoing contact with the individual and his or her family, to ensure services are implemented as per the service plan. Monitoring is intended to ensure that individuals and his or her family are getting the support they need, when they need them, in order to see measurable improvements in their lives. Activities under the monitoring function include all of the following, as well as the documentation of the activities:

- Monitor the health and welfare of individuals through regular contacts at the minimum frequency outlined in Appendix D-2-a of the Waivers or increased monitoring frequency based on the need of the individual. Monitoring the health and welfare of individuals includes the review of information in health risk screening tools and assessments, when applicable, or whether there have been any changes in orders, plans or medical

interventions prescribed or recommended by medical or behavioral professionals and whether those changes are being implemented;
- Monitor service plan implementation through monitoring visits with the individual, at the minimum frequency outlined in Appendix D-2-a of this Waiver or increased monitoring frequency based on the need of the individual;
- Visit with the individual and his or her family, and providers of service for monitoring of health and welfare and service plan implementation;
- Respond to and assess emergency situations and incidents and assure that actions taken are appropriate and timely in order to protect the health and welfare of individuals;
- Review individual progress on outcomes and initiate service plan team discussions or meetings when services are not achieving desired outcomes;
- Monitor individual and his or her family satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary to address the needs of the individual, and modify the service plan accordingly;
- Ensure that services are identified in the service plan;
- Communicate the authorization status to service plan 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 community 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.

Supports Coordination teleservices may be used for locating, coordinating and monitoring activities when all of the following are met:
- Service delivery complies with the requirements in the service definition, ODP policies and regulations,
- Teleservices must be provided by means that allow for live two-way communication with the individual, no recording of the interaction shall be captured,
- Teleservices via video communication devices in bathrooms is prohibited,
- Teleservices via video communication devices in bedrooms may only occur when all of the following are met:
    - The individual has chosen to receive teleservices in their bedroom due to a medical condition which makes it difficult or impossible for them to leave their bedroom to receive services in another room in the house, or the individual would like privacy from others in the home during receipt of services;
    - The individual turns the video communication device on and off themselves or requests assistance in turning the video communication device on and off; and
    - Teleservices will not be performed as part of any activity during which privacy would generally be expected (while an individual is in a state of undress, during sexual activities, etc.).

Additional requirements for monitoring individuals using teleservices outlined in Appendix D-2-a must be followed.

The following activities are excluded from Supports Coordination as a billable Waiver service:
- Intake for purposes of determining whether an individual has an intellectual disability, autism and/or developmental disability and qualifies for Medical Assistance;

- 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);
- Any function that is delegated to the Supports Coordination Organization by an Administrative Entity;
    - This means that AE functions outlined in the Administrative Entity Operating Agreement (AEOA) are not permitted to be delegated to an SCO that provides ID/A Waiver services.
- 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;
- Travel time incurred by the Supports Coordinator 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 Supports Coordinator 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;
- Direct Representative payee functions; and
- Activities that occur from the point of an individual’s date of death and forward.

An SCO may become an Organized Health Care Delivery System (OHCDS) for any vendor service authorized in the individual’s ISP. An individual's SCO may not own or operate providers of vendor services with which it is acting as an OHCDS. SCOs must enroll and qualify as an OHCDS and comply with all requirements regarding OHCDS in Appendix I-3-g-ii of the current approved Waivers, as well as 55 Pa. Code § 6100.803.

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

Service Unit: 15 minutes
Age Limits & Funding:

Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old
Allowable Place of Service: 11-Office; 12-Home; 21- Inpatient Hospital (🩺); 99-Other (Community)

(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope (🩺) when an individual is in the hospital.)

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W7210 🩺	Waiver-Funded Supports Coordination	Locating, coordinating, and monitoring needed services and supports for waiver individuals. Supports Coordination Staffing Ratio 1:1

Section 14.26: Therapy Services

Therapy services include the following:

- Physical therapy based on a prescription for a specific therapy program by a physician.
- Occupational therapy based on a prescription for a specific therapy program by a physician.
- Speech/language therapy based on an evaluation and recommendation by an American Speech-Language-Hearing Association (ASHA) certified and state licensed speech-language pathologist or a physician.
- Orientation, mobility and vision therapy based on an evaluation and recommendation by a trained mobility specialist/instructor or a physician.

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 service plan. Training caretakers and development and monitoring of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Therapy services. Therapy teleservices may be provided in accordance with the requirements listed in this manual under Teleservices on page 47. 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 service plan 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.

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

Additional Service Definition Clarification
Implementation of a Home Therapy Program can be done by the individual and those people who 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 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 individual. Evaluation, development, training, and monitoring of a home program should be done by the appropriate licensed therapist.

All individuals, families and direct service professionals 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 can only be provided to adults (individuals age 21 and older). All medically necessary Therapy services for children under age 21 are covered through Medical Assistance pursuant to the EPSDT benefit. Further, Therapy services delivered to adults must differ in scope from therapy services covered by Medical Assistance.

Therapy services must be delivered in a home and community-based setting and cannot be provided in a clinic or rehabilitative facility setting.

- 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 a certified nurse practitioner to determine their need for Therapy services. They will not automatically receive therapy services through ODP.
- Individuals authorized to receive Therapy services may not receive the direct portion of following services at the same time as this service: Community Participation Support; Shift Nursing; Consultative Nutritional Services; Benefits Counseling; Behavioral Support; Supported Living; Supported Employment; Small Group Employment; Music, Art and Equine Assisted Therapy; Education Support and Transportation.

SC documentation requirements:

- Therapy services may only be funded for adults through the waivers if documentation is secured by the SC that shows the service is medically necessary and there is documentation of one of the following: either the Therapy service is not covered by the individual's insurance, Therapy services have been denied by the insurance carrier or insurance limitations for Therapy services have been reached. An individual's insurance includes Medical Assistance (MA), Medicare and/or private insurance. While written documentation from insurance carriers of limitations, lack of coverage for services and denials must be requested; ODP will also accept the following documentation when insurance carriers decline to provide written documentation:
    - A copy of the policy or some other written statement documenting that the service, item or amount requested exceeds the allowable service limit or that the service is not covered.
    - Written confirmation of information received verbally from an insurance carrier should the insurance carrier decline to send a denial letter is acceptable only when it: a) is sent to the insurance carrier, b) identifies the item or service in question, and c) requests that the insurance carrier advise the writer of any inaccuracy.

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."

Determining the need for services:

This service is designed to do the following:

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

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

- Does the individual have a prescription for this service?
- Is there a formal assessment by an occupational therapist that establishes a need for occupational therapy?
- Does this individual have fine motor limitations?
- Does this individual have a diagnosis of a clinical condition known to have an impact on fine motor skills (e.g. cerebral palsy, hemiplegia or quadriplegia)?
- Does this individual need to work on specific skills in the areas listed above?
- Does this individual need to have regular stretching to prevent contractures because of increased or decreased muscle tone?
- Is this individual capable of, or does he or she have someone supporting him or her who can maintain, working on a home program?
- Does this individual have a degenerative condition that impacts on their fine motor skills and abilities to perform ADLs?
- Does this individual have a feeding problem (dysphasia) and is it safe for him or her 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 direct service professionals implementing learned skills outside of the Occupational Therapy sessions?

Service limits:

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

✎SC documentation requirements:

- Functional limitation in fine motor skills.
- Evaluation of the need for Occupational Therapy.
- Need for Occupational Therapy.
- Ability to benefit from Occupational Therapy.

- How Occupational Therapy supports outcome statements (e.g. to increase range of motion or to lean to feed self either independently or with an assist).

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

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 02-Telehealth; 12-Home; 99-Other (Community)

Procedure Code	**Allowable Modifiers**	**Service Level**	**Service Description** **HCSIS Description**
T2025	**GO**	**Occupational Therapy**	Occupational Therapy service delivered under an outpatient occupational therapy plan of care. Occupational Therapy-15 min Staffing ratio 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with all the Waiver Procedure Codes and modifiers in this table for the direct provision of this service. 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.

Modifier GO is used to identify services rendered by an Occupational Therapist.

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

1st – GO
2nd - U1

Physical Therapy

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

Additional Service Definition Clarification

Physical therapy is a service designed to do the following:

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

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

Service limit:

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

✎SC documentation requirements:

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

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

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old
Base Funding: 0-120 years old
Allowable Place of Service: 02-Telehealth; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
T2025	**GP**	**Physical Therapy**	Physical Therapy service delivered under an outpatient physical therapy plan of care. Physical Therapy-15 min Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the direct provision of this service. 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.

Modifier GP is used to identify services rendered by a Physical Therapist.

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 to individuals with a wide variety of speech, language, and swallowing differences and disorders. Communication includes speech production and fluency, language, cognition, voice, resonance, and hearing. Swallowing includes all aspects of swallowing, including related feeding behaviors. Speech and language therapy includes:

- Counseling individuals, families and caregivers regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders.
- Prevention and wellness activities that are geared toward reducing the incidence of a new disorder or disease, identifying disorders at an early stage, and decreasing the severity or impact of a disability associated with an existing disorder or disease.
- Screening individuals for possible communication, hearing, and/or feeding and swallowing disorders.
- Assessing communication, speech, language and swallowing disorders. The assessment process includes evaluation of body function, structure, activity and participation, within the context of environmental and personal factors.
- Developing and implementing treatment to address the presenting symptoms or concerns of a communication or swallowing problem or related functional issue. Treatment establishes a new skill or ability or remediates or restores an impaired skill or ability.
- Teaching American Sign Language or another form of communication to an adult waiver individual (a individual who is 21 years of age or older) who is deaf and has been assessed as benefitting from learning American Sign Language or another form of communication is covered under Speech and Language Therapy. Consultation regarding the communication needs of a individual who has nontraditional communication needs is also included under Speech and Language Therapy.

Additional Service Definition Clarification:

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

This service is designed to do the following:

- Help the individual 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.

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 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 direct service professionals 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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 years old;
Base Funding: 0-120 years old
Allowable Place of Service: 02-Telehealth; 12-Home; 99-Other (Community)

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
T2025	**GN**	**Speech and Language Therapy**	Speech/Language Therapy service provided by an ASHA certified and state licensed speech-language pathologist. Speech/Language Therapy-15 min

			Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with all of the Waiver Procedure Codes and modifiers in this table for the direct provision of this service. 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.

Modifier GN is used to identify services rendered by a Speech and Language Therapist.

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

1st – GN
2nd – U1

Orientation, Mobility and Vision Therapy

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

Additional Service Definition Clarification
This service is designed to do the following:

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

Determining the need for services:

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

- Is this individual blind or do they have a visual impairment that impacts their ability to navigate their environment?
- Is there a formal or informal assessment by an ACVREP certified professional that establishes a need for orientation, mobility and vision therapy?

SC documentation requirements:

- Documentation that the individual has a visual impairment or is blind.
- Denial from the Department of Labor and Industry's Bureau of Blindness and Visual Services http://www.dli.pa.gov/Individuals/Disability-Services/bbvs/Pages/default.aspx.
- Difficulty getting around in the environment related to the visual problems.
- Evaluation from an ACVREP certified professional that specifies:
  - Ability to benefit from orientation, mobility and vision therapy.
  - Need for orientation, mobility and vision therapy to help the individual navigate their environment.
  - Outcome actions related to navigating in his or her environment.

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

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

Service Unit: 15 minutes
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 21-120 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 HCSIS Description
W7246		**Visual/Mobility Therapy**	Visual/Mobility Training for individuals who are blind or have visual impairments. Orientation-Mobility and Vision Therapy-15 min Staffing Ratio 1:1
	U1		Enhanced Communication Service - This modifier can be utilized with the Waiver Procedure Code in this table for the direct provision of this service. 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 14.27: Transportation

Transportation is a direct service that enables individuals to access services and activities specified in their approved ISP. There are three types of transportation that can be authorized under Transportation services (see below for detailed descriptions):

- Transportation – Mile
- Public Transportation
- Transportation - Trip

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

Additional Service Definition Clarification:

- When discrete Transportation services are provided to transport individuals as part of Companion or In-Home and Community Support services, only the mileage that exceeds 30 miles on any given day may be billed as the discrete Transportation service.
- Transportation is not included in the wage range for In-Home and Community Support services provided by Support Service Professionals in participant directed services. As such, Transportation services for all miles can be authorized and billed as a discrete service.
- The Medical Assistance Transportation Program should be the first avenue explored when an individual requires assistance getting to and from a medical appointment. The individual's county of residence will provide the least expensive type of transportation that still meets the individual's needs for each appointment type. See matp.pa.gov for more info and to be directed to the appropriate county web page.

Service limits:

- For individuals under the age of 21, Transportation services may only be used to travel to and from waiver services or a job that meets the definition of competitive integrated employment.
- This service cannot be authorized on an individual's ISP when the individual receives the following services (because the services include transportation that is the responsibility of the provider):
    - Community Participation Support,
    - Small Group Employment,
    - Supported Employment,
    - Advanced Supported Employment – job acquisition and job retention,
    - Benefits Counseling,
    - Therapies,
    - Education Support,
    - Music, Art, and Equine Assisted Therapy, and
    - Consultative Nutritional Services.
- Individuals authorized to receive Residential Habilitation, Life Sharing or Supported Living services may only be authorized for Transportation services as a discrete service when the individual requires transportation to or from a job that meets the definition of competitive integrated employment.
- 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 individuals who use types of locally available transportation (such as buying a train pass, bus pass, etc.) and there are any initial fees or costs, such as a reusable card or pass, that cost may not be included as part of the public transportation service. If an individual loses or damages the card or pass, the individual will need to pay for the new card out of personal funds.

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, competitive integrated employment, and other specified destinations as described in the individual's ISP. The unit of service is one mile. Mileage will be paid per trip. A trip is defined as from the point of pick-up to the destination while the individual is in the car as identified in the ISP. 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.

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).

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

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W7271*	**Transportation Mile**	Transportation by providers, family members, surrogates who are the employer or managing employer, and other qualified licensed drivers for using vehicles to transport the individual to and from services specified in the individual's approved individual support plan. Round trip mileage is eligible for reimbursement. When Transportation Mile is provided to more than one individual at a time, the total number of units of service provided is equitably divided among the people for whom transportation is being provided. Mileage

		reimbursement to providers is limited to situations where transportation costs are not included in the provider's rate for other services. Transportation-Mile

Public Transportation

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

Additional Service Definition Clarification:

- The Pennsylvania Department of Transportation has clarified that waiver funding **cannot** be used to pay an individual's copay for their Rural Transportation Program for Persons with Disabilities.
- When entering units in the ISP for public transportation the number of tokens, bus passes, taxi rides, etc., that will be purchased for the individual should be entered.
- The Public Transportation service may be used to provide ridesharing services such as Uber or Lyft to individuals. The OHCDS or FMS purchases gift cards for individuals or sets up business accounts and adds individuals to those accounts. The OHCDS or FMS is reimbursed once it obtains and submits receipts for the rides taken by individuals. Further details are available in ODP Announcement 22-044 and through ODP regional offices.

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).

Service Unit: Vendor Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 99-Community

Procedure Code	Service Level	Service Description HCSIS Description
W7272*	**Public Transportation**	Public transportation costs to enable individuals to access services and resources specified in the individual's approved and authorized individual support plan. Transportation-Public

Transportation-Trip

This service is to provide transportation to individuals for which costs are determined on a per-trip basis. A trip is defined as transportation to a waiver service or resource specified in the individual's ISP:

- from an individual's private home,
- from the waiver service or destination to the individual's home,
- from one waiver service or destination to another waiver service or destination, or
- to and from a job that meets the definition of competitive integrated employment.

Taking an individual to a waiver service and returning the individual to their home is considered two trips or two units of service. Trip distances are defined by ODP through the use of zones.

Zones are defined as the following:

- Zone 1 - Greater than 0 and up to 10 miles.
- Zone 2 - Greater than 10 and up to 30 miles.
- Zone 3 - Greater than 30 miles.

Providers that transport more than 6 individuals as part of Transportation Trip are required to have an aide on the vehicle (see below for determining the need for service).

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 number of individuals in the vehicle.
    - 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 used for billing purposes only.
- 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.

Service Limits:

- The mileage that determines a trip zone is calculated by determining the distance from each specific individual's home, from the service to the individual's home, or from one waiver service to another waiver service. The number 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 individual does not take into account the total miles an individual 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 their home is considered two trips or two units of service. (Note: Individuals within different zones may ride the same vehicle.)

The procedure codes and service units for Transportation-Trip Services:

Provider Type **26** - Transportation
Specialty **267**, Non-Emergency
Service Unit: Per trip
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 99-Community

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W7274	Zone 1	Zone 1 – greater than 0 and up to 10 miles. Transportation(Zone 1)-Trip
W7275	Zone 2	Zone 2 – greater than 10 and up to 30 miles. Transportation(Zone 2)-Trip
W7276	Zone 3	Zone 3 – greater than 30 miles. Transportation(Zone 3)-Trip

Section 14.28: Vehicle Accessibility Adaptations

Vehicle accessibility adaptations consist of certain modifications to the vehicle that the individual uses as their primary means of transportation to meet their 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 Life Sharing provider agency.

Vehicle accessibility adaptations 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 individuals, 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:

- Individuals receiving Vehicle Accessibility Adaptations cannot be authorized for Residential Habilitation services during the same time period.
- This service is limited to $20,000 per individual during a 10-year period. The 10-year period begins with the first utilization of authorized Vehicle Accessibility Adaptations.

SC documentation requirements:

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

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

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

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

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

Service Unit: Vendor Goods and Services
Age Limits & Funding:
Consolidated, Community Living & P/FDS Waivers: 0 - 120 years old;
Base Funding: 0 – 120 years old
Allowable Place of Service: 99-Community

Procedure Code	**Service Level**	**Service Description** **HCSIS Description**
W7278*	Vehicle Accessibility Adaptations	Adaptations to vehicles for improved access and/or safety for individuals with intellectual disability. Maximum limit for vehicle adaptations is $20,000 per individual every 10 years. Vehicle Accessibility Adaptations

Section 15: Policy for Waiver Services Provided by Relatives, Legal Guardians and Legally Responsible Individuals

During the ISP team meeting, the team is responsible for discussing whether having services furnished by relatives, legal guardians, or legally responsible individuals is in the best interest of the individual. The decision should be consistent with the information contained in the "know and do", "important to" and "what makes sense" sections of the ISP. The Administrative Entity, when reviewing and authorizing the ISP, is responsible for ensuring that the individual has been offered a choice of providers and that the provider chosen can meet the needs of the individual.

Definitions

- **Relative:** A relative is any of the following by blood, marriage or adoption who have not been assigned as legal guardian for the individual: a spouse, a parent of an adult, a stepparent of an adult child, grandparent, brother, sister, aunt, uncle, niece, nephew, adult child or stepchild of an individual or adult grandchild of an individual.
- **Legal Guardian:** A legal guardian is a person who has legal standing to make decisions on behalf of a minor or adult (e.g. a guardian who has been appointed by the court).
- **Legally Responsible Individual:** A person who has legal obligation under the provisions of law to care for another person, including parents of minor children (under the age of 18) and legally assigned relative caregivers of minor children.

Relatives or Legal Guardians may be paid to provide services funded through the Waivers on a service-by-service basis

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

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

Services that relatives or legal guardians can provide are limited to the following: In-Home and Community Support, Companion, Life Sharing, Supported Employment, Shift Nursing, Transportation (Mile) and Family Medical Support Assistance.

Relatives or legal guardians who are not the individual's primary caregiver may also provide Supports Broker services, and Respite services when the conditions listed above are met.

Legally responsible individuals as defined in appendix C-2-d may also provide the following services that do not have a personal care component:

- Supported Employment; and
- Transportation Mile solely to drive a minor child to and from a waiver service or a job that meets the definition of competitive integrated employment.

Services Provided by Legally Responsible Individuals

In accordance with CMS requirements, payment generally may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of an individual. The paragraph below describes the circumstances in which payment may occur for waiver services performed by legally responsible individuals when there are personal care components involved in the service.

The only waiver services legally responsible individuals can provide that have personal care components are In-Home and Community Support and Life Sharing. These individuals may be paid to provide In-Home and Community Support or Life Sharing services when the following conditions are met:

- The service is considered extraordinary care. A parent is legally responsible to meet the needs of a minor child, including the need for assistance and supervision typically required for children at various stages of growth and development. A parent can, however, receive payment for In-Home and Community Support or Life Sharing when this support goes beyond what would be expected to be performed in the usual course of parenting, and when needed support exceeds what is typically required for a child of the same age;
- The service would otherwise need to be provided by a qualified provider of services funded under the Waiver;
- The legally responsible individual is not the common law employer or managing employer for the individual that they will provide the service to;
- 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.

Payments for Relatives, Legal Guardians, and Legally Responsible Individuals

Payments to relatives, legal guardians and legally responsible individuals who provide services are made through a Financial Management Services (FMS) Organization or a provider agency. Payments are based upon documentation such as time sheets, if applicable, submitted by the relative, legal guardian, or legally responsible individual to the FMS or agency, which is consistent with the individual's authorized services on their ISP. The relative, legal guardian or legally responsible individual who provides services must document service delivery per Department standards, 55 Pa. Code Chapter 1101 (Medical Assistance Regulations), and ODP policy requirements, which are stated in ODP's Technical Guidance for Claim and Service Documentation. Documentation of service delivery is reviewed during the QA&I process.

Guidance Regarding Limits on the Number of Hours of In-Home and Community Support and Companion by Relatives and Legal Guardians

Any one relative or legal guardian may provide a maximum of 40 hours per week of authorized In-Home and Community Support and/or Companion (when both services are authorized in the ISP). If a combination of both services occurs, the relative or legal guardian may only render 40 hours total between the two services. Further, when more than one relative or legal guardian provide the service(s), each individual may receive no more than 60 hours per week of authorized In-Home and Community Support, Companion or a combination of In-Home and Community Support and Companion (when both services are authorized in the ISP) from all relatives and legal guardians.

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

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

- Unexpected circumstances such as inclement weather, sudden illness, or the unplanned extension of medical leave, that prevent a regularly scheduled worker from arriving at the job site and where another worker/caregiver is not immediately available to work;
- Situations where a worker unexpectedly quits or is terminated from employment such that relatives and legal guardians must perform paid work in excess of the 40/60 limitation.
- or
- The sudden loss of a caregiver who kept the provision of paid services by relatives and legal guardians at or below 40/60 hours per week.

In the event that any of the above situations occur, ODP requires the back-up plan to be reviewed and revised as necessary to prevent recurrence of the above. Please see ODP communication 23-041 for more information.

Section 16: Waiver Travel Policy Related to Service Definitions

Travel Policy: Temporary travel is defined as a day in which the individual visits another destination that is away from the individual's primary residence or community. A day includes staying away from home for at least one overnight. A day is when the individual is traveling, and waiver services are rendered and reimbursed. Examples of temporary travel could include: an overnight away from home, a full week (7 days) vacation, or other extended time away from the individual's home.

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

- In-Home and Community Support
- Residential Habilitation (licensed and unlicensed)
- Life Sharing (licensed and unlicensed)
- Supported Living
- Shift Nursing
- Supports Coordination
- Specialized Supplies
- Supports Broker
- Behavioral Support
- Companion
- Respite

These services may be provided anywhere during temporary travel. The only exception is Respite Camp which can only be provided in Pennsylvania, Washington DC, Virginia or a state contiguous to Pennsylvania.

The direct portion of the Supported Employment service may be delivered in any state when an individual is traveling out of state for work-related trips such as for training, conferences, or business trips.

The following conditions apply during travel:

- The provision of waiver services during travel is limited to no more than 90 calendar days per individual's ISP plan year.
  - The 90 calendar days do not need to be used consecutively. In other words, the individual can sporadically use the 90 days throughout the ISP plan 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 and the qualified person providing the waiver service (SSP, DSP, or relative) are the same during travel as at home.
- The Waivers will not fund the travel costs of the individual, the provider or the person providing the waiver service:
  - The individual is responsible to fund their own travel costs through private or non-ODP funds.
  - Travel costs for agency staff, contracted personnel or individual providers may be funded through private funds of family members of the individual or non-ODP funds generated through fundraising efforts or other means.

  - If the individual decides to pay for the travel costs, there must be documented team consensus that this was the voluntary and willful decision of the individual.
- An individual cannot exceed the authorized units for a service while on temporary travel.
- All service and program requirements, such as provider qualification criteria and documentation of services, apply during the period of travel.
- The location for temporary travel is not limited to Pennsylvania. Temporary travel can occur anywhere as long as the individual's health and welfare can be met during the temporary travel.
- Temporary travel includes when the individual is away from home and receiving teleservices in accordance with the requirements listed in this manual under Teleservices on page 47.

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

Section 17: Base-Funded Services

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

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

Respite Care, 24 hours (Base-Funded)

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

Individuals can receive Respite Care 24-hour for a period of more than 16 hours to 24 hours. Base-Funded Respite Care is limited to a **total** of four weeks (28 days) per individual per fiscal year.

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

When Base-Funded Respite is provided in a location where Waiver services are provided, Waiver Procedure Codes must be used. Base-Funded Respite Procedure Codes can only be used for locations where Waiver services are not provided, including 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 Home (55 Pa. Code Chapter 6400) located in Pennsylvania
- Unlicensed or Licensed Family Living Home (55 Pa. Code Chapter 6500) located in Pennsylvania
- 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 family that the County Program has approved
- Medical facilities, such as hospitals, nursing homes, or ICFs/ID when there is documented medical needs, and the County Administrator approves the Respite service in a medical facility
    - Please note: Waiver Respite Procedure Code H0045 may be used when an individual receiving base-funded respite meets the criteria for Exceptional Respite Care

- State-operated ICFs/ID when the individual has documented medical or behavioral needs and is unable to locate a respite provider to render services in a community setting. ODP must provide approval prior to the individual receiving Respite in a State-operated ICF/ID
- Hotels or rentals during temporary travel in accordance with ODP's travel policy

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

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

Provider Type **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.)

Service Unit: Day
Age Limits & Funding: Base Funding: 0-120 years old

Procedure Code	Allowable Modifiers	Service Level	Service Description HCSIS Description
W7287*		Basic Staff Support	The provision of the service at a staff-to-individual ratio range of 1:4. Respite-Base Out-of-Home 24 Hours (Basic)-Day
W7288*		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:4 to >1:1. Respite-Base Out-of-Home 24 Hours (Level 1)-Day
W7290*		Staff Support Level 2	The provision of the service at a staff-to-individual ratio of 1:1. Respite-Base Out-of-Home 24 Hours (Level 2)-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. Respite-Base Out-of-Home 24 Hours (Level 2 Enh)
	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. Respite-Base Out-of-Home 24 Hours (Level 2 Enh)-TD Respite-Base Out-of-Home 24 Hours (Level 2 Enh)-TE
W7100*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio of 2:1. Respite-Base Out-of-Home 24 Hours (Level 3)
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. Respite-Base Out-of-Home 24 Hours (Level 3 Enh)

	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff members are licensed nurses. Respite-Base Out-of-Home 24 Hours (Level 3 Enh)-TD Respite-Base Out-of-Home 24 Hours (Level 3 Enh)-TE
	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.

Support (Medical Environment)

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

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

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

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

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

Service Unit: 15 minutes
Age Limits & Funding: Base Funding: 0-120 years old
Allowable Place of Service: 99-Other (Community)

Procedure Code	**Allowable Modifiers**	**Service Level**	**Service Description** **HCSIS Description**
W7305*		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6. Support (Medical Environment) (Basic)-15 Mins
W7306*		Staff Support Level 1	The provision of the service at a staff-to-individual ratio range of <1:6 to 1:3.5. Support (Medical Environment) (Level 1)-15 Mins

W7307*		Staff Support Level 2	The provision of the service at a staff-to-individual ratio range of <1:3.5 to >1:1. Support (Medical Environment) (Level 2)-15 Mins
W7309*		Staff Support Level 3	The provision of the service at a staff-to-individual ratio range of 1:1. Support (Medical Environment) (Level 3)-15 Mins
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. Support (Medical Environment) (Level 3 Enh)
	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. Support (Medical Environment) (Level 3 Enh)-TD Support (Medical Environment) (Level 3 Enh)-TE
W7322*		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1. Support (Medical Environment) (Level 4)-15 Mins
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. Support (Medical Environment) (Level 4 Enh)
	TD or TE		The provision of the service at a staff-to-individual ratio of 2:1 where both staff member are licensed nurses. Support (Medical Environment) (Level 4 Enh)-TD Support (Medical Environment) (Level 4 Enh)-TE

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

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

Procedure Code	Service Level	Service Description HCSIS Description
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).

		Child Resid 9+ Indiv Home (3800 Inelig)

Community Residential Rehabilitation Services for the Mentally Ill (CRRS)

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

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

Procedure Code	Service Level	Service Description HCSIS Description
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). Comm Resid Rehab 9+ Indiv Home (5310 Inelig)

Community Home Services for Individuals with Intellectual Disability or Autism (Base-Funded)

Residential Habilitation services are direct and indirect services provided to individuals who live in licensed and unlicensed provider owned, rented or leased residential settings (see service1 definition, page 148). Services consist of assistance, support and guidance (physical assistance, instruction, prompting, modeling, and reinforcement) in the general areas of self-care, health maintenance, decision making, home management, managing personal resources, communication, mobility and transportation, relationship development and socialization, personal adjustment, participating in community functions and activities and use of community resources.

The 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

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

Procedure Code	Service Level	Service Description HCSIS Description
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). Comm 9+ Indiv Home (6400 Inelig)

Life Sharing (Base-Funded)

Life Sharing services are direct and indirect, provider agency managed services that occur in a private home setting (see service definition, page 140). Services consist of assistance, support and guidance (physical assistance, instruction, prompting, modeling, and reinforcement) in the general areas of self-care, health maintenance, decision making, home management, managing personal resources, communication, mobility and transportation, relationship development and socialization, personal adjustment, participating in community functions and activities and use of community resources.

The procedure code and service unit for Life Sharing:

Provider Type **52** – Community Residential Rehabilitation
Specialties: **522** – Family Living Homes – Ch. 6500; **524** - Unlicensed

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

Procedure Code	Service Level	Service Description HCSIS Description
W8997	Life Sharing	The provision of this service necessary to enable the individual to meet habilitation outcomes. Life Sharing (Base Only)

Supported Living (Base-Funded)

These are direct and indirect services provided to individuals who live in a private home that is owned, leased or rented by the individual or provided for the individual's use via a Special or Supplemental Needs trust and located in Pennsylvania (see service definition, page 169). Through the provision of this service individuals will be supported to live in their own home in the community and to acquire, maintain or improve skills necessary to live more independently and be more productive and participatory in community life.

The procedure code and service unit for Supported Living:

Provider Type **52** – Community Residential Rehabilitation
Specialties: **524** – Unlicensed

Service Unit: Day
Age Limits & Funding:

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

Procedure Code	Service Level	Service Description HCSIS Description
W8998	Supported Living	The provision of this service necessary to enable the individual to meet habilitation outcomes. Supported Living (Base Only)

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

Service Unit: 15 minutes
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 HCSIS Description
W7310		Basic Staff Support	The provision of the service at a staff-to-individual ratio of no less than 1:6. Family Aide (Base) - 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. Family Aide (Level 1) - 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. Family Aide (Level 2) - 15 Minutes

W7314		Staff Support Level 3	The provision of the service at a staff-to-individual ratio range of 1:1. Family Aide (Level 3)-15 Mins
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. Family Aide (Level 3 Enh)-15 Mins
	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. Family Aide (Level 3 Enh)-15 Mins-TD Family Aide (Level 3 Enh)-15 Mins-TE
W7325		Staff Support Level 4	The provision of the service at a staff-to-individual ratio of 2:1. Family Aide (Level 4)-15 Mins
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. Family Aide (Level 4 Enh)-15 Mins
	TD or TE		The provision of the service at a staff-to-individual ratio of 1:1 where both staff members are licensed nurses. Family Aide (Level 4 Enh)-15 Mins-TD Family Aide (Level 4 Enh)-15 Mins-TE

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

Service Unit: Outcome based
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** **HCSIS Description**
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. Special Diet Preparation

Recreation/Leisure Time Activities

This service is provided to enable individuals to participate in regular community activities that are recreational or leisure in nature. Participation in activities with non-related people, within the community, is encouraged. Entrance and membership fees may be included in the cost of recreation/leisure time activities. This service is available to individuals enrolled in a waiver and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated, owned, leased, or rented settings. In addition, this service may be used to provide Overnight Camp and Day Camp services to individuals who receive base-funding who live at home or who reside in provider-operated, owned, leased, or rented settings.

The procedure code and service unit for Recreation/Leisure Time Activity Services:

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

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

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

Procedure Code	Service Level	Service Description HCSIS Description
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. Recreation/Leisure Time Activities

Home Rehabilitation

The Home Rehabilitation service provides for minor renovations to an individual's or family's home where the individual lives to enable the continued care and support of the individual in the home. A renovation is defined for reimbursement purposes as minor if the cost is $10,000 or less, as per 55 Pa. Code § 4300.65(1). This service is available to individuals enrolled in a waiver and to individuals receiving base-funded services, including both individuals living at home and those residing in provider-operated, owned, leased, or rented settings.

The procedure code and service unit for Home Rehabilitation Services:

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

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

Service Unit: Outcome based

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 HCSIS Description
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. Home Rehabilitation

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

Service Unit: Dollar
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 HCSIS Description
W7320	**FSS/Individual Payment**	This is an indirect service to allow cash and/or voucher payments to individuals and families for FSS. FSS/Individual Payment-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

Service Unit: Outcome based
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** **HCSIS Description**
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. Base Service Not Otherwise Specified

Section 18: Targeted Support Management (TSM)

Targeted Support Management (TSM) is a valuable service that assists individuals with creating a vision of how they want to live an everyday life now and in the future. It includes planning for how to achieve that vision. TSM also helps individuals gain access to needed medical, social, educational, and other services. The purpose of TSM is to promote an individual's right to an everyday life utilizing person centered planning and self-determination principles.

TSM includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, education, social or other services or supports.
- Gathering information related to educational, social, emotional, and medical events by interviewing the individual, family, medical providers, educators and others necessary to complete an assessment of the individual.
- Identifying the strengths, skills, abilities, and preferences of the individual.
- Utilizing a life course framework to assist individuals and families to identify both the immediate and long-term vision for the person including the types of information, community resources, experiences, opportunities, and specialized services and supports necessary to promote growth and development and to achieve the person's desired outcomes. Those desired outcomes include:
    - Acquiring independent living skills,
    - Employment, and
    - Establishing a social network outside the family.
- Identifying the individual's needs for services and supports and completing the related documentation.
- An initial assessment shall be completed within 45 days of referral with reassessments completed annually thereafter.

- Development (and periodic revision) of a specific individual plan that is based on the information collected through the assessment that:
    - Includes the active participation of the individual and others specified by the individual in the development of the plan.
    - Specifies the individual's desired outcomes including: acquiring independent living skills, employment, and establishing a social network outside the family.
    - Identifies a course of action to address the individual's needs and to achieve the individual's desired outcomes including in-home and community supports and services.
    - Specifies the services and supports necessary to address the individual's needs and to achieve their desired outcomes. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
        - Activities that help link the individual with medical, social, and educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the individual plan.

- Monitoring and follow-up activities:
    - Activities and contacts that are necessary to ensure the individual plan is implemented and adequately addresses the eligible individual's needs, including ensuring the individual's health and safety, and which may be with the individual,

family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring meeting, to determine whether the following conditions are met:

- Services are being furnished in accordance with the individual plan;
- Services in the individual plan are adequate; and
- Changes in the needs or status of the individual are reflected in the individual plan. Monitoring and follow-up activities include making necessary adjustments in the individual plan and service arrangements with providers.

TSM includes locating, coordinating and monitoring needed services and supports when an individual is admitted to a nursing home for less than 30 days or an acute care hospital for any duration of time.

Face-to-face monitoring shall occur at least once a year that is separate from the annual service plan meeting. Monitoring shall occur more frequently as needed to ensure the individual's needs are met; as well as to maintain a continuing relationship between the individual, family members, and any providers responsible for services. Please refer to Section 12: Monitoring of Services.

TSM is provided to individuals who are MA eligible and not enrolled in a waiver. Once an individual is enrolled in a waiver, this service is referred to as Supports Coordination.

A service authorization for TSM is not attached in the individual's ISP in HCSIS. The individual or the individual's representative must consent to receive TSM by signing the ISP Signature Form (DP 1032) as part of the ISP process. The approved ISP should include the provision of TSM activities which may be documented throughout the ISP such as, Know and Do, Important To and Important For, and in the Outcome Actions Section under what actions are needed, Who's Responsible, and Frequency and Duration.

Refer to ODP Bulletin 00-22-01 for more information about TSM.

The procedure code and service unit for Targeted Support Management Services:

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

Service Unit: 15 minutes
Age Limits & Funding:
Medicaid State Plan: 0-120 years old

Allowable Place of Service: 11-Office; 12-Home; 21- Inpatient Hospital (🩺); 99-Other (Community)
(Providers should submit a claim using the Place of Service Code 21-Inpatient Hospital-for all the procedure codes that have a stethoscope (🩺) when an individual is in the hospital.)

Procedure Code	Service Level	Service Description HCSIS Description
T1017 🩺	Targeted Support Management	Targeted Support Management Staffing Ratio 1:1

Section 19: Resources

Section 19.1: Prioritization of Urgency of Need for Services (PUNS)

PUNS is the process for categorizing an individual's urgency of need for services. The focus of the PUNS is on the existing services and supports (waiver and non-waiver) 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 – 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.

The PUNS should be reviewed at every ISP meeting and updated as necessary based on changes in the individual's needs. The ISP team determines if the individual will have any anticipated unmet needs in the next five years and also identifies any resources and opportunities available through unpaid supports such as family members or other resources in the community that could address these unmet needs. Individuals enrolled in the Consolidated Waiver are entitled to have assessed needs addressed through the use of non-waiver supports and through the waiver within the allowable service limits identified in the waiver. If an individual has unaddressed needs, the SC must complete or update the PUNS to reflect current needs of the individual as per the current ODP bulletin *Prioritization of Urgency of Need for Services (PUNS) Manual*, or any approved revisions. The PUNS must be completed and/or updated with the individual or family at every annual review update meeting. It is recommended that anyone in the emergency status in PUNS should have a full ISP, not an abbreviated ISP.

SC service note documentation requirements for PUNS:

- Date of meeting/conversation when form was completed.
- Date mailed to the individual/family.
- If it is recommended that a form not be completed due to no anticipated supports need within five years.
- The request for completion over the phone.
- If individual/family refuses to sign and reason for refusal.

Section 19.2: Independent Monitoring for Quality (IM4Q)

IM4Q is the method that Pennsylvania has adopted to independently review the quality of life for individuals statewide who receive services from ODP. 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.

IM4Q differs from other quality management components within the intellectual disabilities and autism service system in that it is not used to measure compliance with rules or laws. IM4Q also helps to:

- Provide a more comprehensive view of quality by engaging individuals with disabilities, families and citizens as stakeholders in the lives of people in their community.
- Strengthen the advocacy base for individuals with disabilities in the community.
- Reinforce to the community what human services professionals already know about the individual or raise issues that the community would want to know.
- Offer an additional safeguard for the health and well-being of individuals receiving services.

When an individual receiving services participates in an IM4Q interview, the individual may choose whether to share the information supplied with the appropriate AE or SCO. If the individual chooses not to share the information, the survey data is entered into the business partner's secure database 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 them to the SCO. A consideration is a suggestion of something the individual could need or that could improve the quality of life. The consideration may be offered by the individual, a family member, a paid staff, or a survey team member. Actions to address considerations are developed with the individual and his or her ISP team. SCOs and provider agencies are involved to the extent necessary to address service and outcome-related issues and concerns. Considerations are linked to the ISP process when there is a change in services stemming from the IM4Q consideration, or when the individual or family wants the ISP team to be involved in decisions related to a consideration.

SC service note documentation requirements for IM4Q:

- Considerations are 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 20: 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, P/FDS and Community Living 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 an Individual or Individual's Surrogate acting as the Managing Employer in the management of the Individual's Support Service Professional (SSP) and supports and services authorized in the Individual's Individual Support Plan (ISP).

Amount (of service) – The total volume of funded services (measured in units) that are authorized in the ISP and rendered to the individual.

Annotated ISP – An ISP template that contains ODP's expectations of required documentation and recommended best practices for each section of the ISP. The Annotated ISP is located in Learning Management System (LMS).

Annual Review ISP Meeting – A team meeting held annually to review and update necessary information in the individual's ISP.

Annual Review Update Date – The Annual Review Update Date is the end date of the current plan ISP. The team and the AE must ensure that an Annual Review ISP is completed, approved, and services authorized by the Annual Review Update Date.

Assessed Needs – Needs of individuals identified through the Statewide Needs Assessment or other valid assessments and identified as a required need by the individual's ISP team.

Assessments – Instruments and documents used by the ISP team to identify an individual's needs for Home and Community Based Services (HCBS).

Base Funding Services – A state funded HCBS.

Bridge Plan – A term used to describe an individual's initial ISP, which has a timeline shorter than the Fiscal Year to accommodate varying timelines for initial annual review meetings.

Bureau of Hearings and Appeals (BHA) – The DHS entity charged with conducting administrative hearings and timely adjudication of appeals.

Centers for Medicare and Medicaid Services (CMS) – The agency in the federal Department of Health and Human Services that is responsible for federal administration of the Medicaid, Medicare and State Children's Health Insurance Programs (CHIP).

Common-Law Employer – The person under the VF/EA FMS option who is considered the employer and is responsible for some employer-related responsibilities.

Community Living Waiver – A Federally approved 1915(c) waiver program designed to help individuals with an intellectual disability or autism of any age, children with a developmental disability age 0 through 8 with a high probability of resulting in an intellectual disability or autism diagnosis, and individuals under age 22 with a developmental disability due to a medically complex condition to live more independently in their homes and communities.

Consent to Share ISP – A field on the ISP in HCSIS that identifies that the individual and his or her family, guardian, surrogate, or advocate provide consent to share the ISP with qualified providers online in HCSIS after it is approved and services are authorized.

Consolidated Waiver – A Federally approved 1915(c) waiver program designed to help individuals with an intellectual disability or autism of any age, individuals with a developmental disability age 0 through 8 with a high probability of resulting in an intellectual disability or autism diagnosis, and individuals under age 22 with a developmental disability due to a medically complex condition to live more independently in their homes and communities.

Direct Service – The performance of activities outlined in the service definition where direct service professionals are actively engaged with the individual and ensure the health and safety needs of the individual.

Draft Plan – An ISP in HCSIS that can be edited or used for adding, deleting, or revising information in that ISP.

Duration (of a service) – The length of time that a service will be provided.

Fiscal Year – The period of time extending from July 1 of one calendar year through June 30 of the next calendar year.

Financial Management Services (FMS) – A type of provider (either AWC or VF/EA) that provides administrative support to an individual who self-directs all or some of their services. An FMS provider processes payments for delivered services and performs some financial functions on behalf of the individual. An FMS provider may also process payments on behalf of an individual who is not self-directing but who requires a one-time vendor payment.

Frequency (of a service) – How often a service will be rendered to an individual.

Home and Community Services Information System (HCSIS) – The secure internet information system serving the DHS state program offices that oversee Medicaid Waivers.

Hospital- A hospital is a health care institution that provides medical care and other related services for surgery. Hospital settings do not include psychiatric hospitals, nursing facilities, or rehabilitation facilities**.**

Independent Monitoring for Quality (IM4Q) – A survey and interview process focusing on the quality of services and supports for individuals with intellectual disabilities which provides a source of data to support ODP initiatives.

Indirect Service – The performance of activities outlined in the service definition that do not require the individual to be present. Examples could include scheduling medical appointments, working with an employer as part of the delivery of an employment service, and collecting needed information for a behavior support plan.

Individual Monitoring Tool – The tool used to document the regularly scheduled and ongoing monitoring of an individual's ISP to ensure that the ISP is implemented as written, including that services are provided as indicated in the ISP.

Individual Provider – A person who is not employed by an agency and who directly provides the service. This term includes an individual practitioner, independent contractor or Support Service Professional through the Vendor Fiscal/Employer Agent model or Agency With Choice model.

Individual Support Plan (ISP) – An individual's summary of planned services (as well as preferences, outcomes, health, safety and medical information), identified as a result of review by the individual, family and plan team members.

Intermediate Care Facility for persons with an Intellectual Disability (ICF/ID) – A state-operated or privately operated facility, licensed by DHS, providing a level of care specially designed to meet the needs of individuals who have an intellectual disability, who require specialized health and rehabilitative services.

Intermediate Care Facility for persons with Other Related Condition (ICF/ORC) – A state-operated or privately operated facility, licensed by DHS, providing a level of care specially designed to meet the needs of persons with other related conditions who require specialized health and rehabilitative services; that is, active treatment. Persons with other related conditions are persons with severe physical disabilities, such as cerebral palsy, spina bifida, epilepsy or other similar conditions which are diagnosed prior to age 22 and result in at least three substantial limitations to activities of daily living.

Invitation to ISP – The letter sent by the SC which invites members of the individual's plan team to the plan meeting.

ISP Signature Form (DP 1032) – Required form used to document attendance and review of required waiver compliance elements at the time of the annual review meeting and during team meetings that result in critical revisions to ISPs.

Legal Guardian – A person not affiliated with a provider agency who has legal standing to make decisions on behalf of a minor or adult (for example, a guardian who has been appointed by the court).

Legally Responsible Individual – A person who has a legal obligation under the provisions of the law to care for another person, including parents of minors and legally-assigned relative caregivers of minor children.

Live Real-Time Video Communication: The individual and staff engage and communicate with each other during this provision of a service.

LMS – Learning Management System – Contains a variety of information about HCSIS including instructional web-based courses and job aids.

Outcome Actions – The team's plan to achieve what the individual considers important to him or her, including natural supports and paid services.

Outcome Statements – Levels of achievement and personal preferences the individual chooses to acquire maintain or improve.

Participant-Directed Services (PDS) – The list of identified services in the service definitions and approved waivers that are available to self-direct.

Pending Revision – The screen used to review ISPs that have been disapproved and require revision. An ISP will appear on this screen only if it has been disapproved, which means the ISP has the status of pending revision. The screen contains a hyperlink to comments entered by the ISP Approval role and explains why the ISP was not approved. The SC reviews the comments and converts the ISP back to a draft status so the appropriate changes can be made to the plan. A plan will not appear on this screen if it is in draft status, approved status, or pending approval status.

Person/Family Directed Support (P/FDS) Waiver – A Federally approved 1915(c) waiver program designed to help individuals with an intellectual disability or autism of any age, an individual with a developmental disability age 0 through age 8 with a high probability of resulting in an intellectual disability or autism diagnosis, and individuals under age 22 with a developmental disability due to a medically complex condition to live more independently in their homes and communities.

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 MyODP website.

Prioritization of Urgency of Needs for Services (PUNS) –The current process for categorizing an individual's need for services. The focus of the PUNS is on the existing services and supports received by the individual, the prioritization of urgency of need for requested services and the categories of services needed. This information is used by AEs, County Programs and ODP to prioritize waiting lists and for budgeting. The following are the PUNS categories of need:

- Emergency Need – Indicates a need for services within the next six months.
- Critical Need – Indicates a need for services greater than six months but less than two years in the future.
- Planning Need – Indicates a need for services greater than two years but less than five years in the future.

Private Home – When not otherwise defined within the specific service definition, a home that is owned or leased by the individual, their family, or another person with whom the individual lives. Homes owned, rented, leased, or operated by a provider are not private homes. Homes owned, rented, leased, or operated by a provider and subsequently leased to an individual or their family are also not private homes.

Qualified Provider – A provider who meets applicable qualification criteria and agrees to provide services to an individual as stated in their ISP. Waiver providers must meet qualification criteria included in the approved Consolidated, Community Living and P/FDS Waivers.

Self-Directed Services – This means the individual or his or her surrogate (representative) manages and directs the supports and services in the individual's ISP. In order to self-direct, they must become either a Common Law Employer or Managing Employer, use one of the FMS options, and must live in their own private residence or the residence of family.

Services and Supports Directory (SSD) – An online database of all the qualified service providers registered in HCSIS that is accessible to individuals and families during the registration process to locate qualified providers within a geographic area. The directory is intended to expand individuals' ability to make informed choices. This is the section of HCSIS where SC's choose qualified service providers and attach them to the ISP.

Supports Coordinator (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.

Video Monitoring Equipment: Allows for the individual to be seen by staff. However, the staff and individual are not actively engaging or communicating with each other.

Waiver Cap: The per individual limitation for waiver services funded through either the P/FDS or Community Living Waiver during a state FY.

- For the P/FDS Waiver, costs for supports coordination and supports broker services and other administrative costs of administrative services are excluded. The limit can be exceeded by $15,000 for Advanced Supported Employment, Supported Employment, and Benefits Counseling services that are authorized on an individual's ISP.

- For the Community Living Waiver, costs for supports coordination and other administrative costs of administrative services are excluded.

Section 21: 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. The full 15 minutes of service does not need to be provided consecutively but must be rendered during the same dates of service indicated on the claim for the same individual, same 13-digit MPI and same service.

Day Unit of Service: The day service unit (and any exceptions) 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 an individual or base funding for a non-waiver individual.

For waiver-funded Residential Habilitation a SC will use both the eligible and ineligible procedure codes, when applicable, when developing the ISP.

For base-funded Residential Habilitation services for eight or fewer individuals, the SC will only use the ineligible procedure code with an individualized rate when developing the ISP. For base-funded Residential Habilitation service for nine or more individuals, the SC will use only the nine or more procedure code when developing the ISP.

Enhanced Levels of Service: Many home and community-based services have enhanced levels of staffing ratios for 1:1 and 2:1 staffing where the direct service professional must have a certificate, license or a degree as specified in the provider qualification requirements for each service to render the service.

Hour Unit of Service: The hour unit of service will be comprised of 60 minutes of continuous or non-continuous service. The full 60 minutes of service does not need to be provided consecutively but must be rendered during the same dates of service indicated on the claim for the same individual, same 13-digit MPI and same service.

Organized Health Care Delivery System (OHCDS): An arrangement in which a provider that renders at least one direct MA waiver service also chooses to offer a different vendor HCBS by subcontracting with a vendor to facilitate the delivery of vendor goods or services to an individual.

Outcome-Based Unit: A service unit that is additional, delayed payment made to providers upon the delivery of the service. Advanced Support Employment is an outcome-based service. Payment is made upon providers achieving milestones as described in the service definition.

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.

A description of each allowable modifier is listed after the tables contained in the service definitions 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.

Vendor Goods and Services-Based Unit: A service unit tied to the actual cost of a purchased good. These services are reimbursed based on the cost charged to the general public and must be the most cost-effective to meet the individuals' needs.