



# DEVELOPMENTAL PROGRAMS BULLETIN

## COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE  
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**July 1, 2009**

NUMBER  
**00-08-17**

SUBJECT:

**Service Definitions**

BY

  
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### SCOPE:

Administrative Entity Administrators or Directors (for Waiver participants)  
County Program Administrators (for Base-funded individuals)  
Supports Coordination Organization Directors  
Providers of Mental Retardation Services

### PURPOSE:

The purpose of this bulletin is to distribute new service definitions to reflect changes made as a result of the amendments of the Person/Family Directed Support (P/FDS) and Consolidated Waivers.

### BACKGROUND:

On December 31, 2003, in preparation for HCSIS/PROMISe billing, the Office of Developmental Programs (ODP) disseminated service definitions under Bulletin 00-03-12, entitled "*Service Definitions and Procedure Codes for Healthcare and Non-Healthcare Waiver and Base Services*" (now obsolete). The healthcare related codes were updated on September 3, 2004, under Bulletin 00-04-10, entitled "*Service Definitions and Procedure Codes for Healthcare Waiver and Base Services*" (now obsolete). ODP revised the service definitions effective July 1, 2006, to include one unit per service to facilitate standardized rate setting. These revised service definitions were published under Bulletin 00-06-04, "*Revised Units for Service Definitions*" (now obsolete).

On December 23, 2006, the Centers for Medicare and Medicaid Services (CMS) approved the renewal of the Consolidated Waiver. The approved renewal application included some revisions to previous waiver service definitions, and these changes were issued in Bulletin 00-07-03, "*Revised Service Definitions*" (now obsolete).

On February 22, 2008, CMS approved the renewal of the P/FDS Waiver, retroactive to July 1, 2007; and on May 16, 2008, CMS approved the amendment of the Consolidated Waiver, also retroactive to July 1, 2007. These approvals included some minor changes

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

**The Appropriate Developmental Programs Regional Office**

to service definitions, which were issued in Bulletin 00-08-12, “*Revised Service Definitions*”.

During the CMS review of the P/FDS Waiver renewal application and Consolidated Waiver amendment, ODP began to work with a small group of family members, advocates, and professionals regarding the service definitions. The aim of this group was to identify recommendations for revisions to the service definitions that would improve the clarity of the definitions, promote consistency of their application across the State, promote integrated service options, and strengthen compliance with federal guidelines related to service delivery. The recommendations were used by ODP to develop service definition amendments to the Consolidated and P/FDS Waivers. CMS approved the amendments on September 4, 2008.

The revised service definitions involve the:

- Addition of 3 services – Companion, Behavioral Support, and Specialized Supplies
- Deletion of 1 service – Permanency Planning
- Renaming of 2 services – Personal Support to Supports Broker, and Adaptive Appliances and Equipment to Assistive Technology
- Unbundling of 2 services – Environmental Accessibility Adaptations is now separated into two services, Home Accessibility Adaptations and Vehicle Accessibility Adaptations; and the definition for Residential Habilitation clarifies those services that are part of the habilitation service, and which must be billed separately

In addition to the above changes, many definitions were revised to promote greater clarity in the scope of the service, as well as to promote consistency in application of the definition.

## **DISCUSSION:**

The attached service definitions chart, narrative, and grid reflects the current definitions for services. As with previous versions of the service definition bulletins, the appropriate modifiers must be billed with the corresponding codes, in the order specified. Supports Coordination Organizations are responsible to use the correct transaction codes in the development of Individual Support Plans. All providers who are billing for Waiver and base services through HCSIS/PROMISe must use the local (“W” codes) and national healthcare codes (“T” codes) specified in the attachment for claims to be processed through HCSIS/PROMISe. Electronic billers must use these codes to be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). All Administrative Entities and County Programs must review Individual Support Plans during approval and authorization to ensure the correct transaction codes are utilized in the Plans. Administrative Entities and County Programs must also review provider claims to ensure the correct codes are used in processing claims through HCSIS/PROMISe.

**ATTACHMENTS:**

Attachment 1: Consolidated Waiver, Person/Family Directed Support (P/FDS) Waiver, Administrative Services, and Base-Funded Services Chart

Attachment 2: Service Definitions Narrative for Consolidated Waiver, Person/Family Directed Support Waiver, Administrative Services, and Base/Waiver Ineligible Services

Attachment 3: Home and Community Services Grid

**OBSOLETE BULLETIN (effective July 1, 2009):**

00-08-12, *"Revised Service Definitions"*