



For Review and Comment Purposes Only – Not for Implementation
DEVELOPMENTAL PROGRAMS BULLETIN
COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

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SUBJECT:

**Service Definitions for FY 10/11 for the
Pennsylvania Mental Retardation Program**

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 for FY 2010/2011 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 to service definitions, which were issued in Bulletin 00-08-12, "*Revised Service Definitions*".

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The Appropriate Developmental Programs Regional Office

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On September 4, 2008, CMS approved the service definition amendments to the Consolidated and P/FDS Waivers which were effective on July 1, 2009. These approvals included many changes to service definitions, which were issued in Bulletin 00-08-17, “*Service Definitions*”.

Because of the many changes to the service definitions, ODP received lots of questions that required clarification to the service definitions. The attached FY 10/11 service definitions include the clarifications that were distributed to ODP’s stakeholders in FY 09/10.

The revised service definitions involve the:

- Addition of 1 service – Additional Individualized Staffing.
- Deletion of 2 services – Home Finding and Base-funded Respite, 15 Minutes.
- Revision of the Behavior Therapy and Behavior Support Service Definitions.
- Prior Authorization requirements for Supplemental Habilitation and Additional Individualized Staffing.
- Revised Travel Policy.
- Revised Services by Relatives, Legal Guardians, and Legally Responsible Individuals Policy.

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 narrative (Attachment 1) 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: Service Definitions Narrative for Consolidated Waiver, Person/Family Directed Support Waiver, Administrative Services, and Base/Waiver Ineligible Services

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OBSOLETE BULLETIN (effective July 1, 2010):

00-08-17, “*Service Definitions*”

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