Table of Contents

1.0 Description of the Service

Community Living and Support is an individualized service that enables individuals 3 years of age or older to live successfully in their own home, the home of their family or natural supports and be an active member of their community. Group services may be provided as long as services outlined within the Person Centered Plan (PCP) or Individual Support Plan (ISP) are able to be fully addressed. The PCP or ISP documents the supports needed based on the Support Needs Assessment Profile (SNAP), Supports Intensity Scale (SIS), and/or Traumatic Brain Injury (TBI) assessment(s). A paraprofessional assists the individual to learn new skills and/or supports the individual in activities that are individualized and aligned with their preferences.

Community Living and Support provides technical assistance to unpaid supports who live in the home of the individual to assist the individual to maintain the skills they have learned. This assistance can be requested by the unpaid support or recommended by the person centered planning team and must be a collaborative decision. The technical assistance is incidental to the provision of Community Living and Supports.

Community Living and Support may include the following services and supports:

- Learn and practice new, and improve existing skills related to the following: interpersonal, independent living, community living, self-care, and self-determination.
- In conjunction to new skill acquisition, provides supervision and assistance for the individual to complete an activity to their level of independence: assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, and daily living skills.

Transportation to and from the residence and points of travel in the community as outlined in the PCP or ISP is included to the degree that they are not reimbursed by another funding source and not used for personal use.

Exceptional Needs

Community Living and Support (CLS) Exceptional Needs are used to meet exceptional, typically short-term situations that require CLS services beyond 28 hours per week. Over 28 hours per week of CLS shall not be requested for individuals concurrently receiving Day Supports or Supported Employment. The PCP or ISP shall document the exceptional supports needed based on the SNAP, SIS, and/or Traumatic Brain Injury (TBI) assessment(s) that explain the nature of the issue and the expected intervention. A plan to transition the individual to sustainable supports is required. Medical, behavioral, and other support issues require documentation of when the situation is expected to resolve, evaluations/assessments needed to assist in resolving issues, and other service options explored.

All Requests for Community Living and Supports require prior approval by the LME/MCO. Requests for up to 8 hours daily of CLS may be authorized for up to six (6) months at a time.

1.1 Definitions

Telehealth - The use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

2.0 Eligibility Criteria

2.1 Provisions

2.1.1 General

An eligible individual shall be enrolled with the LME/MCO on or prior to the date of service, meet the criteria for the IDD or TBI state-funded Benefit Plan and shall meet the criteria in Section 3.0 of this policy.

2.1.2 Specific

State funds may cover Community Living and Support (I/DD & TBI) for an eligible individual who is 3 years of age or older and meets the criteria in Section 3.0 of this policy.

3.0 When the Service is Covered

3.1 General Criteria Covered

State funds shall cover the service related to this policy when medically necessary, and

a. the service is individualized, specific, and consistent with the symptoms or confirmed diagnosis under treatment, and not in excess of the individual's needs;
b. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the service is furnished in a manner not primarily intended for the convenience of the individual, the individual's caretaker, or the provider.

3.1.1 Telehealth Criteria Covered

As outlined in Attachment A, select services within this clinical coverage policy can be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in State-Funded Telehealth and Virtual Communications Services, at https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/service-definitions.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

State funds may cover Community Living and Supports (I/DD & TBI) when ALL of the following criteria are met:

a. 3 years of age or older and express a desire to obtain and maintain service,

AND

b. The individual has a condition that is identified as a developmental disability or Traumatic Brain Injury as defined in G.S. 122-C-3(12a) or G.S. 122-C-3(38a),

AND

c. NC Support Needs Assessment Profile (Level 3 or higher), Supports Intensity Scale (Level D or higher), or TBI Assessment requiring a moderate to high level of supervision and support in most settings, such as in the community, home, work, etc.

3.2.1.2 Telehealth Specific Criteria

State funds shall cover services delivered via telehealth services when the all the following additional criteria are followed before rendering services via telehealth:

a. Provider(s) shall ensure that services can be safely and effectively delivered using telehealth;

b. Provider(s) shall consider a recipient's behavioral, physical and cognitive abilities to participate in services provided using telehealth;

c. The recipient's safety must be carefully considered for the complexity of the services provided;

d. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth their ability to assist and their safety must also be considered;

e. Delivery of services using telehealth must conform to professional standards of care: ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements, such as Practice Act and Licensing Board rules;

f. Provider(s) shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented;

g. Recipients shall be informed that they are not required to seek services through telehealth and shall be allowed access to in-person services, if the recipient requests;

h. Provider(s) shall verify the recipient's identity using two points of identification before initiating service delivery via telehealth;

i. Provider(s) shall ensure that the recipient's privacy and confidentiality is protected to the best of their ability.

3.2.1.3 Admission Criteria

State funds shall cover Respite services when the following Admission Criteria are met:
The recipient meets the Specific Criteria for this service as outlined in **Subsection 3.2.1.**

- To demonstrate that an individual has a developmental disability as defined by G.S. 122-C-3(12a) for Autism Spectrum Disorder, Intellectual Disability or Traumatic Brain Injury, an individual must have:
    - A psychological, neuropsychological, or psychiatric assessment that includes Appropriate psychological / neuropsychological testing (with validated tools) performed by a licensed clinician within their scope

    - The disability is manifested before the person attains age 22, unless the disability is caused by a traumatic brain injury, in which case the disability may be manifested after attaining age 22.
- To demonstrate that an individual has a developmental disability as defined by G.S. 122-C-3(12a) without accompanying intellectual disabilities, an individual must have:
    - A physician assessment, substantiating a definitive diagnosis and associated functional limitations consistent with a developmental disability. Associated psychological or neuropsychological testing is not required in this situation.

Relevant clinical information must be obtained and documented in the individual's Person-Centered Plan or Individual Service Plan.

Prior authorization by the LME/MCO is required. A service authorization request that indicates the recipient would benefit from Community Living and Support must be completed by a Qualified Professional and submitted to the LME/MCO prior to services.

The individual requires this service to learn and practice new skills and improve existing skills related to the following: interpersonal, independent living, community living, self-care, self-determination in conjunction with requiring supervision and assistance for the individual to complete an activity on their level of independence: assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills instead as documented by detailed deficiencies and planned goals which reflect strategies to correct deficiencies.

3.2.1.4 Continued Stay Criteria

The individual continues to require this service to learn and practice new skills and improve existing skills related to the following: interpersonal, independent living, community living, self-care, self-determination in conjunction with requires supervision and assistance for the individual to complete an activity to their level of independence: assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills instead as documented by detailed deficiencies and planned goals which reflect strategies to correct deficiencies.

Community Living and Support should be maintained when the individual meets criteria for continued stay if ONE of the following applies:

a. The desired outcome or level of functioning has not been acquired, sustained, restored, or improved over the time frame documented in the individual's PCP or ISP;

OR

b. The individual has documentation to support it can be reasonably anticipated that regression is likely to occur if the service is withdrawn based on current clinical assessment, and history, or the tenuous nature of the functional gains;

OR

c. Continuation of service is supported by documentation of the individual's progress toward goals within the individual's PCP or ISP.

Prior authorization by the LME/MCO is required. A service authorization request must be completed by a Qualified Professional and submitted to the LME/MCO prior to services.

3.2.1.5 Transition and Discharge Criteria

The individual's level of functioning has improved with respect to the goals outlined in the PCP or ISP, or no longer benefits from this service. The individual meets criteria for discharge if any ONE of the following applies:

a. Individual's level of functioning has improved with respect to the goals outlined in the PCP or ISP (i.e., goals do not show a progression),
b. Individual no longer benefits from this service.
c. Individual has achieved PCP or ISP goals, discharge to a lower level of care is indicated
d. Individual is not making progress, or is regressing, and all realistic treatment options within this modality have been exhausted.
e. Individual has expressed they desire discharge from the service.

4.0 When the Service is Not Covered

4.1 General Criteria Not Covered

State funds shall not cover the service related to this policy when:

a. the individual does not meet the eligibility requirements listed in Section 2.0;
b. the individual does not meet the criteria listed in Section 3.0;
c. the service duplicates another provider's service; or
d. the service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by State Funds

State funds shall not cover the following activities of Community Living and Support (I/DD & TBI):

a. Transportation to and from the school setting is not covered and is the responsibility of the school system.
b. This service includes only transportation to/from the individual's home or any community location where the individual is receiving services.
c. The paraprofessional is responsible for incidental housekeeping and meal preparation only for the individuals.

d. Incidental housekeeping and meal preparation for other household members is not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State funded Community Living and Support (I/DD & TBI) shall require prior approval. Refer to **Subsection 5.3** for additional limitations.

A service order must be signed prior to or on the first day Community Living and Support (IDD & TBI) are rendered. Refer to **Subsection 5.4** of this policy.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the LME/MCO both of the following:

a. the prior approval request; and
b. all health records and any other records that support the individual has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible individual.

Initial Authorization

Services are based upon a finding of medical necessity, must be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific habilitative goals detailed in the individual's PCP or ISP. Medical necessity is determined by North Carolina community practice standards, as verified by the LME/MCO who evaluates the request to determine if medical necessity supports intensive services. Medically necessary services are authorized in the most cost-effective manner (ie., if the treatment that is made available is similarly efficacious as services requested by the individual's physician, therapist, or another licensed practitioner). The medically necessary service must be recognized as an accepted method of treatment.

To request an initial authorization, the psychological evaluation, service order for medical necessity, PCP or ISP, and the required LME/MCO authorization request form must be submitted to the LME/MCO. Refer to **Subsection 5.4** for Service Order requirements.

Reauthorization

Reauthorization requests must be submitted to the LME/MCO 14-days prior to the end date of the individual's active authorization.
Reauthorization is based on medical necessity documented in the PCP or ISP, the authorization request form, and supporting documentation. The

duration and frequency at which Community Living and Support (IDD & TBI) is provided must be based on medical necessity and progress made by the individual toward goals outlined in the PCP or ISP.

If medical necessity dictates the need for increased service duration and frequency, clinical consideration must be given to other services and interventions with a more intense clinical component.

Note: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person or both about the individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules10A NCAC27I .0601-.0609.

5.3 Additional Limitations or Requirements

a. Only one Community Living and Support provider can provide this service to an individual at a time.
b. An individual who receives Community Living and Support may not receive any residential services or Supported Living Peridoc.
c. An individual who receives Community Living and Support may not receive Community Networking, Day Supports or Supported Employment at the same time of day.
d. This service is not available at the same time as State Plan Medicaid Services that works directly with the individual, such as Private Duty Nursing.
e. This service may not exceed 15 hours per week when school is in session for individuals 3 – 22 years of age who have not graduated.
f. This service may not exceed 28 hours a week.
g. Community Living and Support Services (I/DD & TBI) must not be duplicative of other state funded services the individual is receiving.
h. Individuals eligible to receive services through a NC Medicaid HCBS Waiver, individuals eligible to receive or individuals receiving I/DD or TBI-related 1915(b)(3) meaningful day services (e.g., In Home Skill Building, Innovations look-alike services), 1915i services and In Lieu Of Services with meaningful day component (e.g., services in-lieu of ICF-IID).

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the individual's needs. A signed service order must be completed by a qualified professional, physician, licensed psychologist, physician assistant, or nurse practitioner, per the individual's scope of practice.

ALL the following apply to a service order:

a. Backdating the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
c. A service order must be in place prior to or on the first day that the service is initially provided to bill state funds for the service; and

d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP or ISP service order.

5.5 Documentation Requirements

Documentation is required as specified in the Records Management and Documentation Manual and service definition.

The service record documents the nature and course of an individual's progress in treatment. To bill state funds, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed with state funds. The staff person who provides the service shall sign and date the written entry. A Service Note or a Service Grid, as outlined in the Records Management and Documentation Manual, may be utilized for this service.

5.5.1 Contents of a Service Record

For this service, a full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in a service note, if applicable. A service note must document ALL following elements:

a. Individual's name;
b. Service record identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (face-to-face, telehealth) Services eligible to be provided via telehealth must be provided according to State-Funded Telehealth and Virtual Communications Services policy, at: https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/service-definitions;
f. Place of service;
g. Purpose of contact as it relates to the PCP or ISP goals;
h. Description of the intervention/prompting provided. Documentation of the intervention must accurately reflect services for the duration of time indicated;
i. Duration of service, start and end time of intervention; total amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

6.0 Provider(s) Eligible to Bill for the Service

To be eligible to bill for the service related to this policy, the provider(s) shall:

a. meet LME/MCO qualifications for participation; and

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement;
c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity, if applicable.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Community Living and Support (I/DD & TBI) Services must be delivered by practitioners employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Division of MH/DD/SUS;
b. meet the requirements of 10A NCAC 27G;
c. demonstrate that they meet these standards by being credentialed and contracted by an LME/MCO;
d. within one calendar year of enrollment as a provider with the LME/MCO, achieve national accreditation with at least one of the designated accrediting agencies; and
e. become established as a legally constituted entity capable of meeting all the requirements of the DMH/DD/SUS Bulletins and service implementation standards. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.

Community Living and Supports is designed to be a supportive therapeutic relationship between the provider and the individual which addresses and/or implements interventions outlined in the person centered/individual support plan.

Community Living and Support providers:

a. Help develop community involvement and relationships that promote full citizenship,
b. Coordinate education and assistance related to finances, healthcare, and other needs,
c. Assist with day-to-day planning and problem solving,
d. Train and support people who assist the individual incidental to the PCP or ISP,
e. Train and support individuals on accessing public transportation,
f. Train and support individuals with new skill acquisition related to interpersonal, independent living, community living, self-care, and self-determination.

6.2 Provider Certifications

Community Living and Support must be provided by a legally constituted entity that meets all of the requirements of the LME/MCO and is contracted with the LME/MCO to serve individuals with I/DD and TBI.

6.2.1 Staffing Requirements

The Community Living and Support (I/DD & TBI) service is provided by qualified providers with the capacity and adequate workforce to offer this service to individuals meeting the IDD/TBI state-funded Benefit Plan. The service must be available during times that meet the needs of the individual

which may include evening, weekends, or both. The service must have designated competent developmental disability and/or traumatic brain injury qualified professionals to provide supervision to the paraprofessional. The Community Living and Support (I/DD & TBI) paraprofessional must meet the requirements according to 10A NCAC 27G .0104 (15).

Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to the supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

The maximum program staff ratios are as follows: group ratio for Community Living and Support (I/DD & TBI) Group Paraprofessional to Individuals is 1:3.

6.2.2 Staff Training Requirements

The provider shall ensure that staff who are providing Community Living and Support (I/DD & TBI) Group have completed special population training based on staff experience and training needs (e.g., intellectual and developmental disabilities, geriatric, traumatic brain injury, deaf and hard of hearing, co-occurring intellectual and mental health and co-occurring intellectual and developmental disabilities and substance use disorder) as required. Such training should be completed prior to working with individuals and updated as individuals' needs change.

Agency staff that work with individuals:

a. Are at least 18 years of age
b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
c. Criminal background check presents no health and safety risk to person/s
d. Not listed in the North Carolina Health Care Personnel Registry
e. Qualified in CPR and First Aid
f. Staff that work with person/s must be qualified in the specific needs of the beneficiary as described in the PCP or ISP.
g. Staff that work with individuals who are responsible for medication administration must be trained in medication administration in accordance to 10A NCAC 27G .0209, as applicable.
h. Staff that work with individuals must be trained in alternatives to restrictive intervention and restrictive intervention training (as appropriate).
i. High school diploma or high school equivalency (GED).

Professional Competency

Paraprofessionals have competencies through training and supervision in the following areas:

A. Communication - The Paraprofessional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
B. Person-Centered Practices - The Paraprofessional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
C. Evaluation and Observation - The Paraprofessional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
D. Crisis Prevention and Intervention - The Paraprofessional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
E. Professionalism and Ethics - The Paraprofessional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
F. Health and Wellness - The Paraprofessional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
G. Community Inclusion and Networking - The Paraprofessional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
H. Cultural Competency - The Paraprofessional respects cultural differences and provides services and supports that fit with an individual's preferences.
I. Education, Training and Self-Development - The Paraprofessional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

6.3 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the individual's PCP or ISP. Further, expected outcomes of Community Living and Support (I/DD & TBI) is the following:

1. To increase the individual's life skills and independent living skills,
2. Maximize their self-sufficiency,
3. Increase self-determination, and
4. Ensure the individual's opportunity to have full membership in their community as defined within the PCP and ISP goals.

7.0 Additional Requirements

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 and record retention requirements; and
b. All NC Division of MH/DD/SUS's service definitions, guidelines, policies, provider manuals, implementation updates, and bulletins, DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: April 1, 2021

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	
04/05/2022	Section 3.2.2	Updated service definition language, "To demonstrate that an individual has a developmental disability as defined by G.S. 122-C-3(12a) without accompanying intellectual disabilities, an individual must have: • A physician assessment, substantiating a definitive diagnosis and associated functional limitations consistent with a developmental disability. Associated psychological or neuropsychological testing is not required in this situation."
04/05/2022	Section 5.5	Updated service definition language, "The staff person who provides the service shall sign and date the written entry. A Service Note or a Service Grid, as outlined in the Records Management and Documentation Manual, may be utilized for this service."

06/01/2022	Section 3.2.2 and Section 3.2.3	Updated service definition language, “Prior authorization by the LME/MCO is required. A service authorization request must be completed by a Qualified Professional and submitted to the LME/MCO prior to services.”
10/12/2022	Section 5.3	Updated service definition language, “An individual who receives Community Living and Support may not receive any residential services or Supported Living Peridoc.”
12/01/2022	Section 1.0	Added “Exceptional Needs” clause to service definition.
06/01/2023	Section 1.1, Section 3.1.1, Section 3.2.1.2 and Attachment A, Section 5.5.1	Added telehealth language
06/01/2023	Attachment A	Added alternative locations due to COVID-19
10/01/2023	Section 1.0, Section 2.1.2, Section 3.2.1	Updated age requirement to 3 years of age and older
10/01/2023	Section 5.3	Updated service definition language “Individuals eligible to receive services through a NC Medicaid HCBS Waiver, individuals eligible to receive or individuals receiving I/DD or TBI-related 1915(b)(3) meaningful day services (e.g., In Home Skill Building, Innovations look-alike services), 1915i services and In Lieu Of Services with meaningful day component (e.g., services in-lieu of ICF-IID).”
10/01/2023	Section 5.3	Added: Individuals eligible to receive services through a NC Medicaid HCBS Waiver, individuals eligible for or receiving IDD or TBI-related 1915(b)(3) meaningful day services (i.e., In Home Skill Building, Innovations look-alike services), 1915i services and In Lieu Of Services with meaningful day

		component (e.g., services in-lieu of ICF-IID).

Attachment A: Claims-Related Information

Provider(s) shall comply with the, NC Tracks Provider Claims and Billing Assistance Guide, DMH/DD/SUS bulletins, fee schedules, NC Division of MH/DD/SUS service definitions and any other relevant documents for specific coverage and reimbursement for state funds:

A. Claim Type

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedure Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s)shall use the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s)shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)		Billing Unit
YM851	Individual	1 unit =15 minutes
YM852	Group	1 unit = 15 minutes

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Telehealth Claims: Modifier GT must be appended to the HCPCS code to indicate that a service has been provided via interactive audio-visual communication.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Units are billed in 15-minute increments.

LME/MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME/MCOs shall assess their Community Living & Supports (I/DD & TBI) network providers' adherence to service guidelines to assure quality services for individuals served.

F. Place of Service

The service may be provided in the home or community that meet the home and community based characteristics established by Centers for Medicare & Medicaid Services and adopted by NC DHHS. The involvement of unpaid supports in the generalization delivery of the service is an important aspect to ensure that achieved goals are practiced and maintained. Services may be provided in the individual's home and/or in the community. Services may not be provided in the home of provider staff rxcept for COVID-19 related issues.

Telehealth claims should be filed with the provider's usual place of service code(s).

Community Living & Supports (I/DD & TBI) service may be provided in a hotel, shelter, church, or alternative facility-based setting or the home of a direct care worker due to COVID-19 related issues, as long as ALL the following criteria are met:

a. health and safety of the recipient can be maintained;
b. the individual's ISP and PCP plan has been updated indicating service delivery needed in an alternative location due to COVID-19 related issue; and
c. documentation provided confirming a COVID-19 diagnosis.

This service is not Medicaid billable.

G. Co-payments

Not applicable

H. Reimbursement

Provider(s) shall bill their usual and customary charge. When the GT modifier is appended to a code billed for professional services, the service is paid at the allowed amount of the fee schedule. Reimbursement for these services is subject to the same restrictions as face-to-face contacts (such as: place of service, allowable providers, multiple service limitations, prior authorization).

Note: DMH/DD/SUS will not reimburse for conversion therapy.