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| NC Division of Mental Health, Developmental Disabilities, and Substance Use Services | State-Funded Residential Supports (I/DD & TBI) Date Amended: June 1, 2023 |
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1.0 Description of the Service

Residential Supports (I/DD and TBI) provides individualized services and supports to enable an individual 16 years and older to live successfully in a licensed Supervised Living facility (i.e., Group Home, licensed Alternative Family Living (AFL) home) or an unlicensed Alternative Family Living (AFL)) setting of their choice and be an active participant in the individual’s community. Residential Supports shall comply with home and community based service (HCBS) standards.

The individual requires this service to learn and practice new skills and improve existing skills to assist the individual in increasing their level of independence for the I/DD population. For the Traumatic Brain Injury population, the service includes training and support for relearning skills, developing compensatory strategies and practicing new skills and for improvement of existing skills to assist the individual to complete activities to the greatest level of independence possible. Residential Supports includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety.

Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs. Residential Supports may not be billed on the same day as Respite if Respite is billed for more than four hours on that day.

The cost associated with Therapeutic Leave is included in the per diem.

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

Residential Supports levels 1 through 3 are determined by the individual’s evidence of support need, NC Support Needs Assessment Profile (SNAP) (Level 2 – Level 4) or Supports Intensity Scale (SIS) (Level C – Level E). The SNAP level or SIS level is only one piece of evidence that may be considered.

LEVEL 1: Moderate intervention and supervision comparable to SNAP level 2 or SIS level C

Individuals have the capacity to spend up to 50%-80% of their time at home and/or community without active intervention or supervision from caregiver or staff member. Goals for individuals in this level of service should receive interventions that support increasing independence, which could lead to a lower level of care. These behavioral needs are not extreme, they likely require increased monitoring or intervention to address behavioral challenges such as prevention of outbursts, self-harm, and/or wandering.

Individuals require minimal to low levels of supervision and support in most settings such as in the community, home, work, etc. Most individuals are diagnosed with mild/moderate intellectual disabilities and/or a related condition. Individuals may also have mental health conditions that may need specialized behavioral support. They often need low to moderate support to manage many aspects of their life. Needs related to teaching, monitoring, and/or supports are usually low to moderate and will typically reflect an on-going schedule. Support needs related to behavior and medical may range from minimal to moderate. When appropriate, assistive technology should be considered to maximize the individual’s independence.

LEVEL 2: Moderate - High intervention and supervision comparable to SNAP level 3 or SIS level D

Individuals have the capacity to spend up to 50%-60% of their time at home and/or community without active intervention or supervision from caregiver or staff member. Individuals

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require moderate to high levels of supervision and support in most settings such as in the community, home, work, etc. Most members are diagnosed with moderate/severe intellectual disabilities and/or a related condition. Some members may also have mental health conditions and/or medical support needs but these needs are not extreme. They often need moderate to high support to manage many aspects of their life. Needs related to teaching, monitoring, and/or supports are usually moderate to high and will typically reflect an on-going schedule. Support needs related to behavior and medical may range from minimal to moderate. When appropriate, assistive technology should be considered to maximize the individual's independence.

LEVEL 3: High intervention and supervision comparable to SNAP level 4 or SIS level E -

Individuals have the capacity to spend up to 50% of their time at home and/or community without active intervention or supervision from caregiver or staff member. Individuals require high levels of supervision and support in most settings such as in the community, home, work, etc. Most members are diagnosed with severe/profound intellectual disabilities and/or a related condition characterized by significant physical limitations. They often need a high level of support to manage many aspects of their life. Many individuals in this category require full physical support to assure their daily needs are met. Needs related to teaching, monitoring, and/or supports are usually high and will typically reflect an on-going schedule. Support needs related to behavior and medical may range from minimal to moderate, but these needs are not extraordinary. When appropriate, assistive technology should be considered to maximize the individual's independence.

Note: Regardless of individual's level of independence, facility licensing standards must be upheld in accordance with licensure rules.

1.1 Definitions

Assistive Technology as a device can be any item or piece of equipment that helps a person with a disability increase, maintain, or improve their ability to function. Assistive Technology as a device can range from low-tech to high tech. Example of devices:

Low-tech devices:

1. Wheelchair or cane
2. Handheld grabber for reaching items
3. Adaptive culinary utensils

High-tech device:

1. Hearing and visual aids
2. Software program on a computer/screen readers
3. A communication device

Note: Medical devices that are surgically implanted are not considered assistive technology devices

Assistive technology as a service can involve any combination of the following:

1. The evaluation of an individual's needs,
2. The acquiring of assistive technology devices (i. e. purchasing, leasing, or loaner programs)
3. The selection, fitting or repairing of a device

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4. The training of individual or caregiver on how to use the assistive technology

Compensatory Strategies are strategies used to help an individual perform tasks in an alternative manner or by using adaptive aids so that they can be more independent.

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 I/DD state-funded Benefit Plan and shall meet the criteria in Section 3.0 of this policy.

2.1.2 Specific

State funds may cover Residential Supports (I/DD and TBI) for an eligible individual who is 16 years of age and 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 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
- the service is furnished in a manner not primarily intended for the convenience of the individual, the individual's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

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

- a. 16 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 a Traumatic Brain Injury as defined in G.S. 122-C-3(12a),
AND
- c. NC Support Needs Assessment Profile (SNAP) (Level 2 – Level 4) or Supports Intensity Scale (SIS) (Level C – Level E) requiring a moderate to high level of supervision and support in most settings, such as in the community, home, work, etc.,

Residential Supports Levels 1 through 3:

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LEVEL 1: SNAP Level 2 or SIS Level C – Moderate intervention and supervision

LEVEL 2: SNAP Level 3 or SIS Level D – Moderate - High intervention and supervision

LEVEL 3: SNAP Level 4 or SIS Level E – High intervention and supervision

3.2. Admission Criteria

- 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.

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.

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

The individual requires this service to learn and practice new skills and improve existing skills to assist the individual in increasing their level of independence for the I/DD population. For the Traumatic Brain Injury population, the service includes training and support for relearning skills, developing compensatory strategies and practicing new skills and for improvement of existing skills to assist the individual to complete activities to the greatest level of independence possible. Evidence of exploration (e.g., case notes, electronic communication with providers, provider denials, etc.) of community based services provided in the individual's home setting should be explored prior to the provision of Residential Supports services.

3.3 Continued Stay Criteria

The individual continues to require this service to learn and practice new skills and improve existing skills to assist the individual in increasing their level of independence for the I/DD population.

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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.

Residential Supports should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. 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.

3.4 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.

The person centered planning team should document an agreed upon discharge plan within the PCP or ISP.

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.

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4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by State Funds

None that apply.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State funded Residential Supports (I/DD and 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 Residential Supports (I/DD and TBI) are rendered. Refer to Subsection 5.4 of this policy.

Providers shall collaborate with the individual's existing provider to develop an integrated plan of care.

Prior authorization is not a guarantee of claim payment.

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 and support goals to the degree detailed in the individual's PCP or ISP. The goals should be designed to support with increasing individual's level of independence; therefore, habilitative goals for individuals with I/DD and rehabilitative goal for individuals with TBI should be 75% of goals noted within the plan. 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 modes, if the treatment that is made available is similarly efficacious as services requested by the individual's physician, therapist, or another licensed qualified professional. 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, SIS evaluation and/or SNAP evaluation 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 updated PCP or ISP, the authorization request form, and supporting documentation to include a current SNAP or SIS, where applicable. The duration and frequency at which Residential Supports (I/DD and 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 NCAC 27I .0601-.0609.

5.3 Additional Limitations or Requirements

- a. Transportation to and from the high school setting is not covered and is the responsibility of the school system.
- b. 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.
- c. Relatives may not provide Residential Supports service to family members.
- d. Relatives who own provider agencies may not provide Residential Supports services to family members. Other staff employed by the provider agency may provide other services to the individual.
- e. Individuals who receive Residential Supports may not receive state funded Community Living and Supports, Supported Living Periodic, Developmental Therapy, Personal Care Services, or State Funded Personal Care or Personal Assistance.
- f. This service is not available at the same time of day as state-funded periodic services, State Plan Medicaid Services that works directly with the individual, such as Private Duty Nursing.
- g. Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs. Residential Supports may not be billed on the same day as Respite if Respite is billed for more than four hours on that day.

- h. Residential Supports cannot be used to purchase Assistive Technology Equipment & Supplies.
- i. Assistive Technology Equipment & Supplies may be accessed only when the item belongs to the individual and can transition to other settings with the individual. Assistive Technology Equipment & Supplies may not be used to supplant staff where required by rule, but utilized to support the individual's independence.
- j. Payments for Residential Supports do not include payments for room and board or the cost of facility maintenance and upkeep.
- k. The cost associated with Therapeutic Leave is included in the per diem.
- l. Primary AFL Staff who provide Residential Supports should not provide other state funded services to the individual. Agencies providing Residential Supports can provide other state-funded services to the individual.
- m. Individuals receiving this service may not be an HCBS Waiver member/beneficiary or individual receiving Medicaid funded residential services, inclusive of Medicaid ICF-IID In Lieu of Services (ILOS) with a residential component.
- n. Residential Supports services (I/DD and TBI) must not be duplicative of any other services the individual is receiving.
- o. This service is a daily 24/7 service.

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 of 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

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who provides the service is responsible for documenting the services billed to and reimbursed by 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 or service grid for each contact or intervention for each date of service. More than one intervention, activity, or goal may be reported in one service note, if applicable. The minimum requirements must include ALL of the following elements:

- a. Name of the individual on each page;
- b. The service record number or unique identifier on each page;
- c. Date [month/day/year] that the service was provided;
- d. Name of the service being provided on each page [e.g., Residential Supports];
- e. Type of contact(face-to-face)
- f. Goals addressed;
- g. A number or letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed;
- h. A number/letter/symbol as specified in the appropriate key that reflects the assessment of the individual's progress toward goals;
- i. Duration;
- j. Initials of the individual providing the service – the initials shall correspond to a full signature and initials on the signature log section of the note/grid; and
- k. A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the individual's response to the interventions provided and progress toward goals. Each entry in the comment section must be dated.

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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Residential Supports (I/DD and TBI) Services must be delivered by qualified professionals 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 contracted with an LME-MCO;

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- 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;
- f. an HCBS provider self-assessment is not required for state-funded services. However, if individuals receiving Medicaid HCB services are also served, a provider self-assessment is required.

Residential 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.

Residential Supports 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,
- e. Train and support individuals on accessing public transportation,
- f. Train and support individuals with new skill acquisition related to interpersonal skill development, independent living, community living, self-care, and self-determination.

6.2 Provider Certifications

Residential Supports (I/DD and TBI) must be provided by an I/DD agency contracted with the LME-MCO and must be established as a legally constituted entity capable of meeting all of the requirements of the LME-MCO.

6.2.1 Staffing Requirements

The Residential Supports (I/DD and TBI) service is provided by qualified providers with the capacity and adequate workforce to offer this service to individuals meeting the I/DD 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 Residential Supports (I/DD) 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 supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and

according to licensure or certification requirements of the appropriate discipline.

6.2.2 Staff Training Requirements

The provider shall ensure that staff who are providing Residential Supports 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 customized 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.

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- 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 Residential Supports (I/DD and TBI) is the following:

- 1. To increase the Individual's life skills and independent living skills,
- 2. Maximize self-sufficiency towards independent living,
- 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:

History:

| Date | Section or Subsection Amended | Change |
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| | All Sections and Attachment(s) | |
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| 06/01/2022 | Section 1.0 and Section 5.3 | Updated service definition language, "The cost associated with Therapeutic Leave is included in the per diem." |
| 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." |
| 06/1/2023 | Attachment A | Added alternative locations due to COVID-19 |

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTRACKS Provider Claims and Billing Assistance Guide, DMH/DD/SUS bulletins, fee schedules, NC Division of MH/DD/SUS’s 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 Procedural Coding System(PCS)

Provider(s) shall report the ICD-10-CM and Procedural 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), Health Care 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 |
|---------------|---------|---------------------|
| YM846 | Level 1 | 1 unit = daily rate |
| YM847 | Level 2 | 1 unit = daily rate |
| YM848 | Level 3 | 1 unit = daily rate |

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 at a daily rate.

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 Residential Supports (I/DD and 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 site must be the primary residence of the AFL provider who receives reimbursement for the cost of care. These sites are licensed in accordance with state mental health licensure rules.

5600 Supervised Living facilities Type B for Children:

- 4 beds or less for newly developed facilities; 6 beds or more for existing facilities

5600 Supervised Living facilities Type C for Adults:

- 4 beds or less for newly developed facilities; 6 beds or more for existing facilities

5600 Supervised Living facilities Type F for Children or Adults:

- 3 beds or less for newly developed and existing facilities

Residential Supports 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.

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