To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

8H-1 1915(i) Supported Employment
8H-2 Individual Placement and Support
8H-3 Individual and Transitional Support
8H-4 1915(i) Respite
8H-6 Community Transition

1.0 Description of the Procedure, Product, or Service

1915(i) Community Living and Supports (CLS) is an individualized or group service that enables the beneficiary to live successfully in their own home, the home of their family or natural supports and be an active member of their community. A paraprofessional assists the beneficiary to learn new skills and supports the beneficiary in activities that are individualized and aligned with the beneficiary's preferences.

The intended outcome of the service is to increase or maintain the beneficiary's life skills or provide the supervision needed to empower the beneficiary to live in the primary private residence of their family or natural supports or in their private primary residency. The goal is to maximize self-sufficiency, increase self- determination and enhance the beneficiary's opportunity to have full membership in their community. Community Living and Support enables the beneficiary to learn new skills, practice or improve existing skills, provide supervision and assistance to complete an activity to their level of independence.

Community Living and Supports provides the beneficiary the following:

a. : the ability to gain skills in:
    1. independent living;
    2. community living;
    3. self-care; and
    4. self-determination.
b. : Support or assistance in or with:
    1. monitoring a health condition;
    2. monitoring nutrition;
    3. monitoring of a physical condition;
    4. incidental supervision;
    5. daily living skills;
    6. community participation; or
    7. interpersonal skills.

1.1 Definitions

Traumatic Brain Injury (TBI)

An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all the following criteria:

a. Involves an open or closed head injury;
b. Resulted from a single event or resulted from a series of events which many include multiple concussions;
c. Occurs with or without a loss of consciousness at the time of injury;
d. Results in impairments in one or more areas of the following functions: cognition, language, memory, attention, reasoning, abstract thinking, judgement, problem-solving, sensory, perceptual, and motor abilities, psychosocial behavior, physical functions, information processing, and speech, and;
e. Does not include brain injuries that are congenital or degenerative.

Intellectual or Developmental Disability (I/DD)

A severe, chronic disability attributed to a cognitive or physical impairment, or a combination of cognitive and physical impairments diagnosed or that become obvious before reaching 22 years of age. The condition is likely to continue indefinitely and substantially impacts the beneficiary's functioning in three (3) or more of the following areas:

a. Self-care;
b. Receptive and expressive language;
c. Learning;
d. Mobility;
e. Self-direction;
f. Capacity for independent living; or
g. Economic self-sufficiency;

Meaningful Day Services

Are habilitative or rehabilitative in nature and focus on keeping, learning or improving skills and functioning for daily living.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in The NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

a. Medicaid

This service is available for beneficiaries who meet the IDD or TBI eligibility criteria.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/early-periodic-screening-diagnostic-and-treatment-medicaid-services-children

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover Community Living and Supports when ALL following criteria are met:

a. The beneficiary is ages 3 or above; AND
b. One of the following is met:
   1. I/DD as defined currently in **section 1.1;** or
   2. A DSM 5 (or later) diagnosis of ID, Unspecified ID, or ASD; or
   3. A genetically diagnosed syndrome that is typically associated with I/DD (e.g., Down Syndrome); or
   4. TBI as defined currently in **section 1.1**.

and

c. The beneficiary can benefit from skill acquisition, monitoring and/or supervision (beyond what is expected of natural supports) in one or more areas listed below:
   1. interpersonal, independent living, community living, self-care, and self-determination; or
   2. a health condition, nutrition or physical condition, incidental supervision, daily living skills, community participation, or interpersonal interactions.

3.2.3 Admission Criteria

a. A standardized independent evaluation completed by the Division of Health Benefits to determine beneficiary eligibility for 1915(i) benefit based on the needs-based criteria; and
b. An Independent Assessment completed by a tailored care manager or the Cherokee Indian Hospital Authority (CHIA) for Tribal members that indicates the beneficiary would benefit from Community Living and Supports.

3.2.4 Continued Stay Criteria

Medicaid shall cover continued stay if:

a. The beneficiary continues to meet Admission Criteria for service. Refer to **Subsection 3.2.4**.
b. The beneficiary requires assistance with at least one functional deficit and who can benefit from either skill acquisition in at least one area from the following: interpersonal, independent living, community living, selfcare, and self-determination or assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills, community participation, and interpersonal skills.

3.2.5 Transition and Discharge Criteria

The beneficiary meets the criteria for discharge if any ONE of the following applies:

a. The beneficiary no longer meets Admission Criteria for service. Refer to **Subsection 3.2.4**;
b. The beneficiary no longer requires assistance with at least one functional deficit;
c. The beneficiary has requested discharge; or
d. The beneficiary is enrolled in an NC Medicaid Home and Community Based Services Waiver.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply

4.2.2 Medicaid Additional Criteria Not Covered

Transportation to and from the school setting is not covered under Community Living and Supports and is the responsibility of the school system.

a. Community Living and Supports provide only transportation to and from the beneficiary's primary private residence or any community location where the beneficiary is receiving services.
b. Incidental housekeeping and meal preparation for other household members is not covered under Community Living and Supports.
c. A beneficiary who receives 1915(i) Community Living and Supports shall not receive services through a 1915(c) waiver.
d. Relatives who live in the same primary private residence, as a beneficiary who is under 18 years old, cannot provide Community Living and Supports.
e. Relatives who live in the same primary residence as beneficiary, who is over 18 years old, can provide Community Living and Supports if the relative meets the required staffing qualifications.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Community Living and Supports. The provider shall obtain prior approval before rendering service.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary 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 beneficiary. Units are 15-minute increments.

Initial Authorization

Authorization is an aspect of utilization management and validates approval to provide a medically necessary covered service to an eligible beneficiary.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, as verified by the DHHS Utilization Management Review Contractor or the Cherokee Indian Hospital Authority, 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 beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment. Reauthorizations is be based on the level of intensity required to acquire stable employment or interventions required for continued employment.

To request an authorization, the individual assessment, independent evaluation, and service order and the required NC Medicaid authorization request form must be submitted to the DHHS Utilization Management Review Contractor or the Cherokee Indian Hospital Authority.

Reauthorization

Reauthorization must be submitted prior to initial or concurrent authorization expiring. Authorizations are based on medical necessity documented in the service plan, the authorization request form, and supporting documentation.

5.3 Additional Limitations or Requirements

A beneficiary who is in school is eligible for up to 15 hours (or 60 units) a week on weeks school is in session and up to 28 hours (or 112 units) a week on weeks school is not in session.

Community Living and Supports may be authorized up to 28 hours or 112 units a week for a beneficiary 22 years of age and older. If a beneficiary is age 18 or older and has graduated (graduation with a degree indicating a standard course of study or an occupational course of study, a GED, a Certificate of Completion or proof of the exhaustion of their educational course of study) then they are eligible for over 22 limits.

1915(i) Community Living and Supports (CLS) and 1915(i) Supported Employment (SE) are available as a meaningful day option. 1915(i) CLS and SE cannot exceed a combined

limit of 40 hours per week. (If a beneficiary is receiving 1915(i) Community Living and Supports (CLS) for 25 hours per week then Supported Employment (SE) cannot exceed 15 hours per week.) A beneficiary 16 years of age and older can access 1915(i) Support Employment based on the limits outlined in that policy.

For Community Living and Supports Group, group size cannot exceed three (3) beneficiaries to one (1) staff. The group size may be smaller if the staff is not able to maintain health and safety at all times, for all beneficiaries in the group.

5.4 Service Order

A Service order is a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be:

a. completed by one of the following;
b. qualified professional;
c. licensed behavioral health clinician;
d. licensed psychologist;
e. physician;
f. nurse practitioner; or
g. physician assistant per their scope of practice.

Note: A Service order is valid for one calendar year. Medical necessity must be revisited, and service must be ordered at least annually, based on the date of the original service order.

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
c. indicate the date on which the service was ordered; and
d. A service order must be in place prior to or on the first day that the service is initially
e. provided, to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

5.5 Documentation Requirements

To bill Medicaid, 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 by Medicaid. The staff member providing the service shall sign and date the written entry. The signature must contain credentials for the staff member who provided the service.

Contents of a Service Note or Grid

For this service, a full service note or grid for each date of service, written and signed by the person who provided the service is required. A service note or grid must document all following elements:

a. Beneficiary's name;
b. Medicaid identification number;
c. Month/day/year of the service provision;
d. Name of service provided;
e. Place of service;

f. Purpose of contact as it relates to the person-centered plan or individual support plan goals:
g. Description of the intervention provided. Documentation of the intervention must accurately reflect activities for the duration of time indicated;
h. Duration of service, amount of time spent performing the intervention;
i. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goals; and
j. Date signature with credentials or job title of the staff member who provided the service.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

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

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Provider shall comply with Refer to 10A N.C.A.C. 27G and NC G.S. 122 C;

6.2 Provider Certifications

An I/DD or TBI agency contracted with the Tailored Plan and PIHP shall provide Community and Living and Supports (I/DD & TBI) and be established as a legally constituted entity capable of meeting all of the requirements of the Tailored Plan and PIHP.

6.2.1 Staff 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. The service must be available during times that meet the needs of the beneficiary which can consist of evening, weekends, or both. Community Living and Supports (I/DD & TBI) must be under the Supervision of a Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104 (19).

6.2.2 Staffing Training Requirements

The provider shall ensure that staff who are providing Community Living and Support have completed special population training based on staff experience and training needs (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).

Agency staff that works with a beneficiary shall meet the following requirements:

a. Are at least 18 years of age;
b. If providing transportation, must have a valid North Carolina driver's license or other valid driver's license, a safe driving record, and has automobile liability insurance coverage;
c. Criminal background check presents no health and safety risk to beneficiary;
d. Not listed in the North Carolina Health Care Personnel Registry;
e. Trained in Cardiopulmonary resuscitation (CPR) and First Aid;
f. Staff that work with a beneficiary shall be qualified in the customized needs of the beneficiary as described in the ISP or PCP and receive supervision from a QP with at least 2 years' experience working with the population served focused on the provision of IDD or TBI services;
g. High school diploma or high school equivalency (GED); and
h. Supervision of a paraprofessional 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.

6.2.3 Professional Competency

Direct Support Professional shall have competency in the following areas:

a. Communication - The Direct Support Professional builds trust and productive relationships with people they support, coworkers and others through respectful and clear verbal and written communication.
b. Person-Centered Practices - The Direct Support Professional uses person centered practices, assisting the beneficiary to make choices, plan goals, and provides services to help the beneficiary achieve their goals.
c. Evaluation and Observation – The Direct Support Professional closely monitors the beneficiary's physical and emotional health, gathers information about the beneficiary, and communicates observations to guide services.
d. Crisis Prevention and Intervention - The Direct Support Professional 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 Direct Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting the beneficiary and their family rights.
f. Health and Wellness - The Direct Support Professional plays a vital role in helping the beneficiary to achieve and maintain good physical and emotional health essential to their well-being.
g. Community Inclusion and Networking - The Direct Support Professional helps the beneficiary to be a part of the community through valued roles and relationships and assists the beneficiary with major transitions that occur in community life.
h. Cultural Competency - The Direct Support Professional respects cultural differences and provides services and support that fit with the beneficiary's preferences.
i. Education, Training and Self-Development - The Direct Support Professional obtains and maintains necessary certifications and seeks opportunities to

improve their skills and work practices through further education and training.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

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) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s). Federally recognized tribal and Indian Health Services (IHS)providers may be exempt to one or more of these items in accordance with Federal law and regulations.

8.0 Policy Implementation and History

Original Effective Date
History:

Date	Section or Subsection Amended	Change
10/15/2023	All Sections and Attachment(s)	8H-5 Community Living and Supports is a new policy under the 1915(i) waiver

Attachment A: Claims-Related Information

Provider(s) shall comply with the *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid. Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

A. Claim Type
Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

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.

HCPCS Code(s)
T2012 Community Living and Supports only in the community non-EVV
T2013 Community Living and Supports

D. Modifiers
Provider(s) shall follow applicable modifier(s)

HCPCS Code(s)
T2012 U4- Community Living and Supports (only in the community, non-EVV)
T2013 TF HQ U4- Community Living and Supports Group (subject to EVV)
T2012 GC U4- Community Living and Supports relative as provider lives in home (non-EVV)
T2013 TF U4- Community Living and Supports Individual (subject to EVV)

E. Billing Units
Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Provider will follow the PIHP billing guidelines for Community Living and Supports. Federally recognized Tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service

The beneficiary's primary private residence or in the community.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov//