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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:
8P- North Carolina Innovations

1.0 Description of the Procedure, Product, or Service

Community Transition provides one-time funding for initial set up expenses to a beneficiary transitioning from an institutional or other approved setting into their own private residence in the community where they are responsible for their own living expenses. An institutional or other approved setting can include a state developmental center, community intermediate care facility (ICF-IID), nursing facility, licensed group home, alternative family living (AFL) facility, foster home, adult care home (ACH) ~~including those determined to be an Institution for Mental Disease)~~, State Operated Healthcare Facility, or a Psychiatric Residential Treatment Facility (PRTF). Community Transition can support a beneficiary being diverted from entry into ACHs or any institutional level of care due to preadmission, screening, and diversion efforts, provided that the beneficiary is moving to a living arrangement where the beneficiary is directly responsible for their own living expenses.

a. Community Transition can be provided to a beneficiary with any one of the following:
   1. an intellectual or developmental disability (I/DD);
   2. a Traumatic Brain Injury (TBI);
   3. a Serious Mental Illness (SMI);
   4. a Severe and Persistent Mental Illness (SPMI); or
   5. a severe Substance Use Disorder (SUD).

b. Covered Community Transition items and services are:
   1. Security deposits that are required to obtain a lease on an apartment or a home;
   2. Essential furnishings, which can include furniture, window coverings, food preparation items, bed, bath and linens;
   3. Moving expenses required to occupy and use a community domicile;
   4. Set-up fees or deposits for utility or service access, including telephone, internet, electricity, heating, and water; and
   5. Services necessary for the beneficiary's health and safety, such as one-time pest eradication and one-time cleaning prior to occupancy.

1.1 Definitions

1.1.1 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.

1.1.2 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 manifests before 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.

1.1.3 Severe and Persistent Mental Illness (SPMI)

As defined in NC General Statute 122C-3. Definitions (33a). Refer to GS_122C-3.pdf (ncleg.gov)

1.1.4 Serious Mental Illness (SMI)

As defined by the Substance Abuse Mental Health Services Administration (SAMHSA), "SMI is defined by someone over 18 years of age having within the past year a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC 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.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider can file for reimbursement with Medicaid for these services.

Medicaid shall cover Community Transition services for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

b. NCHC

NCHC beneficiaries are not eligible for Community Transition.

2.2 Special Provision

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://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 and NCHC 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 both Medicaid and NCHC

None Apply

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover Community Transitions when a beneficiary is 18 years of age or older and ALL following criteria are met:

a. Has a primary diagnosis of an I/DD, TBI, SMI, or SPMI as defined in **Section 1.1**, or has a primary diagnosis of severe SUD as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material; and
b. is transitioning from an institutional or other approved setting to a living arrangement where the beneficiary is directly responsible for their own living expenses in a private home or apartment with a lease in the beneficiary's name, legal guardian or representative's name or a home owned by the beneficiary.

3.2.3 NCHC Additional Criteria Covered

None Apply

3.2.4 Admission Criteria

A standardized independent evaluation completed by a Tailored Plan (TP) or Prepaid Inpatient Health Plan (PIHP) to determine beneficiary eligibility for 1915(i) benefit based on the needs-based criteria; and

A functional needs assessment, as identified by the Division of Health Benefits (DHB) as required for 1915(i) option services, completed by a care management agency that indicates the beneficiary would benefit from Community Transition.

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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 and NCHC 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 both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover all of the following:

a. monthly rental or mortgage expenses;
b. repairs to a property;
c. regular or recurring utility bills or fees associated with lawn care, property facilities, homeowners' associations;
d. regular or recurring pest eradication;
e. household appliances (exception a microwave);
f. recreational items such as televisions, gaming systems, cell phones, compact disc (CD) or digital videodisc (DVD) players and components;
g. food or groceries;
h. care management services or activities; and
i. service and maintenance contracts and extended warranties.

4.2.3 NCHC Additional Criteria Not Covered

a. None Apply.
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
    1. No services for long-term care.
    2. No nonemergency medical transportation.
    3. No EPSDT.
    4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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 Transition. The provider shall obtain prior approval before rendering Community Transition.

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

None Apply

5.3 Additional Limitations or Requirements

Community Transition must be furnished only to the extent that the beneficiary is unable to meet such expense, or when the support cannot be obtained from other sources or services. The following limitations or requirements apply:

a. If a beneficiary lives with a roommate, Community Transition services cannot duplicate items that are currently available.
b. Community Transition may not be provided to beneficiaries on the Innovations Waiver.
c. Community Transition services may not be provided by family members.
d. Community Transition expenses cannot exceed $5,000.
e. Service is available up to three (3) months in advance of a beneficiary's move to an integrated living arrangement, and up to 90 consecutive days post move in date.
f. Service is only provided to a beneficiary once per five (5) year period.
g. Community Transition may not be provided to a beneficiary residing in an Institution for Mental Disease (IMD) regardless of the facility type.

5.4 Documentation Requirements

The Community Transition Checklist, found in **Attachment B**, must be completed to document the items requested under this policy. The Community Transition Checklist is submitted to the PIHP or TP by the agency that is providing the services.

Receipts of purchases, deposits, or other fees paid using Community Transition must be maintained in the beneficiary record.

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 NCHC 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

a. Specialized Vendor Suppliers must meet applicable regulations for the type of service that the provider or supplier is providing as approved by the PHP.
b. Agencies that provide Care Management services shall meet applicable regulations and NC G.S. 122C, as applicable.
c. Commercial or retail businesses shall meet applicable regulations for the type of service that the supplier is providing.

6.2 Provider Certifications

None Apply.

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 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: April 1, 2023

History:

Date	Section or Subsection Amended	Change
April 1, 2023	All Sections and Attachment(s)	New policy.

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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 and NCHC. 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)
T2038

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

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 Transition services. Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service

Not Applicable

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

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

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Attachment B: Community Transitions Checklist

Name:
Date of Birth:
Medicaid ID:
Community Transition Agency:
Date of completion:

$	MOVING EXPENSES	$	SMALL APPLIANCES
	Lease deposit (cannot equal more than 2 months rent)		Clock, alarm clock, clock radio
	Telephone or internet deposit (no equipment)		Lamps
	Electric deposit		Vacuum cleaner
	Water deposit		Can opener
	Moving van rental expenses		Toaster, toaster oven
$	**KITCHEN SUPPLIES**		Microwave
	Dishes, plates, bowls, glasses, mugs		Coffee maker, tea pot
	Utensils – eating and cooking	$	**LIST ADDITIONAL ITEMS:**
	Kitchen towels, dishcloths, scrubbers, potholders		Apartment Application Fees
	Dish drainer		Iron, ironing board
	Pots, pans, skillet, sauce pan, baking sheet		
	Plastic storage containers		
	Ice cube trays		
	Cutlery, cutting board		
	Trash cans		
	Table and chairs		
$	**LIVING ROOM FURNITURE**		
	Couch, sofa		
	Table		
	Lamps		**EXCLUSIONS**
$	**BEDROOM FURNITURE & LINENS**	Ø	Washer, dryer
	Mattress, box, foundation, frame	Ø	Refrigerator, freezer
	Dresser, chest	Ø	Dishwasher
	Nightstand	Ø	Radio, stereo
	Sheets, blanket, pillows	Ø	Rent, mortgage
$	**BATHROOM SUPPLIES**	Ø	Recurring cable, internet
	Bath towels, washcloths, mat	Ø	TV, VCR, DVD player, or similar recreation items
	Plunger, toilet brush	Ø	Telephone equipment

	Trash can	**Ø**	Computer
$	**CLEANING SUPPLIES**	**Ø**	Exercise equipment
	Mop, bucket, broom, dust pan	**Ø**	Stove

*This is not an exhaustive list. Providers shall obtain prior approval for expenses and items from the Tailored Plan prior to purchasing to ensure all items are eligible for reimbursement.