2024-2025 Innovation Waiver Services Benefit Plan

General Innovations Waiver Information

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Service Code(s):	***Services Included (Sorted by Alphabetical Order):***
T2029	Assistive Technology Equipment and Supplies (ATES)
T2012, T2012GC, T2012GCHQ, T2012HQ, T2013TF, T2013TFGT, T2013TFHQ, T2013TFHQGT	Community Living and Support (CLS)
T2041, T2041GT, T2041U1	Community Navigator
H2015, H2015GT, H2015HQ, H2015HQGT, H2015U1, H2015U2	Community Networking
T2038	Community Transition
H2011U1, T2025U3, T2034	Crisis Services
T2021, T2021GT, T2021HQ, T2021HQGT, T2027	Day Supports

Codes / modifier combinations not mentioned for specialized services will be found within contracts.
For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.
When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.

T2025U1, T2025U2	Financial Support Services & Employer Supplies
S5170	Home Delivered Prepared Meals
S5165	Home Modifications
T1999	Individual Goods and Services
S5110, S5110GT, S5111, S5111GT	Natural Supports Education
H2016, H2016CG, H2016CGGT, H2016GT, T2014, T2014CG, T2014CGGT, T2014GT, T2020, T2020CG, T2020CGGT, T2020GT, H2016HI, H2016HICG	Residential Supports
S5150, S5150HQ, S5150US, T1005TE, 1005TD	Respite
T2025, T2025GT, T2025HO, T2025HOGT, T2025HT, 2025HTGT	Specialized Consultation Services
H2025, H2025 GT, H2025 HQ, H2025 HQ GT, H2025 TS, H2025 TS GT	Supported Employment Services
T2033, T2033GT, T2033HI, T2033HIGT, T2033TF, T2033TFGT, T2033U1, T2033U1GT, T2033U2, T2033U2GT	Supported Living
T2039	Vehicle Modifications

General Innovations Overview

The North Carolina Innovations Waiver Services (NC Innovations) is a resource for funding services and supports for a Medicaid member with intellectual and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (Please refer to Clinical Coverage Policy 8E for requirements for ICF-IID level of care). NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(c) of the Social Security Act. It operates concurrently with a 1915 (b) Waiver, the North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan (NC MH/DD/SAS Health Plan). CMS approves the services provided under NC Innovations, the number of members that may participate each year, and other aspects of the program.

Definitions

- *Agency With Choice:* An Individual or Family Directed Service Model that is made available to a waiver member who chooses to direct some or all of his or her services. Also known as the "co-employment option," an arrangement wherein an organization (a co- employment agency) assumes responsibility for:
  - employing and paying a worker who have been selected by the waiver member to provide services to the waiver member;
  - reimbursing allowable services;
  - withholding, filing, and paying Federal, state and local income and employment taxes; and
  - providing other supports to the member. Under this model, the member acts as the "Managing Employer" and is responsible for hiring, managing, and possibly dismissing the worker.

  Under this model, the co-employment agency is considered the common law employer of the worker who the waiver member recommends for hire.
- *Annual Plan:* defined as a 12-month period for the Annual Plan/Individual Support Plan year that runs from the first day of the month following the birth month to the last day of the month of the birth month.
- *Care Coordinator:* The role of care coordinator is an individual who provides Treatment Planning Case Management services in the NC Innovations Waiver.
- *Division of Health Care Regulation (DHSR):* This is the agency that licenses home care agencies, certifies home health agencies, and performs a variety of licensure, service monitoring, and health planning activities.
- *Early and Periodic Screening Diagnosis and Treatment (EPSDT):* Medicaid's comprehensive child health program for individuals under the age of 21. *No NC Innovations services are eligible to be provided through EPSDT.*
- *Employer or Record:* In the Individual and Family Directed Model, the Employer of Record is the adult member; the parent of the minor member or the guardian of the member. The Employer of Record may not be an LLC. The Employer of Record may not provide paid supports to the member.
- *Free Choice of Providers:* the right of a Medicaid member to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (a) qualified to furnish the services; and (b) willing to furnish them to the member [as specified in §1902(a)(23) of the Act and 42 CFR§431.51].
- *Home and Community-Based Services (HCBS):* services not otherwise furnished under the State's Medicaid Plan that are furnished under a waiver granted by CMS under Section 1915(c) of the Social Security Act and provide opportunities for Medicaid members to live, work and play in their own home or community in the same fashion as those without services.
- *Home:* a primary private residence.

- *Individual and Family Direction*: also referred to as Participant Direction or Individual and Family Directed Services (IFDS), a waiver member's opportunity to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.
- *Institution:* a hospital, nursing facility or ICF- IID for which the state makes Medicaid payment under the State plan.
- *Intermediate Care Facility for Individual with Intellectual and Developmental Disabilities (ICF-IID):* a public or private facility that provides health and habilitation services to individuals with Intellectual and Developmental Disabilities or related conditions.
- *Level of Care (LOC):* the specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State plan.
- *Medically Necessary (MN):* Are services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.
- *Person-Centered-Planning:* the process for planning and supporting the member receiving services that builds upon the member's capacity to engage in activities that promote community life and that honor the member's preferences, choices and abilities. The person-centered planning process involves the family, friends and professionals as the member desires or requires. The resulting treatment document is the Person-Centered Plan or the Individual Support Plan (ISP).
- *Qualified Professional:* any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Use Services in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors (NC General Statute 122C-3).
- *Relatives:* individuals related by blood or marriage to the waiver member. A waiver member under the age of 18 may not receive services provided by a relative who resides in their home. Note: There is a Community Living & Support exception. Family members living under the same roof as the individual may provide CLS services with objective, written documentation as to why there are no other providers available to provide the services. Family members who provide CLS services in this situation must meet the same standards as providers who are unrelated to the individual. This exception does not apply to parents of minor children who are also the Employer of Record (EOR).
- *Care Management Comprehensive Assessment:* This assessment assists the member and the ISP team in identifying significant risks to the member's health, safety, financial security, and the safety of others around them.
- *Waiver Year:* the 12-month period that CMS uses to authorize, monitor, and control waiver programs and expenditures. The waiver year begins on the effective date of the waiver approval and includes the 12 months following that date.

Eligibility Requirements

- Provider(s) shall verify each Medicaid member's eligibility each time a service is rendered.
- The provision of NC Innovations waiver services using telehealth may only occur when it is clinically indicated for the member and the member needs only verbal cueing or prompting to complete tasks.
- Medicaid shall cover NC Innovations services for a Medicaid member with intellectual or developmental disabilities, or both, who meets all the following criteria:
    - Requirements for ICF-IID level of care;

- Resides in an ICF-IID facility or is at high risk of being placed in an ICF-IID facility;
- Able to maintain his or her health, safety, and well-being in the community with NC Innovations services;
- Requires NC Innovations services as identified through a person-centered planning process. The member shall require at least one waiver service provided monthly as identified in the person-centered planning process and indicated in the Individualized Support Plan (ISP) and Individualized Budget; and
- Lives alone or with his or her family or legal guardian, the member desires NC Innovations participation rather than institutional services.

- Medicaid does not cover procedures, products, and services that duplicates another provider's procedure, product, or service.

Terms of Service

- If the member is hospitalized, placed in an ICF-IID facility, admitted to a state psychiatric facility, becomes an inmate in a public correctional institution or will be absent for 30 calendar days or more, the Care Coordinator should notify DSS as soon as they are aware of an absence of 30 days or more.

Hospitalizations

- NC Innovations services, supplies, and equipment cannot be provided or billed to Medicaid during hospitalizations. No NC Innovations Services may be billed to Medicaid for a member who is hospitalized. The Care Coordinator notifies DSS of the admission and the service providers of the suspension and the projected resumption date.
- Care Coordination may be provided for the purposes of discharge planning as long as activities do not occur that duplicate the services provided by hospital staff.
- For members hospitalized for over 30 calendar days, DSS Medicaid staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed, removing the member from NC Innovations funding. Once the DSS staff determines the effective date of the termination, the Care Coordinator follows the termination procedures.
- If the person later wishes to be re-enrolled to NC Innovations, Trillium and the Care Coordinator considers the person a new member. A member re-enrolled to NC Innovations within the same Waiver year re-enters the slot that he or she left.

Admission to ICF-IID or Other Institution, or Level of Care Changes

- When a NC Innovations funded member is admitted to an ICF-IID facility, nursing facility, or psychiatric institutional setting other than a hospital, the member must be terminated from NC Innovations on the date of institutionalization.
- If the member's level of care is changed to Intermediate, Skilled, or Hospital Level of Care on a Level of Care Form (or on an FL-2), the Care Coordinator terminates the member on the date of admission or date of change of Level of Care.
- If the member wishes to resume NC Innovations participation upon discharge, the PIHP considers the person a new member.
- The provision of Institutional Respite (at a private or State facility) does not constitute admission to an ICF-IID facility.

Temporary Absence from Area

- When a member temporarily leaves the area, the delivery of services is suspended.

- If the absence is 30 calendar days or more, the Care Coordinator notifies the DSS staff. The DSS staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed. Once the Medicaid staff determines the effective date of the termination, the Care Coordinator follows the termination procedures.

Service Breaks
- When an interruption occurs, the service may be rescheduled, depending on the nature of the service missed.
- This exception to providing services as approved on the plan may not be used if the member missed services while he or she was ineligible for Medicaid or NC Innovations. Services missed during periods of ineligibility may not be rescheduled.
- Service breaks do not require Back-Up Staffing Reporting to the PIHP.
- If the termination of NC Innovations is due to the member moving out of the state, the termination is usually the last day of the month.

Failure to Use Services
- The Innovations waiver requires that a service be used at least monthly, excluding: Assistive Technology, Vehicle Modification, Home Modifications, Community Transition, and Respite.
- If a member does not use an Innovations waiver service for a period of 30 calendar days:
  - Trillium must send a written notice to the member that failure to use services for a period of 30 calendar days may result in a termination from the waiver.
  - Trillium must attempt to engage the member in services.
  - After a second 30-day period, the PIHP shall contact NC Medicaid to discuss termination of the member from the waiver. The member must be notified of termination in writing and due process must be followed.
- The exception to monthly service use requirements is if the member is under the age of 21 with a diagnosis of Autism Spectrum Disorder (ASD) and is actively engaged in a research-based intervention for the treatment of ASD.

Terminations
- Termination may be due to a variety of reasons, including ineligibility for Medicaid, moving outside the catchment area, institutionalization, or failure to qualify for program participation. Depending on the reason for termination, it may be initiated by the county DSS, Trillium, or the member or legal guardian.
- All terminations must be coordinated with DSS.
- Written notifications of terminations must be sent trackable to the member or legal guardian, Trillium, and DSS.

Limits on Sets of Services
- An Adult member (age 22 and over) who receives residential supports: no more than 40 hours per week is authorized for any combination of community networking, day supports and supported employment services.
- A Child member (through age 21) who receives residential supports: during the school year, no more than 20 hours per week is authorized for any combination of community networking, day supports and supported employment services. When school is not in session, up to 40 hours per week

may be authorized. If the member is age 18 or older and has graduated (graduation with a degree or occupational course of study or GED indicating a standard course of study) then the member may access the adult level of limits on sets of services.

- An Adult member who lives in private homes: No more than 84 hours per week is authorized for any combination of community networking, day supports, supported employment, and/or Community Living and Supports.
- A Child member who lives in private homes: During the school year, no more than 54 hours per week is authorized for any combination of community networking, day supports, supported employment, Community Living and Supports. When school is not in session, up to 84 hours per week may be authorized. If a member is age 18 or older and has graduated (graduation with a degree or occupational course of study or GED indicating a standard course of study) then the member may access the adult level of limits on sets of services.
- Adult and child members who live in private homes with intensive support needs: These members may receive additional hours of Community Living and Supports to allow for 24 hours per day of support with the prior approval of the PIHP.

General Limitations on Coverage

- Trillium cannot approve services in excess of limitations outlined in any service definition or in the limits on sets of services.
- A member may receive funding from only one HCBS Waiver at a time. Currently, the other HCBS Waivers in North Carolina are CAP-C, CAP-DA, and the TBI Waiver.
- There is a $184,000 cost limit within the waiver. An individual may exceed the $184,000 waiver limit, to ensure health, safety and wellbeing, if the following criteria is met. The member:
  - lives independently without his or her family in a home that s/he owns, rents or leases
  - requires 24 hour support
- A waiver member under the age of 18 may not receive services provided by a relative who resides in their home.
- A relative or legal guardian will not be reimbursed for any activity that would be provided to a person without a disability of the same age.
- Waiver services to be delivered out-of-state are subject to the same requirements as services delivered out-of-state under the Medicaid State Plan. For a member living in a county bordering another state, the member may receive services from an enrolled NC Innovations Provider Agency located within 40 miles of the border of the county.

Supports Intensity Scale (SIS) Assessment in NC Innovations

- The SIS is an internationally recognized validated assessment tool published by American Association on Intellectual and Developmental Disability (AAIDD) that measures the level of supports for individuals with disabilities to lead typical, independent, quality lives in their home community. The SIS is designed to be used for both adults and children.
- A member new to the NC Innovations waiver receives a SIS prior to their initial NC Innovations waiver plan.
- A routine assessment occurs every two years for members aged 5-15 years of age and every three years for members 16 years of age and older.
- A new assessment does not occur when a member transfers to a new Managed Care Organization (MCO) service area. A copy of the SIS is transferred to the new MCO per established procedures.
- A request for a re-assessment may occur when the member experiences a major life change. This means a change in the health or safety of a member that merits examination of the types of supports that the member may need. This may occur prior to the regularly scheduled re-assessment date.

- Addendums to the SIS may occur if one or more of the ratings on the SIS do not accurately capture the individual's supports needs.

Individual Budgets

- The Individual Budgeting Tool is a guideline to assist in developing the plan of care. It is not a binding limit on the amount of services that can be requested or approved. Services should be requested and approved if they are medically necessary regardless of the amount of the individual budget.
- No currently authorized services will be reduced as a result of the budget change.
- The Individual Budget includes only Base Budget Services. Non- Base Budget services are not included.
  - Base Budget services are the core habilitation and support services in the waiver. Base Budget Services are:
    - Community Networking Services
    - Day Supports
    - Community Living and Supports
    - Respite
    - Supported Employment
  - Non-Base Budget services are preventative services, and equipment. Non-Base Budget, are:
    - Assistive Technology Equipment and Supplies
    - Community Navigator Services
    - Community Transition Services
    - Crisis Services
    - Financial Support Services
    - Home Modifications
    - Individual Goods and Services
    - Natural Supports Education
    - Specialized Consultation Services
    - Vehicle Modifications
    - Residential Supports
    - Supported Living
- The four categories that make up the Individual Budget Tool (IBT) are:
  - Non-Residential Child (under age 22 and living in a private home)
  - Residential / Supported Living (per diem) Child [under 22 years old and living in a group home, an Alternative Family Living ("AFL") setting or a Supported Living setting]
  - Non-Residential Adult (age 22 and older and living in a private home)
  - Residential / Supported Living (per diem) Adult (age 22 and older and living in a group home, an AFL, or Supported Living Setting).
- Each category has seven levels, which are clinical descriptions representative of groupings of individuals who have similar support needs. The seven levels are A, B, C, D, E, F, and G.

Plan of Care (Individual Support Plan)

- All NC Innovations service members shall have an approved plan at least annually to continue participation in the waiver.
- Person-centered planning is about supporting a member to realize their own vision for their lives. It is a process of building an effective and collaborative partnership with the member and working in partnership with him or her to create a road map for reaching the member's goals.
- The ISP is developed through a person-centered planning process led by the Care Coordinator with participation from member and legally responsible person for the member to the extent they desire. In addition to the member, parents, legal guardians, and Care Coordinator, planning team members may be support providers, family friends, acquaintances and other community members.

- The Care Coordinator offers the member and legally responsible person, if applicable, information about Individual Family Supports, a model for self-directing services in preparation for the ISP. If the member and legally responsible person is interested in learning more about Individual Family support, the Care Coordinator arranges for them to receive additional training and information from a Community Navigator.
- A variety of person-centered toolkits [such as Essential Lifestyles Planning (ELP), Making Action Plans (MAPS), Charting the LifeCourse, Supported Decision Making, Personal Futures Planning] are available to gather information and enable the member to share information with the ISP team.
- During the planning meeting decisions are made regarding team members' responsibilities for service implementation and monitoring. While the Care Coordinator is responsible for overall monitoring of the ISP and the member's situation, other team members, the member and community support, may be assigned monitoring responsibilities.
- The ISP is updated annually; however, if the member's provider changes or needs change and requires services to be added, increased, decreased, or terminated, a revision to the plan is completed and submitted to Trillium Utilization Management for approval.
- The Care Coordinator reassesses each member's needs at least annually and develops an updated ISP based on that reassessment.
- The ISP planning team regularly review the paid service provision of relatives and guardians when they live in the home of the waiver member to ensure that:
  - the member has requested this staffing choice,
  - there are no barriers to full community membership and relationship building with non-family members,
  - the staff qualifications needed, and the unique training needs of the member are met; and
  - the role of relative and legal guardian clearly encourages autonomy and skill building for independence in the community.

Crisis Prevention Plan

- A Crisis Prevention Plan is incorporated within the ISP. The Crisis Prevention Plan contains supports and interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive).
- The Crisis Prevention Plan documents:
  - What positive skills the member has which can be used and increased at times of crisis;
  - How to implement redirection of energies towards exercising these skills that can prevent crisis escalation; and
  - How to implement positive behavioral supports that may be relied upon as a crisis response.
  - Planning for Natural Disasters.
  - Planning for when the primary caregiver is no longer able to support the member in the same capacity.
  - Coping strategies that the member has practiced while calm and may be helpful during a crisis.
  - Any other relevant Crisis Related information important for the Treatment Team to be aware of.

Initial ISP

- Once the level of care determination is complete, the individual support plan must be completed within 60 calendar days.
- The Care Coordinator must send the completed ISP and all required documentation so that it is received by Trillium no later than 60 calendar days after the Level of care approval date (the date that it was approved by Trillium).
  - If the ISP is not received within the time limit, a new Level of Care Eligibility Determination Form must be completed and the approval process reinitiated.

- Services shall be implemented within 45 calendar days of initial ISP approval.

Annual ISP
- Annual updates are due during the birth date month of the member.
- The effective date of the annual update is always the first of the month following the birth month.
- Individual Support Plans do not extend beyond 365 calendar days.
- If an ISP is not submitted with an authorized signature (member or legal guardian) by the expiration of the member's current ISP, the member becomes ineligible for continued NC Innovations services.
  - Trillium terminates the member from NC Innovations and issues appeal rights to the member or legal guardian.
  - DSS is notified and may terminate the member from Medicaid if the individual's Medicaid eligibility is contingent upon NC Innovations waiver participation.
  - If the member wishes to re-enter the waiver in the same waiver year, the procedures for a new waiver member's entry into NC Innovations are followed, including obtaining a new level of care.

ISP Revisions
- Revisions are made to the Individual Support Plan whenever the member's life circumstances change or at the member's request.
- The ISP is updated or revised by adding a new demographic page and/or using the update to ISP. When the update to the ISP involves a change in the budget, the individual budget page is also updated. Updates or revisions consist of adding an outcome, addressing needs related to the back-up staffing plan and adding new information when the member's needs change.
- This consists of any change in the amount, duration or frequency of a service.
  - A temporary, one-time change in approved service does not require a plan revision.
  - A revision is not needed if the member goes on vacation. The member's planning team may use common sense and discretion in applying this exception, and an explanation of the change must be documented in the member's record.
- Revisions are also made to the Individual Support Plan (and budget form) when the cost of a service changes.
- Changes in short-term goals and intervention strategies do not require an ISP update or revision.

ISP Implementation
Service providers are responsible for:
- developing intervention strategies and monitoring progress at the service delivery level;
- ensuring that staff are appropriately qualified and trained to deliver the interventions necessary to support the accomplishment of goals; and
- for clinical supervision of staff.

The Care Coordinator:
- following the PIHP policy, assists the member and legally responsible person in choosing a qualified provider to implement each service in the ISP.
- provides them with a provider listing of each qualified provider within Trillium's provider network;
- encourages the individual/legally responsible person to select providers that they would like to meet to obtain further information;

- provides any additional information that may be helpful in assisting them to choose a provider;
- facilitates arranging provider interviews on behalf of the member, and
- documents the member's choice of provider in the service record, once selected.
- The Care Coordinator is responsible for monitoring the ISP, and reviews goals at a minimum frequency based on the target date assigned to each goal. Care Coordinator monitoring occurs monthly.

ISP Approval Requirements

- The initial ISP and Prior Authorization (PA) request(s) must include:
  - Contact information for the Care Coordinator
  - Authorized signature (member or other legally responsible person)
  - The Freedom of Choice Statement
  - Individual Budget
  - Initial Level of Care assessment and the supporting evaluations, as applicable
  - The Care Management Comprehensive Assessment
  - The Supports Intensity Scale (SIS) and additional assessments, as applicable
  - Behavior Support Plan, as applicable
  - Needed physician orders.

- The annual ISP and Prior Authorization (PA) request(s) must include:
  - Contact information for the Individual Support Plan
  - Freedom of Choice Statement
  - The annual reassessment of the Level of Care
  - Individual Budget
  - The Care Management Comprehensive Assessment
  - The Supports Intensity Scale (SIS) and additional assessments, as applicable
  - Behavior Support Plan, as applicable
  - Needed physician orders.
  - For Annual ISPs, Trillium completes the final determination for the continued authorization of Level of Care. If Trillium questions the need for continued ICF-IID level of care, the process for completing an initial Level of Care is followed and needs to be initiated.

- Revisions ISP and Prior Authorization (PA) request(s) must include:
  - Contact information for the Care Coordinator includes:
  - The completed, update page of the Individual Support Plan
  - The revised Individual Budget
  - Evaluations to support requested services, inclusive of physician orders (if needed)

Relative as Provider

- Community living and Support and Supported Living are the only waiver services that may be provided by a relative who resides in the home of the member.
- Community Living and Supports
  - Parents of minor children enrolled in the waiver may provide CLS services to their child who has been indicated as having extraordinary support needs. Parents of minor children receiving CLS may provide this service (up to 40 hours and not exceeding 56 hours) to their child. Note: This does not apply to parents of minor children who are also the Employer of Record (EOR).
  - CLS service providers may be a relative of an adult waiver member. Relatives as providers for adult waiver members may provide CLS service over 56 hours/week not exceeding 84 hours/week.
  - Family members living under the same roof as the waiver individual may provide CLS services. Objective written documentation is required as to why there are no other providers available to provide the services. Family members who provide these services must meet the same standards as providers who are unrelated to the individual.
- Supported Living services provided by a relative is allowed. The relative must complete background check and training prior to rendering services.
- Trillium ensures compliance with these conditions through a prior approval process.
- The ISP must contain documentation that the waiver member is in agreement with the employment of the relative and has been given the opportunity to fully consider all options for employment of non-related staff for waiver service provision.

Individual and Family Directed Services

- There are two options for Individual and Family Directed Services (IFDS) under the Innovations waiver:
  - Employer of Record
  - Agency With Choice
- All waiver members are offered the opportunity to direct one or more of the following services. The member may direct one or all of these services and may receive additional provider directed services that the member does not choose to self-direct:
  - Community Networking Services
  - Community Living and Supports
  - Individual Goods and Services (in conjunction with at least one other self-directed services)
  - Natural Supports Education
  - Respite Services
  - Supported Employment
  - Supported Living
- Of the services that the member chooses to self-direct; all hours of that service must be self-directed.
- In both models, agreements with Trillium, the Financial Supports Agency, Agency With Choice and employees outline responsibilities of all parties. Community Navigators assist the Employer of Record, or managing employer, with employer duties and responsibilities, as requested or needed. Members in either model of Individual and Family Directed Services have access to Individual Goods and Services when employees begin to provide at least one service to the member. Members in Employer of Record model have access to Employer Equipment and Supplies.
- Employers of Record and Managing Employers participating in the Individual Family Directed option may not be employed to provide waiver services.

- A member in Individual and Family Directed Services may withdraw from the option at any time by notifying the Care Coordinator. The Care Coordinator prepares a revision to the ISP, and submits the revision to Trillium, so that provider directed services are authorized for the member with no service lapse.
- Required Documentation:
  - The completed ISP is submitted to Trillium for approval. Emergency and back-up staffing plans are included.
  - An Individual or Family Directed Supports Assessment.
  - Representative Needs Assessment and Representative Designation or Agreement, as applicable.
  - Verification of Training for Managing Employer and Representative, if applicable.
  - Individual and Family Directed Supports Agreement
- A member in Individual and Family Directed Services may be removed from Individual and Family Directed Services involuntarily under any one of the following circumstances:
  - Immediate health and safety concern, including maltreatment of the member
  - Repeated unapproved expenditures/misuse of NC Innovations funds
  - No approved representative available when the Employer of Record managing employer in the Agency with Choice Option is determined to need one
  - Refusal to accept the necessary Community Navigator services
  - Refusal to allow Care Coordinator to monitor services
  - Refusal to participate in Trillium, state or federal monitoring
  - Non-compliance with individual and family supports, Financial Supports Agency, Agency with Choice and/or employee support agreements
  - Inability to implement the approved ISP or comply with NC Innovations requirements, despite reasonable efforts to provide additional technical assistance and support (for event requiring additional technical assistance/corrective action plan in twelve months).
  - Trillium may remove a member from Individual and Family Supports, after consultation with NC Medicaid, in instances when the member's health and safety are compromised, or after an employer or managing employer has made the same major mistake three different times in one year.
- Termination of the Member Directed Option will occur immediately in the following circumstances:
  - the individual's health and/or safety are compromised
  - misuse of Innovations Waiver funds
  - suspected fraud or abuse of funds
  - no approved representative when one is required
  - refusal to accept required Community Navigator services
  - refusal to allow Care Coordination monitoring
  - refusal to participate in PHIP, State, or federal monitoring
  - If it is determined at any point in an Trillium investigation that the person immediately needs to be returned to the provider directed option to ensure their health and safety, this can be recommended.

Claims

- A diagnosis of an Intellectual Disability or a related condition must be present to bill for Innovation services (42 CFR 435.1010). A related condition is defined as a severe, chronic disability that meets all of the following conditions:

- It is attributable to—
  - Cerebral palsy or epilepsy; or
  - Any other condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of person with intellectual disability, and requires treatment or services similar to those required for these persons.
- It is manifested before the person reaches age 22.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care.
  - Understanding and use of language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.

Out-of-State Travel

- Services are for a member who has been receiving services from direct-care staff while in-state and who is unable to travel without their assistance.
- A member who lives in an alternative family living (AFL) home or foster home may receive services when traveling with their alternative family living or foster family out-of-state under these guidelines.
- A member who resides in a residential setting is allowed to go out-of-state on vacation with their residential provider, and continue to receive services, if the member's cost of care does not increase.
- Written prior approval of the request for their staff to accompany a member out-of-state must be received from the supervisor of the staff person and Trillium.
- Waiver services may not be provided outside of the United States of America.
- Provider agencies shall ensure that the staffing needs of all their members can be met.
- Supervision of the direct-service employee and monitoring of care must continue.
- The ISP must not be changed to increase services while out-of-state. Services can only be reimbursed to the extent they would be had they been provided in-state, and only for the benefit of the member.
- Respite services are not provided during out-of-state travel since the caregiver is present during the trip.
- If licensed professionals are involved, Medicaid cannot waive any other state's licensure laws. A NC licensed professional may or may not be licensed to practice in another state. A licensed professional employed by Tribal Providers can be licensed in any U.S. State.
- Medicaid funds cannot be used to pay for room, board, or transportation costs of the member, family, or staff.
- Provider agencies, Employers of Record, and Agencies with Choice assume all liability for their staff when out-of-state.

General Benefit Plan Limits

- *Auth to a Different Provider:* The requested service cannot be authorized if another provider is currently authorized to provide the requested service, and two providers are not permitted to provide that service at the same time.
- *Backdated Request:* Service dates requested prior to the receipt of the authorization request cannot be authorized.
- *Contract Issue:* The requested service cannot be authorized if the provider is experiencing a contract related issue preventing the service from being approved.
- *Insurance Coverage Expired:* The requested service cannot be authorized if a member does not have active insurance coverage.
- *Missing Individual Support Plan (ISP)/Care Plan/Person Centered Plan (PCP) Information:* The requested service cannot be authorized if the ISP/ Care Plan/ PCP is missing any of the following: 1) The signature page, to include the check boxes not being complete, a missing signature, an undated signature, an electronic signature missing the date stamp, and/or if the signature is dated before the date of the ISP/ Care Plan/ PCP; 2) Is missing a goal for the service requested; 3) Is missing the units/frequency of service requested or if the units requested exceed the frequency detailed in the ISP/ Care Plan/ PCP, and/or; 4) Is missing the Comprehensive Crisis Prevention and Intervention Plan.
- *More than 30 Days in Advance:* The service cannot be authorized if requested more than 30 days in advance. A member's clinical picture can change over time, so medical necessity for a service cannot be established based on a clinical picture that is more than 30 days old.
- *No Documentation:* The requested service cannot be authorized because the request does not include the required documentation, as detailed in the applicable Clinical Coverage Policy, the service definition, or the Benefit Plan. If required, this can include: 1) A missing or invalid service order; 2) A missing ISP/ Care Plan/ PCP; 3) A missing discharge/ transition plan, and/or; 4) Missing information on an IDD member, like a missing SNAP or a missing psychological evaluation that supports the DD diagnosis.
- *No ISP/Care Plan/PCP Update:* The requested service reauthorization cannot be authorized if an updated or revised ISP/ Care Plan/ PCP to not submitted.
- *No New Annual ISP/ Care Plan/ PCP:* The requested service cannot be authorized if the ISP/ PCP annual rewrite has not been completed. This includes when an ISP/ Care Plan/ PCP is submitted that is more than a year old.
- *Out of Catchment:* Trillium is unable to authorize the requested service if a member's Medicaid county of residence is outside of Trillium catchment area.
- *Service Exclusion:* The requested service cannot be authorized if the member is currently authorized for a service that is an exclusion to the requested service.
- *Third Party Insurance:* The requested service cannot be authorized if the member has private insurance, and the provider should seek authorization from primary insurance source. Medicaid is the payor of last resort.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Assistive Technology Equipment and Supplies (ATES) Code(s): **T2029**: Assistive Technology Equipment and Supplies	Assistive Technology, Equipment and Supplies (ATES) are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of individuals. This service covers purchases, leasing, trial periods and shipping costs, and as necessary, repair/modification of equipment required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Cost of Monthly monitoring, connectivity, and internet charges may be covered when it is required for the functioning of the item and system.	**1.** TAR: Prior approval is required for each plan year. for each plan year. **2.** SIS **3.** Individual Budget: shipping costs must be itemized. Taxes are not coverable. **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures, e) a plan for training the individual, the natural support system, and paid caregivers on the use of the requested equipment and supplies, f) Long-range outcomes related to training needs associated with the member's or family's utilization and procurement of the requested equipment or adaptations. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Assessment or Written Recommendation: by an appropriate professional identifying: **a.** the equipment and supplies being requested in the amounts needed **b.** Must be less than one calendar year old from requested date. **7.** Certificate of Medical Necessity/Prescription: completed by the physician, PA, or NP. MN must be documented for every item requested. **8.** MN Letter: written & signed by an MD/ DO, PA, NP, or applicable professional for every item requested. This meets the prescription requirement when created by an MD/ DO, PA, or NP. **9.** When an assessment is completed by another professional recommending the MN of specific items, then an MD/ DO, PA, or NP must write a letter of MN OR sign off on the letter of MN prepared by professional AND write a prescription.	**For Assistive Technology Equipment** **1.** Training Plan: how the person and family will be trained on the use of the equipment **2.** Two quotes for the requested item(s) **For Supplies** **1.** Statement of Medical Necessity: completed by an appropriate professional, to include the amount and type of item(s) **2.** Supplies that continue to be needed at the time of the Annual Plan must be recommended by an annual re-assessment. The assessment or recommendation must be updated if the amount needs change. **3.** Two quotes for the requested item(s) **For Adaptive Car Seats** **1.** A documented chronic health condition or DD which requires the use of an adaptive car seat for positioning. **2.** The following information in the assessment must be included: **a.** Member's weight; **b.** Weight limits of the car seat currently used to transport; **c.** Measurements showing the member has a seat to crown height that is longer than the back height of the largest child car safety seat if the member weighs less than the upper weight limit of the current car seat; **d.** Reasons why the member cannot be safely transported in a car seat belt or convertible or booster seat for individual weighing 30 pounds and up; **e.** Two quotes for the requested item(s)	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

		10. The estimated life of the equipment and the length of time the member is expected to benefit from the equipment. **11.** Submission of applicable records that support the member has met the medical necessity criteria.		

Exclusions, Limitations & Exceptions

- Limited to expenditures of $50,000 (ATES and Home Modifications) over the life of the waiver (excluding nutritional supplements and monthly alert monitoring / connectivity system charges).
- Assistive Technology and Supplies can be requested when the item will belong to the individual.
- Excluded Items include:
  - Recreational items normally purchased by a family
  - Non-Adaptive Computer desks and other furniture items.
  - Service, maintenance contracts and extended warranties
  - Equipment or supplies purchased for exclusive use at the school/home school
  - Computer hardware solely to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any person other than the member.
  - Hot tubs, Jacuzzis, and pools.
  - Items utilized as restraints.
  - Items that are coverable under the Medicaid DME benefit should not be covered by NC Innovations ATES.
- Remote support technology may only be used with consent of the individual and guardian, indicated in the ISP (including preference for the location of any monitoring equipment)
- Service contracts and extended warranties may be covered for a one-year time frame.
- All items must meet applicable standards of manufacture, design, and installation.
- Car seats are not approved for behavioral restraint.
- See the CCP for all covered items and categories
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Community Living and Support (CLS) Code(s): **T2012**: Community Component of CLS, Non-EVV, Individual **T2012 GC**: Live-In Caregiver CLS, Non-EVV, Individual **T2012 GC HQ**: Live-In Caregiver CLS, Non-EVV, Group **T2012 HQ**: Community Component of CLS, Non-EVV, Group **T2013 TF**: In- Home Component of CLS, EVV, Individual **T2013 TF GT**: In- Home Component of CLS, EVV, Individual, Telehealth **T2013 TF HQ**: In- Home Component of CLS, EVV, Group **T2013 TF HQ GT**: In- Home Component of CLS, EVV, Group, Telehealth **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Community Living and Support is an individualized or group service that enables the waiver member to live successfully in their home and be an active member of their community. Community Living and Support enables the member to learn new skills, practice and/or improve existing skills. The intended outcome of the service is to increase or maintain the member's life skills or provide the supervision needed to empower the member to live in the home of their family or natural supports or in their private primary residency, maximize self-sufficiency, increase self- determination and enhance the opportunity to have full membership in the community.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures, e) if applicable, member agrees with the employment of the relative and has been given the opportunity to consider employment of non-related staff. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**Timeframes**: **1.** Requests up to 12 hours daily may be auth'd for the entire plan year. **2.** Requests up to 16 hours daily may be auth'd for 6 months within the plan year. **3.** Requests for more than 16 hours daily are auth'd for up to a 90-days within the plan year. **Units**: One unit = 15 minutes **Other**: **1.** For services provided in the home of a direct service employee, the Provider Agency, Employer of Record or Agency With Choice is required to complete the Health and Safety Checklist and Justification for Services form prior to the delivery of service in that home and every 6 months afterwards. The member or legally responsible person must sign this checklist.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The amount of Community Living and Supports is subject to the limitations on the sets of services.
- A member who receives Community Living and Supports may not receive Residential Supports or Supported Living at the same time.
- This service is not available at the same time of day as Community Networking, Day Supports, Supported Living, Supported Employment, Respite or one of the State Plan Medicaid Services that works directly with the person, such as Private Duty Nursing.
- Transportation to and from the school setting is not covered under the waiver and is the responsibility of the school system. (This service includes only transportation to/from the person's home or any community location where the person is receiving services.)
- Incidental housekeeping and meal preparation for other household members is not covered under the waiver. The paraprofessional is responsible for incidental housekeeping and meal preparation only for the member.

- Parents of minor children enrolled in the waiver may provide CLS services to their child who has been indicated as having extraordinary support needs. Parents of minor children receiving CLS may provide this service (up to 40 hours and not exceeding 56 hours) to their child. Note: This does not apply to parents of minor children who are also the Employer of Record (EOR).
- CLS service providers may be a relative of an adult waiver member. Relatives as providers for adult waiver members may provide CLS service over 56 hours/week not exceeding 84 hours/week.
- Family members living under the same roof as the waiver individual may provide CLS services. Objective written documentation is required as to why there are no other providers available to provide the services. Family members who provide these services must meet the same standards as providers who are unrelated to the individual.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Community Navigator Code(s): **T2041**: Community Navigator **T2041 GT**: Community Navigator (Telehealth) **T2041 U1**: Community Navigator (Training, Periodic) **T2041 U1 GT**: Community Navigator Training for Employer of Record (Training, Periodic, Telehealth) **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	The purpose of Community Navigator Services is to promote self-determination, support the member in making life choices, provide advocacy and identify opportunities to become a part of their community. Community Navigator provides support to the member and planning teams in developing social networks and connections within local communities. Community Navigator Services emphasizes, promotes, and coordinates the use of generic resources to address the members needs in addition to paid services. Community Navigator provides an annual informational session on Self-Determination and Self Direction. The member and legally responsible person may choose to opt out of this annual informational session.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**Units**: One unit = 1 month	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- Community Navigation services are used to support members self-directing waiver services; therefore, it is only available for individuals participating in self-direction. Community Navigation service is only available if the member is self-directing one or more of their services through the Agency with Choice or Employer of Record Model.
- Community Navigator is mandatory for all Employers of Record until competence in directing service is demonstrated.
- This service does not duplicate Care Coordination. Care coordination under managed care includes the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the member consistent with 42 CFR 438.208(c).
- The creation and the facilitation of the Individual Support Plan is the responsibility of the Care Coordinator. The Community Navigator can assist the member with preparing for the Individual Support Plan.
- If a provider does not provide Agency with Choice Services, the only other service that they may provide to the same member, in addition to Community Navigator Services, is Community Transition.
- An agency may provide both Community Navigator Services and Agency with Choice Services to the same individual, in addition to Community Transition, Financial Support Services, Individual Goods and Services, and Primary Crisis Response Services.
- The Community Navigator Self-Directed activities can only to be used to provide support to the individual under Individual and Family Directed Supports: Employer of Record and Agency with Choice Models, as approved in this Waiver.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Community Networking Code(s): **H2015**: Community Networking, Individual **H2015 GT**: Community Networking, Individual, Telehealth **H2015 HQ**: Community Networking, Group **H2015 HQ GT**: Community Networking, Group, Telehealth **H2015 U1**: Community Networking, Class or Conference **H2015 U2**: Community Networking, Transportation **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Community Networking services provide individualized day activities that support the member's definition of a meaningful day in an integrated community setting, with persons who are not disabled. If the member requires paid supports to participate / engage once connected with the activity, Community Networking can be used to refer and link the member. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings. Community Networking services enable the member to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community. As the member gains skills and increase community connections, service hours may fade.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**Units**: One unit = 15 minutes	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website
Exclusions, Limitations & Exceptions				

- Payment for attendance at classes and conferences cannot exceed $1,000/ per member plan year. The amount of community networking services is subject to the "Limits on Sets of Services."
- This service is provided separate and apart from the member's primary private residence, other residential living arrangement, and/or the home of a service provider. These services do not take place in licensed facilities and are intended to offer the member the opportunity to develop meaningful community relationships with non-disabled individuals.
- Service does not cover the cost of hotels, meals, materials or transportation while attending conferences.
- Service does not cover activities that would normally be a component of a member's home/residential life or services.
- Service does not pay day care fees or fees for other childcare related activities.
- The waiver member may not volunteer for the Community Networking service provider.
- Volunteering may not be done at locations that would not typically have volunteers (that is, hair salon or florist) or in positions that would be paid positions if performed by an individual that was not on the waiver.
- This service may not duplicate or be furnished/claimed at the same time of day as Day Supports, Community Living and Support, Residential Supports, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the member.

- For a member who is eligible for educational services under the Individuals With Disability Educational Act, Community Networking does not cover transportation to/from school settings. (Transportation to/from member's home or any community location where the member may be receiving services before/after school is covered for this service.)
- This service does not pay for overnight programs of any kind.
- Classes that offer one-to-one instruction are not covered.
- Classes that are in a nonintegrated community setting are not covered.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Community Transition Code(s): T2038	The purpose of Community Transition is to provide initial set-up expenses for adults to facilitate their transition from a Developmental Center (institution), community ICF-IID Group Home, nursing facility or another licensed living arrangement (group home, foster home, Psychiatric Residential Treatment Facility, alternative family living arrangement), a family home or one person AFL(Alternative Family Living) to a living arrangement where the individual is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the member's, legal guardian's, representative's name or a home owned by the member.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Community Transition Checklist **7.** Submission of applicable records that support the member has met the medical necessity criteria.	These services are available only during the three-month period that commences one calendar month in advance of the member's move to an integrated living arrangement.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The cost of Community Transition has a life of the waiver limit of $5,000.00 per member. Community Transition includes the actual cost of services and does not cover provider overhead charges.
- Community Transition does not cover monthly rental or mortgage expense; regular utility charges; and/or household appliances or diversional/recreational items such as televisions, streaming devices, VCR players and components and DVD players and components. Service and maintenance contracts and extended warranties are not covered.
- Community Transition services can be accessed only one time from either the 1915b or 1915c waiver over the life of the waiver.
- In situations when a member lives with a roommate, Community Transition cannot duplicate items that are currently available.
- Community Transition expenses are furnished only to the extent that the member is unable to meet such expense or when the support cannot be obtained from other sources.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Crisis Services Code(s): **H2011 U1**: Crisis Intervention and Stabilization Supports **T2025 U3**: Crisis Consultation **T2025 U3 GT**: Crisis Consultation (Telehealth) **T2034**: Crisis Services, Out-of-Home **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Crisis Supports provide intervention and stabilization for a member experiencing a crisis. Crisis Supports are for a member who experiences acute crises and who presents a threat to the member's health and safety or the health and safety of others. These behaviors may result in the member losing his or her home, job, or access to activities and community involvement. Crisis Supports promote prevention of crises as well as assistance in stabilizing the member when a behavioral crisis occurs. Crisis Supports are an immediate intervention available 24 hours per day, 7 days per week, to support the individual. Out-of-home crisis is a short-term service for an individual experiencing a crisis and requiring a period of structured support and/or programming. The service takes place in a licensed facility. Out of-home crisis may be used when an individual cannot be safely supported in the home, due to his/her behavior, and implementation of formal behavior interventions have failed to stabilize the behaviors, and all other approaches to ensure health and safety have failed. In addition, the service may be used as a planned respite stay for waiver members who have heightened behavioral needs. Crisis consultation is for individuals that have significant, intensive, or challenging behaviors or medical conditions that have resulted or have the potential to result in a crisis. Consultation is provided by staff that meets the minimum staffing requirements of a Qualified Professional and who have crisis experience.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** Following service auth, any needed modifications to the ISP and individual budget will occur within five working days of the date of verbal service authorization. **2.** Out-of-Home Crisis services are authorized in increments of up to 30 calendar days. **3.** Crisis Intervention & Stabilization Supports may be authorized for periods of up to 14 calendar day increments per event.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions
• This service may not duplicate services provided under Specialized Consultation Services. • Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply. • See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Day Supports Code(s): **T2021**: Day Supports **T2021 GT**: Day Supports (Telehealth) **T2021 HQ**: Day Supports, Group **T2021 HQ GT**: Day Supports, Group (Telehealth) **T2027**: Day Supports, Developmental Day **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Day Supports is a group, facility-based service that helps the member with acquisition, retention, or improvement in socialization and daily living skills and is one option for a meaningful day. Day Supports emphasizes inclusion and independence with a focus on enabling the individual to attain or maintain his/her maximum self-sufficiency, increase self-determination and enhance the person's opportunity to have a meaningful day.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** Day Supports is billed in 1-hour unit increments.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The amount of Day Supports is subject to the Limits on Sets of services.
- For individuals who are eligible for educational services under the Individuals with Disability Educational Act, Day Supports is the payer of last resort for Developmental Day.
- Day Supports are furnished in a non-residential setting, separate from the home or residential setting where the member resides.
- Transportation to/from the member's home, the day supports facility and travel within the community is included in the payment rate. Transportation to and from the licensed day program is the responsibility of the Day Supports provider.
- This service may not duplicate services, nor can they be furnished or billed at the same time of day as services, provided under Community Networking, In-Home Intensive Supports, Community Living and Supports, Supported Living, Residential Supports, Supported Employment and/or one of the State Plan Medicaid Services that works directly with the member.
- Waiver funding is not available for vocational services delivered in facility based, sheltered work settings, or Adult Developmental Vocational Program.
- Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources.
- Each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected.
- Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices.
- Settings facilitate individual choice regarding services and support, and who provides these.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Financial Support Services & Employer Supplies Code(s): **T2025 U1**: Financial Support Services **T2025 U2**: Financial Support, Employer Supplies	Financial Support Services (FSS) is an umbrella service for the continuum of supports offered to NC Innovations individuals who elect the Individual and Family Directed Services Option, Employer of Record Model. Financial Support Services are provided to ensure that funds for self-directed services are managed and distributed as intended. The service also facilitates the employment of support staff by the Employer. A member who chooses to self-direct via the Employer of Record model may require equipment necessary to carry out duties of Employer of Record and may access this service.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	N/A	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- Items not coverable by Employer Supplies (this is not an all-inclusive list): a) Wireless keyboards; b) Mouse (unless the EOR is purchasing a desktop and the desktop does not include a mouse); c) Computer Protective Cases (outside of one laptop bag for EORs who utilize a laptop); d) Additional Computer Screens (a desktop computer should include one monitor); e) IT help desk service for support to operate the equipment; f) Office/Desk Chair.
- The provider of financial support services may only additionally provide Community Navigator services. The financial support service may bill for the following services: community transition services, and individual goods and services under the NC Innovations waiver.
- The financial supports agency may be an Agency with Choice and provide Community Navigator. They may bill for community transition and individual goods and services to the same member. Community Transition Services and Individual Goods and Services are not directly provided by the FMS.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Home Delivered Prepared Meals Code(s): S5170	Up to seven home delivered meals per week.	Prior approval is not required. Service should be included on the ISP, to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements.	N/A	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website NC Medicaid Guidance on Sunsetting of Innovations Waiver Appendix K Flexibilities

Exclusions, Limitations & Exceptions

- Up to seven meals per week/one per day
- Not available to individuals receiving a per diem residential service.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Home Modifications Code(s): S5165	Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the member or to enhance the individual's level of independence. Home Modifications are intended to increase the member's ability to access his/her environment and are of direct or remedial benefit to the member or in some way related to the member's disability. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.	**1.** TAR: Prior approval is required **2.** SIS **3.** Individual Budget: to include itemized shipping costs **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) Long-range outcomes related to training needs associated with the adaptations, e required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Letter of MN or Written Assessment/ Recommendation: by an MD/ DO, PA, NP, or appropriate professional, outlining MN for every item provided. If the MD/ DO, PA, or NP complete the Letter, as separate prescription is not required. **7.** Certificate of MN/Prescription: completed and signed by an MD/ DO, PA, or NP. MN must be documented for every item requested. **8.** Training Plan: how the person and family will be trained on the use of the equipment **9.** Two quotes for the requested item(s) **10.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** A private residence is a home owned by the individual or his/her family (natural, adoptive, or foster family). **2.** All Home Mods requiring a building permit must meet county code to pass inspection. **3.** All services must be provided in accordance with applicable State or local building codes and other regulations. **4.** All items must meet applicable standards of manufacture, design, and installation. **5.** When an assessment is completed by another professional recommending the MN of specific items, then an MD/ DO, PA, or NP must write a letter of MN OR sign off on the letter of MN prepared by professional AND write a prescription.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The service is limited to expenditures of $50,000 of supports (ATES, Home Modifications) over the duration of the waiver.
- A member who receives Residential Supports may not receive this service.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- Central air conditioning; general plumbing; swimming pools; Jacuzzis; fences; service and maintenance contracts and extended warranties are not covered.
- Locks that are used to restrict an individual's rights are not a covered modification.
- Equipment or supplies purchased for exclusive use at the school/home school are not covered.
- Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.
- Home Modifications do not cover new construction, costs associated with building a new home, financing of a new home, and/or down payment of a new home.
- Items that would normally be available to any child, and are ordinarily provided by the family, are not covered.

- Home Modifications exclude adaptations, improvements or repairs to the residence which are of general utility and are not of direct or remedial benefit to the individual or in some way related to the individual's disability.
- Items that are portable may be purchased for use by a member who lives in a residence rented by the member or his/her family.
- Items that are not of direct or remedial benefit to the member are excluded from this service.
- Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The member or his/her family must own any equipment that is repaired.
- If an approved Modification is in the process of being completed, and additional issues are discovered that would prevent the approved Modification from being completed in a safe manner or from passing inspection; a plan revision must be submitted to request the necessary materials and labor to complete the modification in a safe manner.
- Incidental issues that are discovered during the home modification process, that do not impact safety; and are not necessary for the approved home modification to be able to be completed; and do not impact the modification passing inspection, are the responsibility of the homeowner.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Individual Goods and Services Code(s): T1999	Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Support Plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: a) the item or service would decrease the need for other Medicaid services, OR; b) promote inclusion in the community, OR; c) increase the member's safety in the home environment, AND; d) the member does not have the funds to purchase the item or service.	**1.** TAR: Prior approval is required **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) how each of the applicable requirements are met, e) that the member does not have the funds to purchase the item or service, f) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	N/A	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The cost of individual directed goods and services for each member cannot exceed $2,000.00 per member plan year annually.
- Individual Goods and Services do not include experimental goods and services inclusive of items which may be defined as restrictive under NC G.S. 122C-60.
- This service is available only to members who self-direct at least one of their services. The purchase, rental, or leasing of cars/ vans/ trucks is not permissible.
- The purchase of animals, food, nutritional supplements, alcohol, and tobacco are not covered.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Natural Supports Education Code(s): **S5110**: Natural Supports Education, Individual **S5110 GT**: Natural Supports Education, Individual (Telehealth) **S5111**: Natural Supports Education, Conference **S5111 GT**: Natural Supports Education, Conference (Telehealth) **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Natural Supports Education provides training to families and the members' natural support network in order to enhance the decision-making capacity of the natural support network, provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the member, provide education and training on intervention and strategies, and provide education and training in the use of specialized equipment and supplies. The requested education and training must have outcomes directly related to the needs of the member or the natural support network's ability to provide care and support to the member. The expected outcome of this training is to develop and support greater access to the community by the member by strengthening his or her natural support network.	**1.** TAR: Prior approval is required **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) Long range outcomes directly related to the needs of the member or natural support's ability to provide care and support to the member, e) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** In addition to individualized natural support education, reimbursement will be made for enrollment fees and materials related to attendance at conferences and classes by the primary caregiver.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website
Exclusions, Limitations & Exceptions				

- Reimbursement for conference and class attendance will be limited to $1,000 per year.
- The cost of transportation, lodging, and meals are not included in this service.
- Natural Supports Education excludes training furnished to family members through Specialized Consultation Services.
- Training and education, including reimbursement for conferences, are excluded for family members and natural support networks when those members are employed to provide supervision and care to the member.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Residential Supports Code(s): **H2016**: Residential Supports Level 1 **H2016 CG**: Residential Supports Level 1 AFL **H2016 CG GT**: Residential Supports Level 1 AFL (Telehealth) **H2016 GT**: Residential Supports Level 1 (Telehealth) **T2014**: Residential Supports Level 2 **T2014 CG**: Residential Supports Level 2 AFL **T2014 CG GT**: Residential Supports Level 2 AFL (Telehealth) **T2014 GT**: Residential Supports Level 2 (Telehealth) **T2020**: Residential Supports Level 3 **T2020 CG**: Residential Supports Level 3 AFL **T2020 CG GT**: Residential Supports Level 3 AFL (Telehealth) **T2020 GT**: Residential Supports Level 3 (Telehealth) **H2016 HI**: Residential Supports Level 4 **H2016 HI CG**: Residential Supports Level 4 AFL **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Residential Supports provides individualized services and supports to enable a member to live successfully in a Group Home or Alternative Family Living (AFL) setting of their choice and be an active participant in his/her community. The intended outcome of the service is to increase or maintain the member's life skills, provide the supervision needed, maximize his/her self-sufficiency, increase self- determination, and ensure the person's opportunity to have full membership in his/her community. Residential Supports includes learning new skills, practice and improvement of existing skills, and retaining skills to assist the person to complete an activity to his/her level of independence. Residential Supports includes supervision and assistance in activities of daily living when the member is dependent on others to ensure health and safety.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria. **Levels** Residential Supports levels are determined by the IBT and other evidence of support need. The SIS Level is only one piece of evidence that may be considered. Level 1: SIS Level A Level 2: SIS Level B Level 3: SIS Level C and D Level 4: SIS Level E, F, and G	**1.** Residential Supports may be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. Primary AFL Staff who provide Residential Supports should not provide other waiver services to the member. **2.** Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources. **3.** Individuals select the setting from among available options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources)	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website
Exclusions, Limitations & Exceptions				

- The amount of Residential Supports is subject to the Limits on Sets of Services.
- A member who receives Residential Supports may not receive Home Modifications, Community Living and Supports, Respite (unless the individual resides in an AFL), Supported Living, or State Plan Personal Care Services.
- Assistive Technology Equipment & Supplies may be accessed when the item belongs to the individual and can transition to other settings with the individual.

- This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Supports, Supported Living, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.
- Payments for Residential Supports do not include payments for room and board, the cost of facility maintenance and upkeep.
- In specific situations, to ensure member health and safety Trillium may approve the AFL to serve as short term back up staff for day services (Day Supports, Community Networking or Supported Employment). This approval must be documented in the Individuals record at both Trillium and the provider agency.
- Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source.
- NC Innovations respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports. Respite may also be provided for participation in non-integrated camps or for participation in non-integrated Support Groups
- Back-up staff must be employees of the agency.
- The setting is integrated in and supports full access of a member to the greater community.
- Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices.
- Settings facilitate individual choice regarding services and supports, and who provides these.
- In Provider Owned or Controlled Residential Settings: a) Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity; b) Provide privacy in sleeping or living unit; c) Provide freedom and support to control individual schedules and activities, and to have access to food at any time; d) Allow visitors of the member's choosing at any time; e) Are physically accessible.
- Refer to North Carolina DHHS's HCBS Transition Plan for additional information https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule/hcbs-resources.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Respite Code(s): **S5150**: Respite Care, Community Individual **S5150 HQ**: Respite Care, Community Group **S5150 US**: Respite Care, Community Facility **T1005 TE**: Respite Care, Nursing (LPN) **T1005 TD**: Respite Care, Nursing (RN)	Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the member. This service also enables the individual to receive periodic support and relief from the primary caregiver(s) at his/her choice. NC Innovations respite may also be used to provide temporary relief to a member who resides in Licensed or Unlicensed AFL, but it may not be billed on the same day as Residential Supports unless it is for a member to access a summer camp or support group. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. Respite may be utilized during school hours for sickness, injury, or when a student is suspended or expelled.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Documentation that clearly indicates the service is needed for support and relief of the member or primary caregiver. **7.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis).	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- This service may not be used as a regularly scheduled daily service for individual support.
- This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Supports, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.
- Residential Support AFL cannot be billed on the same day as Per Diem Respite for the same member.
- This service is not available to members who reside in licensed facilities that are licensed as 5600B or 5600C.
- Staff sleep time is not reimbursable.
- Respite services are only provided for the member; other family members, such as siblings of the member, may not receive care from the provider while Respite Care is being provided/billed.
- Respite Care is not provided by any person who resides in the member's primary place of residence.
- For a member who is eligible for educational services under Individual's With Disability Educational Act, Respite does not include transportation to and from school settings. This includes transportation to and from the member's home, provider home where the member is receiving services before/after school or any community location where the member may be receiving services before or after school.
- Respite may not be used for a member who is living alone or with a roommate.
- The primary caregiver(s) is the person principally responsible for the care and supervision of the member and must maintain his/her primary residence at the same address as the member.
- Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional.

- For services provided in the home of a direct service employee, the Provider Agency, Employer of Record or Agency With Choice is required to complete the Health and Safety Checklist and Justification for Services form prior to the delivery of service in that home and every six months afterwards, as long as the service continues to be provided in that location. The member or legally responsible person must sign this checklist.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Specialized Consultation Services Code(s): **T2025**: Specialized Consultative Services **T2025 GT**: Specialized Consultative Services (Telehealth) **T2025 HO**: Specialized Consultative Services, BCBA **T2025 HO GT**: Specialized Consultative Services, BCBA (Telehealth) **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Specialized Consultation Services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy, nutrition, nursing, and other licensed professionals who possess experience with individuals with Intellectual / Developmental Disabilities) to assist family members, support staff and other natural supports in assisting the member with developmental disabilities. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** This service may be used for evaluations for adults when the State Plan limits have been exceeded.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- Specialized Consultative Services excludes services provided through Natural Supports Education and Crisis Services. This service may not duplicate services provided to family members through natural supports education
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Supported Employment Services Code(s): **H2025**: Supported Employment, Individual **H2025 GT**: Supported Employment, Individual (Telehealth) **H2025 HQ**: Supported Employment, Group **H2025 HQ GT**: Supported Employment, Group (Telehealth) **H2025 TS**: Supported Employment, Long Term Follow-Along **H2025 TS GT**: Supported Employment, Long Term Follow-Along (Telehealth) **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Supported Employment services provide assistance, based on individual circumstances and need, to explore, seek, choose, acquire, maintain, increase and/or advance in competitive integrated employment. Supported Employment services occur in integrated environments with non-disabled individuals or is a business owned by the member. This service is available to any member ages 16 and older for whom individualized, competitive integrated employment has not been achieved, and/or has been interrupted or intermittent. Assistance with increasing or advancing in competitive integrated employment is available to members, ages 16 and older, for whom their current competitive integrated employment is insufficient in terms of meeting the member's goals for hours worked and income earned, or is considered underemployment in that the member desires, and could reasonably be expected to achieve, a promotion to a position with increased responsibilities and pay. Supported Employment- Long Term Follow Along services provide assistance, based on individual circumstances and need, to maintain, increase and/or advance in competitive integrated employment.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) For medical, behavioral and/or physical support needs, narrative supporting the need for Long-Term Follow-Along Supported Employment- services as the most appropriate option for maintaining employment, e) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Long-Term Follow-Along Documentation: required when services are needed to address medical, behavioral and/or physical support needs **7.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** Competitive integrated employment is an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage. **2.** Services should be targeted and time limited. **3.** Job finding is not based on a pool of jobs that are available or set aside specifically for individuals with disabilities. **4.** Fading of initial coaching and employment support activities should begin at some level within the first month of employment and incremental fading gains should be expected to continue over time, as the person becomes more independent on the job and can rely on natural supervisors and co-workers for needed supports, until fading has been maximized and/or the person completes their probation period, at which point the person should transition to Long-Term Follow-Along Supported Employment. **5.** The transition to Long-Term Follow-Along Supported Employment- services should typically occur within one year of the individual starting competitive integrated employment. A focus on identifying and implementing strategies for fading should continue in Long-Term Follow-Along Supported Employment services. **6.** The setting is integrated in and supports full access of a member to the greater community. **7.** Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

			8. Individuals receive services in the community to the same degree of access as individuals not services.	

Exclusions, Limitations & Exceptions

- The amount of Supported Employment Services is subject to the limitation on the sets of services.
- Documentation is maintained in the file of each provider agency specifying that the particular service(s) being provided under this service category is not otherwise available, without undue delay, to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973, or under the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- FFP is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as: a) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; b) Payments that are passed through to users of supported employment programs; or, c) Payments for training that are not directly related to a member's supported employment program.
- While it is not prohibited to both employ a member and provide service to that same member, the use of Medicaid funds to pay for Supported Employment Services to providers that are subsidizing their participation in providing this service is improper. The following types of situations are indicative of a provider subsidizing its participation in supported employment: a) The job/position would not exist if the provider agency was not being paid to provide the service; b) The job/position would end if the member chose a different provider agency to provide service; c) The hours of employment have a one to one correlation with the amount of hours of service that are authorized.
- For a member who is eligible for educational services under the Individuals With Disability Educational Act, Supported Employment does not include transportation to or from school settings. This includes transportation to/from the member's home, provider home where the member may be receiving services before or after school or any other community location where the member may be receiving services before or after school.
- This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Supports, Supported Living, Residential Supports, Respite or one of the State Plan Medicaid services that works directly with the person.
- Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices;
- Settings facilitate individual choice regarding services and supports, and who provides these.
- Refer to North Carolina DHHS's HCBS Transition Plan for additional information https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule/hcbs-resources.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Supported Living Code(s): **T2033**: Supported Living, Level 1 **T2033 GT**: Supported Living, Level 1 (Telehealth) **T2033 HI**: Supported Living, Level 2 **T2033 HI GT** – Supported Living, Level 2 (Telehealth) **T2033 TF**: Supported Living, Level 3 **T2033 TF GT**: Supported Living, Level 3 (Telehealth) **T2033 U1**: Supported Living Periodic (In-Home Services Only) **T2033 U1 GT**: Supported Living Periodic (In-Home Services Only, Telehealth) **T2033 U2**: Supported Living Transition **T2033 U2 GT**: Supported Living Transition (Telehealth) **Note:** Requesting the core service automatically includes the use of the telehealth (GT) code when approved. A separate request is not needed, and the GT service code should not be requested separate from the non-telehealth service code.	Supported Living provides a flexible partnership that enables a NC Innovations member to live in their own home with support from an agency that provides individualized assistance in a home that is under the control and responsibility of the member. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the member, budget management, attending appointments, and interpersonal and social skills building to enable the member to live in a home in the community. Training activities, supervision, and assistance may be provided to allow the member to participate in home life or community activities. Other activities include assistance with monitoring health status and physical condition, and assistance with transferring, ambulation and use of special mobility devices. The purpose of Supported Living Transition is to provide members with the support that they need to facilitate their transition to Supported Living.	**1.** TAR: Prior approval is required for each plan year. **2.** SIS **3.** Individual Budget **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) risk assessment, e) back-up, relief staff, and in the case of emergency or crisis details, f) specific plan for addressing health and safety needs for unsupervised times, g) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** The Supported Living Periodic service is available for a member who uses four or less hours of Supported Living per day. **2.** A member's own home is defined as the place the person lives and in which the person has all of the ownership or tenancy rights afforded under the law. This home must have a separate address from any other residence located on the same property. **3.** A member receiving Supported Living has the right to manage personal funds as specified in the ISP. **4.** A formal roommate agreement, separate from the landlord lease agreement, is established and signed by individuals whose name is on the lease. **Levels** Supported Living levels are determined by the IBT and other evidence of support need. The SIS Level is only one piece of evidence that may be considered. Level 1: SIS Level A & B Level 2: SIS Level C & D Level 3: SIS Level E, F, & G	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The amount of Supported Living is subject to the Limits on Sets of Services.
- Supported Living Transition is only available during the six-month period in advance of the member's move to a Supported Living setting.
- Supported Living is not provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIFD) or residential group homes.

- Supported Living is not covered for persons under age 18 since the home must be under the control and responsibility of the residents.
- A member who receives Supported Living may not receive: Community Living and Supports or State Plan Personal Care Services. Respite may only be provided for participation in non- integrated camps or for participation in non-integrated Support Groups.
- This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person.
- A member receiving Supported Living may only receive Home Modifications if the home is owned by the member or the member's family. If the home is rented, only Home Modifications that are portable and can be removed once the member no longer leases the residence may be used.
- This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the member.
- Relatives who own provider agencies may not provide Supportive Living services to family members. Other staff employed by the provider agency may provide services to the individual.
- The provider of Supported Living services shall not: a) Own the person/s' home or have any authority to require the member to move if the member changes service providers; b) Own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a member if such entity requires, as a condition of renting or leasing, the member to move if the Supported Living provider changes.
- Supported Living must not be provided in a home where a member lives with family members unless such family members are a member receiving Supported Living, a spouse, or a minor child. All members receiving Supported Living services who live in the same household must be on the lease unless the person is a live-in caregiver.
- Reimbursement for Supported Living must not include payment for services provided by the spouse of a person or to family members as defined in this service definition or legal guardian. The Supported Living provider and provider staff shall not be a member of the member's immediate family as defined in this service definition and reimbursement must not include payment for Supported Living provided by such persons.
- A Supported Living home must have no more than three residents including any live-in caregiver providing support.
- Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver.
- Reimbursement cannot include the cost of maintenance of the dwelling.
- Transportation is an inclusive component of Supported Living to achieve goals and objectives related to these activities with the exception of transportation to and from medical services covered through the Medicaid State Plan.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.

Service & Code	Brief Service Description	Auth Submission Requirements	Additional Auth Parameters	Source
Vehicle Modifications Code(s): T2039	Vehicle Modifications are devices, service or controls that enable a member to increase their independence or physical safety by enabling their safe transport in and around the community.	**1.** TAR: Prior approval is required **2.** SIS **3.** Individual Budget: to include itemized shipping costs **4.** Care Management Comprehensive Assessment **5.** ISP: to include a) the service/ support, b) projected frequency, c) provider, d) Long-range outcomes related to training needs associated with the utilization of the adaptations, e) required signatures. See CCP 8P, section 5.3, for all general ISP requirements. **6.** Proof of actively making payments to purchase/own the vehicle **7.** Auto Insurance Policy: w/ coverage sufficient to replace the adaptation in the event of an accident **8.** PT/ OT Recommendation (must be less than 1 calendar year from date of request submission): a) Completed by a professional specializing in vehicle modification or a rehabilitation engineer or vehicle adaptation; b) includes the rationale for the selected mods; c) pre- driving assessment of the member driving the vehicle; d) condition of the vehicle to be modified; e) the insurance on the vehicle to be modified. **9.** Vehicle Evaluation: by an adapted vehicle supplier to include “life expectancy” of the vehicle in relationship to the modifications **10.** Estimated life of the equipment as well as the length of time the member is expected to benefit from the equipment **11.** Certificate of MN /Prescription: completed by the MD/ DO, PA, or NP. **12.** Letter of MN or Written Assessment/ Recommendation: by an MD/ DO, PA, NP, or appropriate professional, outlining MN for every item provided. If the MD/ DO, PA, or NP complete the Letter, as separate prescription is not required. **13.** Two quotes for the requested item(s) **14.** Training Plan: how the person and family will be trained on the use of the equipment **15.** Submission of applicable records that support the member has met the medical necessity criteria.	**1.** When an assessment is completed by another professional recommending the MN of specific items, then an MD/ DO, PA, or NP must write a letter of MN OR sign off on the letter of MN prepared by professional AND write a prescription.	Clinical Coverage Policy No 8P: North Carolina Innovations APSM 45-2 Records Management and Documentation Manuals NCDHHS NC Innovations Waiver Website

Exclusions, Limitations & Exceptions

- The service is limited to expenditures of $20,000 over the life of the waiver.
- If purchasing a vehicle with a lift on it, the price of the new lift may be covered. The cost of a used lift on vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the member or family may not take possession of the lift prior to approval by Trillium.

- Vehicle Modifications are only available to a member who receives Residential Supports, or who lives in licensed residential facility, when the vehicle belongs to the member and can transition to other settings with the individual.
- The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered.
- Items that are not of direct or remedial benefit to the member are excluded from this service.
- Vehicle modifications are not covered for leased vehicles.
- Modifications do not include the cost of the vehicle.
- All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway Traffic Safety Administration guidelines.
- Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.
- If paying for labor and costs of moving devices or equipment from one vehicle to another vehicle, then training on the use of the device is not required.
- The modification must meet applicable standards and safety codes. The Care Coordinator verifies that the modification has been completed and received by the member, and note any health or safety concerns.
- Exclusions, limitations & exceptions detailed in the Eligibility Requirements, Terms of Service, Limits on Sets of Services, General Limitations on Coverage, Relative as Provider, Individual and Family Directed Services, and Claims sections of this Benefit Plan apply.
- See the CCP for all applicable exclusions, limitations & exceptions.