

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	State-Funded Day Supports (I/DD & TBI) Date Published:
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1.0 Description of the Service

Day Supports is a group service that provides assistance to individuals 16 years of age and older with acquisition, retention, or improvement in socialization and daily living skills and is one option for a meaningful day. Group services may be provided as long as services outlined within the Person Centered Plan (PCP) or Individual Support Plan (ISP) are able to be fully addressed. This service has historically been a facility-based service. However, person centered practices should be utilized to determine the appropriate amount of time to be spent on site, verses out in the community.

“Facility-Based” means that individuals who receive this service are often in a licensed Day Supports provider facility or an Adult Day Health provider certified by the NC Division of Aging and Adult Services that serves individuals with Intellectual and Developmental Disabilities (I/DD) or Traumatic Brain Injury (TBI). To promote community integration and inclusion, individuals are required to check-in at the day supports facility as defined within the ISP or PCP.

For individuals who are aging, Day Supports can provide a structured day program of service and support with nursing supervision in an Adult Day Care Program. An adult day care provides an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being.

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 individual’s opportunity to have a meaningful day. To ensure informed choice among a variety of options for a meaningful day, individuals new to the service will receive education on available options during the planning meeting. Education must include exposure to the same day activities as others in the community and the structure of Day Supports must provide the opportunity to discover his or her skills, interests, and talents in his or her community. Grouping must be appropriate to the age and preferences of the individuals.

For working-aged individuals (ages 16 or older) not also working in competitive integrated employment, Day Supports may include career and employment exploration through educational and experiential opportunities designed to identify specific interests and aptitudes for paid work, including experience and skills transferable to competitive integrated employment. Day Supports may also include business tours, informational interviews and job shadows, related to identified interests, experiences, and skills in order to explore potential opportunities for competitive integrated employment in the individual’s local area to explore potential opportunities for competitive integrated employment in the individual’s local area. Individuals receiving prevocational services must have employment-relates goals in their PCP or ISP. Further, it is noted that competitive, integrated employment is considered to be the optimal outcome of prevocational services.

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When Day Supports are provided in a facility-based setting, the setting should comply with home and community based service (HCBS) standards. A provider self-assessment is not required for state-funded services. However, if individuals receiving Medicaid HCB services are also served, a provider self-assessment is required.

Transportation to/from the individual's home, the day supports facility and points of travel in the community as outlined in the PCP or ISP is included to the degree that they are not reimbursed by another funding source and not used for personal use. Transportation to and from the licensed day program is the responsibility of the Day Supports provider.

2.0 Eligibility Criteria

2.1 Provisions

2.1.1 General

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

2.1.2 Specific

State funds shall cover Day Supports (I/DD & TBI) for an eligible individual who is 16 years of age and older and meets the criteria in Section 3.0 of this policy.

3.0 When the Service is Covered

3.1 General Criteria Covered

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

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

State funds shall cover Day Supports (I/DD & TBI) when ALL of the following criteria are met:

- a. 16 years of age or older and express a desire to obtain and maintain service,

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- b. The individual has a condition that is identified as a developmental disability or Traumatic Brain Injury as defined in G.S. 122-C-3(12a),
AND
- c. NC Support Needs Assessment (Level 2 or higher), Supports Intensity Scale (Level C or higher), or TBI Assessment requiring a moderate to high level of supervision and support in most settings, such as in the community, home, work, etc.
AND
- d. Due to one or more functional impairments is expected to cause the individual to have difficulty in obtaining and maintaining integrated competitive employment without additional support.

3.2.2 Admission Criteria

A psychological evaluation that demonstrates medical necessity must be completed by a licensed professional prior to the provision of this service. Relevant clinical information must be obtained and documents in the individual’s Person-Centered Plan or Individual Service Plan.

The results of a SIS and/or SNAP and/or TBI Assessment are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services that may be requested or authorized in a PCP or ISP. Service authorization must be completed by a Qualified Professional prior to the day services are to be provided.

3.2.3 Continued Stay Criteria

The individual requires this service to acquisition, retention, or improvement in socialization and daily living skills within the community as documented by detailed deficiencies and planned goals which reflect strategies to correct deficiencies.

Prior authorization is required for Day Supports.

Day Supports should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The individual meets criteria for continued stay if ONE of the following applies:

- a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame documented in the individual’s PCP or ISP;
OR
- b. The individual has documentation to support that they continue to be at risk of regression based on current clinical assessment, and history, or the tenuous nature of the functional gains;
OR

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

3.2.4 Transition and Discharge Criteria

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

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

4.0 When the Service is Not Covered

4.1 General Criteria Not Covered

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

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by State Funds

State funds shall not cover the following activities of Day Supports (I/DD & TBI):

- a. Transportation to and from the school setting is not covered and is the responsibility of the school system.
- b. Payment for day supports does not include payments made directly to members of the individual’s immediate family.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State funded Day Supports (I/DD & TBI) shall require prior approval. Refer to Subsection 5.3 for additional limitations.

A service order must be signed prior to or on the first day Day Supports (IDD & TBI) are rendered. Refer to Subsection 5.4 of this policy.

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LME-MCOs can offer less restrictive limitations on unmanaged units but cannot impose more restrictive limitations than the State-Funded Policy. All units beyond state-funded limitations or limitations imposed by the LME-MCO require prior approval.

Providers shall collaborate with the individual's existing provider to develop an integrated plan of care. Prior authorization is not a guarantee of claim payment.

5.2 Prior Approval Requirements

5.2.1 General

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

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

5.2.2 Specific

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

Initial Authorization

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

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

Reauthorization

Reauthorization requests must be submitted to the LME-MCO 10-days prior to the end date of the individual's active authorization. Reauthorization is based on medical necessity documented in the PCP or ISP, the authorization request form, and supporting documentation. The duration and frequency at which Day Supports (IDD & TBI) is provided must be based on medical necessity and progress made by the individual toward goals outlined in the PCP.

Additional units may be authorized as clinically appropriate. If medical necessity dictates the need for increased service duration and frequency, clinical consideration must be given to interventions with a more intense clinical component.

Note: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person or both about the individual's appeal rights pursuant to G.S. 43B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

5.3 Additional Limitations or Requirements

Federal Financial Participation (FFP) is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- a. Only one Day Supports provider can provide this service to an individual at a time.
- b. This service is not available at the same time as any other State-funded or Medicaid-funded Service that works directly with the individual.
- c. This service may not be furnished/provided in a residential setting.
- d. Individuals receiving this service may not be Innovations Waiver members/beneficiaries or receiving other residential (b)(3) or in lieu of services.
- e. This service may not exceed 30 hours a week.

Day Supports Services (I/DD & TBI) must not be duplicative of other state funded services the individual is receiving.

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the individual's needs. A signed service order must be completed by a physician, licensed

psychologist, physician assistant, or nurse practitioner, per his or her scope of practice.

ALL the following apply to a service order:

- a. Backdating of the service order is not allowed;
- b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
- c. A service order must be in place prior to or on the first day that the service is initially provided to bill state funds for the service; and
- d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP or ISP service order.

5.5 Documentation Requirements

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

The service record documents the nature and course of an individual's progress in treatment. To bill state funds, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by state funds. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for professionals or job title for associate professionals. A qualified professional (QP) shall countersign service notes written by staff who do not have QP status within 48 hours of service delivery. The PCP and a documented discharge plan must be discussed with the individual and documented in the service record.

5.5.1 Contents of a Service Record

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

- a. Individual's name;
- b. Service record identification number;
- c. Date of the service provision;
- d. Name of service provided;
- e. Type of contact(face-to-face, phone);
- f. Place of service;

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- g. Purpose of contact as it relates to the PCP goals;
- h. Description of the intervention/prompting provided. Documentation of the intervention must accurately reflect services for the duration of time indicated;
- i. Duration of service, start and end time of intervention; total amount of time spent performing the intervention;
- j. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goals; and
- k. Date and signature and credentials or job title of the staff member who provided the service.

6.0 Provider(s) Eligible to Bill for the Service

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

- a. meet LME-MCO qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Day Supports (I/DD & TBI) Services must be delivered by practitioners employed by organizations that:

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

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

Day Supports providers:

- a. Help develop community involvement and relationships that promote full citizenship,
- b. Coordinate education and assistance related to finances, healthcare, and other needs,

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- c. Assist with day-to-day planning and problem solving,
- d. Train and support people who assist the individual incidental to the PCP or ISP,
- e. Train and support individuals on accessing public transportation,
- f. Train and support individuals with new skill acquisition related to interpersonal, independent living, community living, self-care, and self-determination.

6.2 Provider Certifications

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

6.2.1 Staffing Requirements

The Day Supports (I/DD & TBI) service is provided by qualified providers with the capacity and adequate workforce to offer this service to individuals meeting the IDD/TBI state-funded Benefit Plan. The service must be available during times that meet the needs of the individual which may include evening, weekends, or both. Day Supports (I/DD & TBI) must be under the direction of a full-time qualified Paraprofessional who meets the requirements according to 10A NCAC 27G .0104 (15).

The service must have designated competent developmental disability and/or traumatic brain injury qualified professionals to provide supervision to Community Living & Supports (IDD & TBI) during the times of service provision.

The maximum program staff ratios are as follows: group ratio for Day Supports (I/DD & TBI) Group is 1 (one) Paraprofessional to no more than 4 (four) Individuals.

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

6.2.2 Staff Training Requirements

The provider shall ensure that staff who are providing Day Supports have completed special population training based on staff experience and training needs (e.g., intellectual and developmental

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disabilities, geriatric, traumatic brain injury, deaf and hard of hearing, co-occurring intellectual and mental health and co-occurring intellectual and developmental disabilities and substance use disorder) as required.

Agency staff that work with individuals:

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

Professional Competencies

Paraprofessionals have competency in the following areas:

- A. Communication - The Paraprofessional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- B. Person-Centered Practices - The Paraprofessional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- C. Evaluation and Observation - The Paraprofessional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- D. Crisis Prevention and Intervention - The Paraprofessional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.

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- E. Professionalism and Ethics - The Paraprofessional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- F. Health and Wellness - The Paraprofessional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- G. Community Inclusion and Networking - The Paraprofessional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- H. Cultural Competency - The Paraprofessional respects cultural differences and provides services and supports that fit with an individual's preferences.
- I. Education, Training and Self-Development - The Paraprofessional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

6.3 Expected Outcomes

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

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

7.0 Additional Requirements

7.1 Compliance

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

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

8.0 Policy Implementation and History

Original Effective Date:

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History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	

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Attachment A: Claims-Related Information

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

A. Claim Type

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

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

C. Code(s)

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

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

Unlisted Procedure or Service

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

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

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D. Modifiers

There are no modifiers for this service.

E. Billing Units

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

Units are billed in 15-minute increments.

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

F. Place of Service

The service may be provided in the home or community that meet the home and community based characteristics established by Centers for Medicare & Medicaid Services and adopted by NC DHHS.

This service must be provided in the following facilities:
Developmental Day Care Programs licensed according to NC G.S. 122 C.

Adult Day Health and Day Care Programs certified by NC Division of Aging and Adult Services.

This service is not Medicaid billable.

G. Co-payments

Not applicable

H. Reimbursement

Provider(s) shall bill their usual and customary charge