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**NC Division of Medical Assistance
Intermediate Care Facilities for
Individuals with Intellectual
Disabilities (ICF/IID)**

**Medicaid and Health Choice
Clinical Coverage Policy No: 8E
Amended Date: October 1, 2015**

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1.0 Description of the Procedure, Product, or Service

An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (42 CFR 435.1009) is an institution, or distinct part thereof, that:

- a. Functions primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or persons with a related condition; and
- b. Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability.

1.1 Definitions

Active treatment is a continuous program that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services described in 42 CFR 483.440.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

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

2.1.2 Specific

a. Medicaid

1. Medicaid beneficiaries may have service restrictions due to their eligibility category that would make them ineligible for this service.
2. Medicaid beneficiaries who are Medicaid-certified at the ICF/IID level of care are eligible to receive ICF/IID services.

3. Eligibility for ICF/IID level of care is based on each beneficiary's need for ICF/IID services and not merely on the diagnosis.
4. NC Medicaid (Medicaid) beneficiary shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

b. NCHC

NCHC beneficiaries are not eligible for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

2.2 Special Provisions

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

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

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

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

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

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

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

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

problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

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

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

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

The Division of Medical Assistance (DMA) shall deny the claim for coverage for a NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for a NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid or NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover formal educational or vocational services only for those services documented as active treatment. Active treatment is directed toward the following:

- a. The acquisition of behaviors necessary for a beneficiary to function with as much self-determination and independence as possible; and
- b. The prevention or deceleration of regression or loss current optimal functional status. Refer to **Subsection 1.1**.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.3 ICF/IID Level of Care Criteria

In order to be Medicaid-certified at an ICF/IID level of care, a beneficiary shall meet the following criteria:

- a. Require active treatment necessitating the ICF/IID level of care; and
- b. Have a diagnosis of Intellectual Disability per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, text (DSM-5), or a condition that is closely related to mental retardation.
 1. Intellectual Disability is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.
 2. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions:
 - A. is attributable to:
 - I. Cerebral palsy, epilepsy; **or**
 - II. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of Intellectually Disabled persons, and requires treatment or services similar to those required for these persons;
 - B. The related condition manifested before age 22;
 - C. Is likely to continue indefinitely; and
 - D. Have Intellectual Disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (refer to **Attachment B**):
 - I. Self-Care (ability to take care of basic life needs for food, hygiene, and appearance)
 - II. Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)
 - III. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
 - IV. Mobility (ambulatory, semi-ambulatory, non-ambulatory)
 - V. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)
 - VI. Capacity for independent living (age-appropriate ability to live without extraordinary assistance).

Note: Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.

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

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

4.1 General Criteria Not Covered

Medicaid or NCHC shall not cover procedures, products, and services related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover formal educational services or for vocational services except as listed in **Subsection 3.2** of this policy.

Medicaid shall not cover active treatment when it includes services to maintain generally independent beneficiaries who are able to function with little supervision or in the absence of a continuous active treatment program (42 CFR 483.440(a)(2)).

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Prior approval (PA) for ICF/IID level of care shall be obtained in the following circumstances:

- a. When there is an admission to an ICF/IID;
- b. When the utilization review committee recommends change in the level of care;
- c. When residents who were previously private pay or insured by a third party carrier seek Title XIX assistance in an ICF/IID;
- d. When a resident is discharged from an ICF/IID to a lower level of care or to his own home, and later re-applies for ICF/IID level of care, prior approval is required; and
- e. When a Medicaid beneficiary's benefits are terminated for 90 days or more before reinstatement even though the individual remains in the same facility.

For a Medicaid beneficiary who is eligible under fee for service, an MR2 form (signed and dated by a physician) and supporting documentation must be sent directly to the agency that performs PA review and approval.

For a Medicaid beneficiary who is eligible under a 1915 (b)(c) waiver, the primary care physicians shall complete the Medical Evaluation attachment to the MCO Level of Care Eligibility Determination tool. The medical evaluation and MCO Level of Care Eligibility Determination tool are forwarded to the Utilization Management Department of the MCO. The Care Manager shall review the information from the assessment and verify that the documentation supports the eligibility criteria.

The Level of Care Eligibility Determination Tool is valid for 30 calendar days from the date of the physician's signature.

5.2 Prior Approval Requirements

5.2.1 General

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

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

5.2.2 Specific

None Apply.

5.3 Comprehensive Functional Assessment

Within 30 calendar days after a beneficiary is admitted to an ICF/IID, the Interdisciplinary Team shall perform an accurate comprehensive functional assessment or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. (42 CFR §483.440 (c)(3).

The comprehensive functional assessment of each beneficiary must be reviewed annually by the Interdisciplinary Team for relevancy and updated as needed, and the IPP must be revised, as appropriate(42 CFR§ 483.440(f)(2) by the qualified professional(QP).

5.4 Individual Program Plan

The beneficiary's interdisciplinary team shall prepare an Individual Program Plan (IPP) (42 CFR 483.440) which includes opportunities for individual choice and self-management. The IPP identifies the following:

- a. Discrete, measurable, criteria-based objectives the individual is to achieve; and
- b. Specific individualized program of specialized and generic strategies, supports and techniques to be employed.

5.4.1 Contents of the Individual Program Plan

Within 30 calendar days after a beneficiary is admitted to an ICF/IID, the Interdisciplinary Team shall prepare for each beneficiary an individual program plan (IPP) (42 CFR 483.440(c)(4). The IPP must include:

- a. specific objectives necessary to meet the beneficiary's needs as identified by the comprehensive functional assessment;
- b. the planned sequence for dealing with these objectives;
- c. objectives stated separately in terms of a single behavioral outcome:
 1. objectives with assigned projected completion dates;
 2. objectives expressed in behavioral terms that provide measurable indices of performance;
 3. objectives that are organized to reflect a developmental progression appropriate to the individual beneficiary;
- d. a description of relevant interventions to support the individual toward independence;
- e. the location where program strategy information can be found;
- f. for beneficiaries who lack them, training in personal skills essential for privacy and independence, until it has been demonstrated that the client is developmentally incapable of acquiring them; and
- g. identification of mechanical supports, if needed:
 1. the reason for each support;
 2. the situation in which each is to be applied; and
 3. a schedule for the use of each support.

5.5 Reimbursement of Services

Medicaid reimburses only for services documented as active treatment, providers shall differentiate educational goals from other goals in the beneficiary's IPP. Providers shall describe those services that are considered part of active treatment.

5.6 Allowable Costs

Personal laundry and hygiene items can be reported as an allowable cost to the ICF/IID. The following items are included in the Medicaid per-diem rate and cannot be charged to the beneficiary's personal funds:

- a. Bath soap;
- b. Brush;
- c. Comb;
- d. Cotton balls;
- e. Cotton swabs;
- f. Dental Adhesive;
- g. Dental floss;
- h. Dental mouth rinses (non-prescription);
- i. Denture cleaner;
- j. Deodorant;
- k. Disinfecting soaps;
- l. Hair conditioner;
- m. Haircuts and shampooing;
- n. Hospital gowns;
- o. Moisturizing lotion;
- p. Nail care;
- q. Personal laundry;
- r. Razors;
- s. Sanitary napkins and related supplies;
- t. Shampoo;
- u. Shaving cream;
- v. Specialized cleansing agent (skin);
- w. Tissues;
- x. Toothbrush;
- y. Toothpaste;
- z. Towels;
- aa. Washcloths.

5.7 Hair Care Services

- a. The ICF/IID is responsible for providing beneficiary's basic hygiene, including hair care. Basic hair care services (for example, wash, cut, shampoo, and conditioner) furnished to a beneficiary by facility personnel, barber, or beauticians are allowable costs for reimbursement and are included in the facility's per-diem rate.
- b. A beneficiary can be billed for hair care in excess of basic hair care (such as color, style, or permanent wave) because these services are non-allowable costs for Medicaid payment.

5.8 Prescription Drugs

- a. A 34 calendar day grace period is available for obtaining prescription drug prior authorization (PA) for Medicaid beneficiaries in ICFs/ IID. A single 34 calendar day grace period per prescription can be granted and applies to beneficiaries already residing in these facilities as well as newly admitted beneficiaries.
- b. The grace period allows additional time to gather the medical information necessary to request PA from DMA's designated contractor administering the prescription drug PA program. If the contractor determines that the request does not meet the PA criteria, the prescriber may submit a request for exemption.

5.9 Therapeutic Leave

Each Medicaid-eligible beneficiary in an ICF/IID is entitled to take up to 60 calendar days of therapeutic leave in any calendar year. The leave must be for therapeutic purposes only and must be ordered by the beneficiary's attending physician. The necessity for the leave must be documented in the beneficiary's plan of care and therapeutic justification for each instance of leave must be documented in the beneficiary's medical record.

ICF/IIDs shall reserve a therapeutically absent beneficiary's bed and are prohibited from deriving any Medicaid revenue for that beneficiary other than the reimbursement for the bed during the period of absence. ICF/IIDs are reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. ICF/IIDs are not reimbursed for therapeutic-leave days which exceed the legal limit.

Therapeutic leave is not applicable when the leave is for the purpose of receiving either inpatient or nursing services provided either elsewhere or at a different level of care in the facility of current residence, when such services are or will be paid for by Medicaid. Transportation from a facility to the site of therapeutic leave is not considered an emergency. Therefore, ambulance service for this purpose is not reimbursed by Medicaid.

ICF/IID group homes can take residents on vacation within the rules and requirements of the Medicaid program. The time away from the group home is not considered therapeutic leave. Each individual program plan must identify specific goals and objectives to be met during the vacation. Sufficient ICF/IID staff shall accompany residents to assure that all their personal and training needs are met.

Consecutive therapeutic leave days in excess of 15 consecutive days must be approved by the MCO for beneficiaries under a 1915 (b) waiver. Consecutive therapeutic leave days in excess of 15 consecutive days must be approved by DMA/designee for beneficiaries under fee for service.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

6.2.1 Facility Recertification

The Division of Health Service Regulation (DHSR) conducts recertification surveys to determine if the ICF/IID complies with the federal requirements for the Condition of Participation: Active Treatment Services (42 CFR: 483.440). If the ICF/IID fails to comply with the requirement for active treatment of a Medicaid beneficiary, the DHSR notifies the Medicaid program of a change in the beneficiary's level of care from ICF/IID.

6.2.2 Initial Certification and Recertification for ICF/IID Level of Care

A medical doctor shall document the initial certification. The physician, physician assistant, or nurse practitioner may document subsequent recertification; however the physician is responsible for co-signing and dating all recertifications written by the nurse practitioner or physician assistant.

7.0 Additional Requirements

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

7.1 Compliance

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

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Beneficiary Recertification

In all private and state-owned ICF/IID facilities and group homes, a utilization review by a committee must occur for each beneficiary at least every 180 days in order to decide whether ICF/IID level of care is needed, according to the criteria in **Subsection 3.2**. If the committee determines that the beneficiary continues to meet the ICF/IID criteria, the beneficiary is recertified for ICF/IID level of care. A medical doctor must document the initial certification. The physician, physician assistant, or nurse practitioner may document subsequent recertification. The physician is responsible for co-signing and dating all recertifications written by the nurse practitioner or physician assistant.

8.0 Policy Implementation/Revision Information

Original Effective Date: June 1, 1991

Revision Information: May 1, 2013

Date	Section Revised	Change
08/01/2006	Attachment A	Billing information related to the date of admission and date of discharge was added to the Billing Guidelines.
12/01/2006	Subsection 2.2	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	The special provision related to EPSDT was revised.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
05/01/2007	Attachment A	Added the UB-04 as an accepted claims form.
08/01/2007	Subsection 7.2	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
08/01/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 8E under Session Law 2011-145, § 10.41.(b)
08/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
05/01/2013	All sections and attachment(s)	Changed title of policy from Intermediate Care Facility for the Mentally Retarded (ICF MR), to Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID) per change to 42 CFR 440.150.
05/01/2013	All sections and attachment(s)	Replaced "Persons with Mental Retardation (MR)" with "Individuals with Intellectual Disabilities."
05/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
05/01/2013	5.1	Added process for obtaining Prior Approval under a 1915 (b)(c) waiver.
05/01/2013	3.3	Added reference to Diagnostic and Statistic Manual
05/01/2013	5.3	Added Comprehensive Functional Assessment - originally in section 7.0
05/01/2013	5.4	Added Individual Program Plan originally in section 7.0
05/01/2013	6.1	Added Facility Recertification – originally in section 7.0

Date	Section Revised	Change
05/01/2013	6.1	Added Initial Certification and Recertification—originally in section 7.0
05/01/2013	Attachment A	Made reference to Subsection 3.3
05/01/2013	Attachment B	Corrected title to The Developmental Disabilities Assistance and Bill of Rights Act of 2000.
05/01/2013	Table of Contents 6.2	Changed title to Initial Certification and Recertification for ICF/IID Level of Care
05/01/2013	3.3b	Corrected errors in spelling- Disorders, fourth
05/01/2013	5.1	Removed The Case manager must also sign the MR2 form. Added the following statement ‘The Level of Care Eligibility Determination Tool is valid for 30 calendar days from the date of the physician’s signature.’
05/01/2013	6.2	Changed title to Initial Certification and Recertification for ICF/IID Level of Care
05/01/2013	5.8	Clarified approving body for therapeutic leave
08/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
08/01/2014	All Sections and Attachments	Updated: DSM-IV to DSM-5 language
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Institutional Providers shall bill the applicable revenue codes.

B. International Classification of Diseases, 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.

Refer to **Subsection 3.3**

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

Revenue Code(s)
RC 100
RC 183

Unlisted Procedure or Service

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

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

F. Place of Service

ICF/IID services are provided in Intermediate Care Facilities.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

Medicaid beneficiaries that reside in an ICF/IID are excluded from co-payments.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

Reimbursement is at a per diem rate that is all inclusive except for medical and dental services.

Medicaid reimbursement to nursing facilities and intermediate care facilities is based on the facility's midnight census. Because payment can only be paid to one facility for each day of care, the date of admission is counted as the first day the beneficiary occupies a bed at the midnight census.

The date of discharge is counted as the last day the beneficiary occupies a bed at the midnight census. The discharge date is not considered a day of patient care and is not billable to Medicaid. This also applies to the date of death when it occurs prior to the midnight census. The date of death is not considered a day of patient care and is not billable to Medicaid. The only exception to this procedure is if the date of admission and the date of discharge (or the dates of death) occur on the same day.

Attachment B: Functional Limitations As Defined By The Developmental Disabilities Assistance and Bill of Rights Act of 2000

The federal government has defined developmental disabilities as disabilities that are chronic and attributable to mental and/or physical impairments, which are evident prior to age twenty-two. Such disabilities tend to be lifelong and result in substantial limitations in three or more of the following major life activities:

- a. **Self Care:** Daily activities that enable a person to meet basic life needs for eating, hygiene, grooming, health and personal safety. A substantial limitation occurs when a person needs assistance at least one-half the time for one activity, or needs some assistance in more than one-half of all activities normally required for self-care. Assistance is usually in the form of the intervention of another person directly or indirectly by prompts, reminding and/or supervising someone.
- b. **Receptive and Expressive Language:** Communication involving both verbal and nonverbal behaviors that enable the person both to understand others and to express ideas and information to others. The concept of language includes reading, writing, listening and speaking as well as the cognitive skills necessary for receptive language. A substantial limitation occurs when a person is unable to effectively communicate with another person without the aid of a third person, a person with a special skill, or a mechanical device, or is unable to articulate thoughts and/or to make ideas and wants known.
- c. **Learning:** General cognitive competence and ability to acquire new behaviors, perceptions and information and to apply previous experience in new situations. When a person requires special intervention or special programs to assist that person in learning a substantial limitation occurs. Children who meet the eligibility standard for infant/toddler or special education services or need significant special interventions such as assistive devices or special testing procedures in regular education programs in order to learn would have a functional limitation in learning.
- d. **Mobility:** Motor development and ability to use fine and gross motor skills. A substantial limitation occurs when the ability to use motor skills requires assistance of another person and/or a mechanical device in order for the person to perform age appropriate skills in two skill areas, or to move from place to place inside and/or outside the home.
- e. **Self-Direction:** Ability to make independent decisions regarding and to manage and control one's social and individual activities and/or in handling personal finances and or protecting one's own self interest. A substantial functional limitation occurs when a child is unable, at an age appropriate level, to make decisions and exercise judgment, behave in a socially acceptable manner, and/or act in his/her own interest. An adult may require direct or indirect assistance such as supervision by another person or counseling to successfully utilize these skills.
- f. **Capacity for Independent Living:** Maintain a full and varied life in one's own home and community. A child who is unable, at an age appropriate level, to assist with household chores, maintain appropriate roles and relationships with the family, use money, and/or use community resources has a substantial functional limitation in this are. The child requires more assistance to perform these activities than a typical child of the same chronological age. An adult displays a significant functional limitation when he or she requires assistance in the activities more than half the time.