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1.0 Description of the Service

TBI Long Term Residential Rehabilitation provides individualized rehabilitative services and supports for individuals 18 years and older with Traumatic Brain Injury (TBI). This service must be provided in a licensed Supervised Living facility (i.e., Group Home or Alternative Family Living [AFL] setting) of their choice to enable individuals to be active participants in their communities. TBI Long Term Residential Rehabilitation shall comply with home and community based service (HCBS) standards.

This service incorporates cognitive rehabilitation and therapeutic or rehabilitative programming in a home and community based setting. The service includes training and support for relearning skills, developing compensatory strategies and practicing new skills and for improvement of existing skills to assist the individual to complete activities of daily living and/or instrumental activities of daily living to the greatest level of independence possible. TBI Long Term Residential Rehabilitation includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety. Group services may be provided as long as goals/needs outlined within the Person Centered Plan (PCP) or Individual Support Plan (ISP) are able to be fully addressed. The person centered plan or individual support plan documents the supports needed based on the NC TBI Risk Support Needs Assessment, NC TBI Wellness Assessment, or a comparable TBI Assessment that addresses TBI-related Risk and TBI-related Wellness supports needs. Providers shall collaborate with the individual's other providers (existing and new), as relevant, to develop an integrated plan of care for individuals with Substance Use Disorder(s) or Mental Health needs.

Payments for TBI Long Term Residential Rehabilitation do not include payments for room and board or the cost of facility maintenance and upkeep.

Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs. The TBI Long Term Residential Rehabilitation provider forfeits billing on the same day when Respite is billed for more than 4 hours.

The cost associated with Therapeutic Leave is included in the per diem.

The provider of this service is responsible for providing or making provision for "first responder" crisis response on a 24/7/365 basis to individuals experiencing a crisis. Mobile Crisis Management can be utilized for Behavioral Health crisis when medically necessary.

Transportation to and from the residence and points of travel in the community (i.e., employment) 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.

TBI Long Term Residential Rehabilitation levels 1 and 2 are determined by evidence of the individual's support need as determined by the TBI Assessment tool. However, The TBI Assessment tool level is only one piece of evidence that may be considered.

LEVEL 1: Minimum - Moderate intervention and supervision - Individuals have the capacity to spend 25% - 50% of their time at home and/or community without active intervention or supervision from caregiver or staff member. Support needs related to behavior and medical may

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range from minimal to moderate. These behavioral needs are not extreme but are likely to require increased monitoring or intervention to address behavioral challenges such as prevention of outbursts, repeated inappropriate behaviors, and/or wandering.

Individuals require moderate levels of supervision and support in most settings such as in the community, home, work, etc. They often need moderate rehabilitative support to manage many aspects of their life. Needs related to training and support for relearning skills, developing compensatory strategies and practicing new skills and for improvement of existing skills to assist the individual to complete activities of daily living and/or instrumental activities of daily living to the greatest level of independence possible. Training, support and monitoring are usually moderate and will typically reflect an on-going schedule. When appropriate, assistive technology should be considered to maximize the individual’s independence. Rehabilitation goals for individuals in this level of service should receive interventions that support increasing independence, which could lead to a lower level of care.

LEVEL 2: High intervention and supervision - Individuals have the capacity to spend up to 25% of their time at home and/or community without active intervention or supervision from caregiver or staff member. Support needs related to behavior and medical may be high. Individuals in this category have behavior support needs that have resulted in multiple episodes of serious consequences such as but not limited to involvement of law enforcement, psychiatric hospitalizations, or professional medical attention. They often require intensive, proactive intervention from staff in one or more settings and also need staff with specialized training or specific characteristics. Individuals may also have mental health conditions. Individuals in this Level will need extensive support for critical and chronic behavioral, cognitive, and/or medical issues such as:

- Persistent Aggressive Behaviors
- Significant impairments in self-awareness
- Chronic Impulsivity
- Chronic Irritability/Frustration Tolerance
- Chronic Impaired Judgement
- Sexual Aggression
- Chronic Seizure management
- Medically related lifting and/or transferring
- Persistent physical or mental fatigue

Individuals require high levels of supervision and support in most settings such as in the community, home, work, etc. They often need high rehabilitative support to manage many aspects of their life. Needs related to training and support for relearning skills, developing compensatory strategies and practicing new skills and for improvement of existing skills to assist the individual to complete activities of daily living and/or instrumental activities of daily living to the greatest level of independence possible. Training, support and monitoring are usually high and will typically reflect an on-going schedule. Rehabilitation goals for individuals in this level of service should receive interventions that support increasing independence, which could lead to a lower level of care.

1.1 Definitions

Assistive Technology as a device can be any item or piece of equipment that helps a person with a disability increase, maintain, or improve their ability to function. Assistive Technology as a device can range from low-tech to high tech. Example of devices:

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Low-tech devices:

1. Wheelchair or cane
2. Handheld grabber for reaching items
3. Adaptive culinary utensils

High-tech device:

1. Hearing and visual aids
2. Software program on a computer/screen readers
3. A communication device

Note: Medical devices that are surgically implanted are not considered assistive technology devices

Assistive technology as a service can involve any combination of the following:

1. The evaluation of an individual's needs,
2. The acquiring of assistive technology devices (i. e. purchasing, leasing, or loaner programs)
3. The selection, fitting or repairing of a device
4. The training of individual or caregiver on how to use the assistive technology

Cognitive Rehabilitation - one-on-one therapy used for the development of thinking skills to improve functional abilities including but not limited to: attention, memory, and problem solving, and to help identify impaired thinking. The initial goal of therapy is to improve cognitive functioning to the fullest extent possible. Compensatory strategies are an integral part of this service.

Compensatory Strategies - strategies used to help an individual perform tasks in an alternative manner or by using adaptive aids so that they can be more independent.

First Responder - Paraprofessional or Qualified Professional who 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.

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 I/DD 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 TBI Long Term Residential Rehabilitation for an eligible individual who is 18 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

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- 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 TBI Long Term Residential Rehabilitation when ALL of the following criteria are met:

- a. The individual is 18 years of age or older,
AND
- b. The individual has a condition that is identified as a Traumatic Brain Injury condition as defined in G.S. 122-C-3(12a) or G.S. 122-C-3(38a)
AND
- c. The recipient is experiencing difficulties in at least one of the following areas due to a TBI:
 - 1. functional impairment in occupational, cognitive, physical and/or behavioral areas
 - 2. crisis intervention/diversion/aftercare needs, and/or
 - 3. at risk of placement in a nursing home or institution**AND**
- d. Any of the following apply:
 - 1. The individual meets at least one of the following:
 - i. At risk for out of home placement, hospitalization, and/or institutionalization due to symptoms associated with traumatic brain injury; and/or
 - ii. Presents with verbal and physical aggression due to symptoms associated with their diagnoses, which are sufficient to create functional problems in a community/home setting; and/or
 - iii. At risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with the diagnosis; and/or
 - iv. Requires a structured setting to foster successful community re-integration through individualized interventions and activities.**OR**
 - 2. The individual's current residential living situation meets any one of the following:
 - i. The individual has no residence.
 - ii. Current placement does not provide adequate structure and supervision to ensure safety
 - iii. Current placement does not provide adequate structure and supervision to ensure participation in treatment.
 - iv. Current placement involves relationships which undermine the stability of treatment.
 - v. Current placement limits opportunity for recovery, community integration and maximizing personal independence.

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3.2.2 Admission Criteria

A Psychological, Neuropsychological, or Psychiatric evaluation, supported by appropriate psychological/neuropsychological testing, that denotes a Developmental Disability, as defined by G.S. 122-C-3(12a) or a Traumatic Brain Injury condition as defined by G.S. 122-C-3(38a), must be completed by a qualified licensed professional prior to the provision of this service.

The following services and documentation must be submitted prior to the provision of this service:

- a. The following TBI Assessments:
 - 1. NC TBI Risk Support Needs Assessment and NC TBI Wellness Assessment, or
 - 2. Comparable TBI Assessment that address Risk and Wellness supports needs,

AND
- b. Comprehensive Clinical Assessment (CCA),

AND

- c. Physical Examination completed by a physician or physician assistant within one year prior to admission and annually thereafter.

AND

- d. Confirmed TBI condition or approved TBI Diagnostic Verification.

The CCA a Comprehensive Clinical Assessment process must include the completion of the NC TBI Risk Support Needs Assessment and the NC TBI Wellness Assessment or a comparable TBI Assessment that addresses both TBI-related risk and TBI-related wellness support needs. The assessment(s) assist in the clinical evaluation of the extent and severity of the brain injury and the identification of rehabilitation goals. The assessment(s) shall also include information on the specific functional limitations the individual is experiencing. The assessment(s) should be updated, at a minimum, of annually and as new strengths and barriers are observed in the residential setting. Relevant diagnostic information must be obtained and be included in the Person-Centered Plan.

TBI Assessment(s) Link information:

<https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/traumatic-brain-injury>

Relevant clinical information must be obtained and documented in the individual's Person-Centered Plan or Individual Service Plan.

The individual requires this service to relearn skills, develop compensatory skills, practice new skills and improve existing skills to assist the individual to complete activities of daily living and/or instrumental activities of daily living to their greatest level of independence possible. Evidence of exploration (e.g., case notes, electronic communication with providers, provider denials, etc.) of alternative community based services should occur prior to the provision of TBI Long Term Residential Rehabilitation services.

Prior authorization by the LME-MCO is required. A service authorization request must be completed by a Qualified Professional and submitted to the LME-MCO prior to services.

3.2.3 Continued Stay Criteria

The individual continues to require this service to relearn skills, develop compensatory strategies and practice new skills and improve existing skills to assist the individual to complete activities of daily living and/or instrumental activities of daily living to their greatest level of independence possible.

TBI Long Term Residential Rehabilitation 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 individual has achieved initial service plan goals and additional goals are indicated;

OR

- b. The individual has documentation to support it can be reasonably anticipated that regression is likely to occur if the service is withdrawn based on current clinical assessment, and history, or the tenuous nature of the functional gains;

OR

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

OR

- d. The individual is making some progress, but the service plan (specific interventions) need to be modified so that greater gains consistent to their premorbid level of functioning are possible or can be achieved.

OR

- e. The individual is not making progress; the service plan must be modified to identify more effective interventions.

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.

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The person centered planning team should document an agreed upon discharge plan within the PCP or ISP.

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

None that apply.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State Funded TBI Long Term Residential Rehabilitation 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 TBI Long Term Residential Rehabilitation are rendered. Refer to Subsection 5.4 of this policy.

Providers shall collaborate with the individual's other providers (existing and new), as relevant, to develop an integrated plan of care for individuals with Substance Use Disorder(s) or Mental Health needs.

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 relevant 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 rehabilitative or support goals to the degree detailed in the individual's PCP or ISP. The goals should be designed to

support with increasing individual's level of independence; therefore rehabilitative goals for individuals with TBI should be a minimum 75% of goals noted within the plan. 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, SIS evaluation and/or SNAP evaluation, or TBI assessment where applicable, 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 14-days prior to the end date of the individual's active authorization. Reauthorization is based on medical necessity documented in the updated PCP or ISP, the authorization request form, and supporting documentation to include a current SNAP, SIS or TBI assessment, where applicable. The duration and frequency at which TBI Long Term Residential Rehabilitation is provided must be based on medical necessity and progress made by the individual toward goals outlined in the PCP or ISP.

If medical necessity dictates the need for increased service duration and frequency, clinical consideration must be given to other services and 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. 143B-147(a)(9) and Rules10A NCAC27I .0601-.0609.

5.3 Additional Limitations or Requirements

- a. If an individual is in high school transportation to and from a school setting is not covered and is the responsibility of the school system.
- b. 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.
- c. Only one TBI Long Term Residential Rehabilitation provider can provide this service to an individual at a time.
- d. This service may not be provided at the same time as any other residential State-funded or Medicaid-funded Service that works directly with the individual.

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- e. Relatives may not provide TBI Long Term Residential Rehabilitation service to family members.
- f. Relatives who own provider agencies may not provide TBI Long Term Residential Rehabilitation services to family members. Other staff employed by the provider agency may provide other services to the individual.
- g. Individuals who receive TBI Long Term Residential Rehabilitation may not receive State Funded or Medicaid Funded Community Living and Supports, Supported Living Periodic, Developmental Therapy, State Funded Personal Care Services and Personal Assistance.
- h. The TBI Long Term Residential Rehabilitation provider forfeits billing on the same day when Respite is billed for more than 4 hours.
- i. TBI Long Term Residential Rehabilitation cannot be used to purchase Assistive Technology Equipment & Supplies.
- j. Assistive Technology Equipment & Supplies may be accessed only when the item belongs to the individual and can transition to other settings with the individual.
- k. Assistive Technology Equipment & Supplies may not be used to supplant staff but where required by rule, utilized to support the individual's independence.
- l. Individuals receiving this service may not be an HCBS Waiver member/beneficiary or an individual receiving Medicaid funded residential services, inclusive of Medicaid ICF-IID In Lieu of Services (ILOS) with a residential component.
- m. This service is not available at the same time of day as State Plan Psychosocial Rehabilitation Services, State Funded Day Activity, Adult Day Vocational Program and State Funded and Medicaid Funded Day Supports.
- n. Payments for TBI Long Term Residential Rehabilitation do not include payments for room and board or the cost of facility maintenance and upkeep.
- o. The cost associated with Therapeutic Leave is included in the per diem.
- p. This service is a daily 24/7 service.

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 qualified professional, physician, licensed psychologist, physician assistant, or nurse practitioner, per the individual's 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

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- 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.

5.5.1 Contents of a Service Record

For this service, a full service note or service grid for each contact or intervention for each date of service. More than one intervention, activity, or goal may be reported in one service note, if applicable. The minimum requirements must include ALL of the following elements:

- a. Name of the individual on each page;
- b. The service record number or unique identifier on each page;
- c. Date [month/year] that the service was provided;
- d. Name of the service being provided on each page [e.g., TBI Long Term Residential Rehabilitation.
- e. Goals addressed;
- f. A number or letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed;
- g. A number/letter/symbol as specified in the appropriate key that reflects the assessment of the individual’s progress toward goals;
- h. Duration;
- i. Initials of the individual providing the service – the initials shall correspond to a full signature and initials on the signature log section of the note/grid; and
- j. A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the individual’s response to the interventions provided and progress toward goals. Each entry in the comment section must be dated.

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; and
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement.

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6.1 Provider Qualifications and Occupational Licensing Entity Regulations

State Funded TBI Long Term Residential Rehabilitation 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 contracted with 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.

State Funded TBI Long Term Residential Rehabilitation 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.

TBI Long Term Residential Rehabilitation providers:

- a. Help individual reengage and develop community involvement and relationships that promote full citizenship,
- b. Coordinate education and assistance related to relearning finances, healthcare, and other needs,
- c. Assist with day-to-day planning and problem solving,
- d. Train and support people who assist the individual incidental to the PCP,
- e. Train and support individuals on relearning accessing public transportation,
- f. Train and support individuals with relearning skill acquisition related to interpersonal skill development, independent living, community living, self-care, and self-determination,
- g. Assist with the individual functional impairment in occupational, cognitive, physical and/or behavioral areas.

6.2 Provider Certifications

TBI Long Term Residential Rehabilitation must be provided by an agency with experience working with the TBI population 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 TBI Long Term Residential Rehabilitation service is provided by qualified providers with the capacity and adequate workforce to offer this service to individuals meeting the I/DD state-funded Benefit Plan. The service must be available during times that meet the needs of the

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individual which may include evening, weekends, or both. The service must have designated competent developmental disability and/or traumatic brain injury qualified professionals to provide supervision to the paraprofessional. The TBI Long Term Residential Rehabilitation paraprofessional must meet the requirements according to 10A NCAC 27G .0104 (15).

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.

The maximum program staff ratios are as follows:

Level 1: Group ratio for TBI Long Term Residential Rehabilitation is 1 (one) Paraprofessional to no more than 3 (three) Individuals.

Level 2: Group ratio for TBI Long Term Residential Rehabilitation is 2 (two) Paraprofessionals to no more than 3 (three) Individuals.

6.2.2 Staff Training Requirements

The provider shall ensure that staff who are providing TBI Long Term Residential Rehabilitation have completed TBI special population training based on staff experience and training needs (e.g., intellectual and developmental disabilities, geriatric, traumatic brain injury, deaf and hard of hearing, co-occurring intellectual and mental health and co-occurring intellectual and developmental disabilities and substance use disorder) as required. Such training should be completed prior to working with individuals and updated as individuals' needs change.

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 Personnel Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with person/s must be qualified in the customized needs of the individual 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).

Time Frame	Training Required	Who	Total Minimum Hours Required
Within 30 calendar days of hire to provide service	<ul style="list-style-type: none"> ✦ 1.5 hours of Introduction to Traumatic Brain Injury training ✦ 3 hours of Crisis Response training, with at least 1 hour of training on supporting individuals with brain injury experiencing crisis ✦ 2 hours of Substance Use and Traumatic Brain Injury Training ✦ 1.5 hours of behavioral and cognitive challenges associated with traumatic brain injury 	All Staff	8 hours
Time Frame	Training Required	Who	Total Minimum Hours Required
Within 12 months of hire to provide service	<ul style="list-style-type: none"> ✦ Certified Brain Injury Specialist (CBIS) Training Certification 	QP	Successful completion of training and exam
Annually	<ul style="list-style-type: none"> ✦ 3 hours of Crisis Response Training, with at least 1 hour of training on supporting individuals with brain injury experiencing crisis ✦ 10 hours of continuing education in evidence based and promising treatment practices, with at least 5 hours focusing specifically on working with an individual with TBI 	All Staff	13 hours
Annually	<ul style="list-style-type: none"> ✦ CBIS Certification Continued Education 	QP	10 hours

Professional Competency

Paraprofessionals have competencies through training and supervision 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.
- 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 TBI Long Term Residential Rehabilitation including the following:

- 1. To independently complete life skills and independent living skills to the greatest extent possible,
- 2. Maximize self-sufficiency,
- 3. Increase self-determination, and
- 4. Ensure the individual's opportunity to have full membership in their community as defined within the PCP and ISP goals.

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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:

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
YM849	Level 1	1 unit = daily rate
YM853	Level 2	1 unit = daily rate

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

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).

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Units are billed at a daily rate.

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 TBI Long Term Residential Rehabilitation 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. The site must be the primary residence of the AFL provider who receive reimbursement for the cost of care. These sites are accordance with state rule.

5600 Supervised Living facilities that meet the individualized needs of the individual.

- 4 beds or less for newly developed facilities; 6 beds or more for existing facilities

This service is not Medicaid billable.

G. Co-payments

Not applicable

H. Reimbursement

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

Note: DMH/DD/SAS will not reimburse for conversion therapy.