North Carolina Utilization Management Guideline for Medicaid

Subject: In Lieu of Service: Family Navigator **Current Effective Date:** 12/01/2026

Status: Active **Last Review Date:** 09/24/2026

Description

Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) | Healthy Blue® Care Together | Medicaid

I/DD (Intellectual/Developmental Disability) and TBI (Traumatic Brain Injury) Family Navigators (I/DD/TBI/FNs) provide or assist a family, caregiver, or self-advocate with an array of formal and informal services and supports provided to individual or families who are experiencing social, medical, health care, emotional, developmental, physical, intellectual, and/or behavioral challenges in their home, school, living arrangement, and/or community. I/DD/TBI/FNs provide a structured, strength-based relationship between an FN and the family, caregiver, or member for the benefit of the member.

Healthy Blue Care Together anticipates receiving referrals for individuals deemed to be at significant risk of placement due to complex needs and a lack of Medicaid funding services for Individuals with Intellectual and Developmental Disability (I/DD) and/or Traumatic Brain Injury (TBI). Medicaid beneficiaries and their families often have a difficult time accessing or navigating health care and other systems because they are not designed to best support this population's unique needs. Family Navigators can assist members and families to navigate these challenges and to understand the changes in systems through lived experience. North Carolina already offers this for adults who experience mental health and substance use disorders using a peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience I/DD or TBI.

Purpose: The purpose of the service is to support individuals with Intellectual or Developmental Disability or TBI, so they can achieve their full potential and are able to live successfully in their community.

Setting: Family Navigator services can be provided in an individual or group setting (in person or via telephone or through advanced telehealth technology).

Family Navigator can provide outreach and promote member engagement to reduce the need for crisis services and stop the cycle of admission and readmissions to emergency departments and to higher levels of care or out-of-home services in residential or institutional restrictive settings.

Family Navigator is a way of working with children, adolescents, and adults with an I/DD or

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TBI diagnosis and who are experiencing challenges navigating the systems that can provide support for the health and well-being of this population. Family Navigator is a critical element of the habilitation model as it allows flexibility to meet members' particular needs in their own environment or current location (i.e. home, hospitals, jail, shelter, streets, etc.) using a variety of methods.

Clinical Indications

Family Navigator services are medically necessary when a member with I/DD or TBI experiences barriers to accessing, navigating, engaging in, or maintaining needed health care and community-based services and supports, and Family Navigator intervention is expected to improve access, engagement, continuity of care, community stability, or the member's/family's ability to independently navigate systems of care.

Utilization Management:

Prior Authorization (PA) is required. Initial authorizations are typically 60 days with anticipated units per month of 40 units (80 units for 60 days); 1 unit =15 minutes.

Submit the following documents with the initial authorization request:

- Prior Authorization Request (PAR) form
- A comprehensive clinical assessment (CCA), or equivalent assessment that reflects the current level of functioning, and contains all the required elements outlined in community practice standards, as well as in state and federal requirements, and also demonstrates medical necessity. Clinical assessment must be completed by a licensed clinician prior to the provision of this service.
- PCP including Crisis/Safety Plan
- Service Order is required and must be written by a Medical Doctor (MD), Doctor of Osteopathic Medicine (OD), Licensed Psychologist, Nurse Practitioner (NP), or Physician Assistant

  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 initiated. Even if the beneficiary is retroactively eligible for Medicaid, the provider shall not bill Medicaid without a valid service order; and
  d. Service orders are valid for one calendar year. Medical necessity must be reviewed

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and service must be ordered at least annually, based on the date of the original PCP.

Continued Stay/Re-Authorization:

Submit:

- Updated PAR (Prior Authorization Request)
- Updated Person-Centered Plan
- Medical necessity rationale
- Discharge plan to include how discharge planning is being coordinated with Healthy Blue Care Together Care Manager

Eligibility/Entrance Criteria: ALL must be met

To be eligible for Family Navigator services, the individual must be enrolled in NC Medicaid and the Children and Families Specialty Plan (CFSP), administered by Healthy Blue Care Together, and meet the following service-specific eligibility criteria:

1. Member is 3 through 26 years of age and up to 64 during Phase 2 Implementation
2. Member has a documented diagnosis of Intellectual/Developmental Disability (I/DD) or Traumatic Brain Injury (TBI).
3. Member experiences barriers to accessing or effectively navigating needed services and supports due to challenges navigating complex systems resulting in inadequate access to medical, educational, vocational, behavioral, nutritional or other services.
4. Family Navigator services are medically appropriate and are expected to address the identified navigation, engagement, advocacy, community-integration, or support needs.
5. The requested services are not duplicative of another Medicaid-covered service.
6. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards;
7. The beneficiary has documented identified needs, in at least ONE or more of the following areas (related to diagnosis):
   1. Acquisition of skills needed to manage symptoms and utilize school-based and/or community resources;
   2. Assistance needed to develop family and self-advocacy skills to achieve decreased dependency on the mental health system;
   3. Assistance and support needed to prepare for a successful work experience or to maintain successful school/educational functioning;
   4. Family Navigator modeling needed to take increased responsibilities for his or her own goal attainment; or

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5. Family Navigator resource linkage supports needed to develop or maintain daily living skills to support and maintain stability in his or her home and community settings.

Note: Indicators of need may include, but are not limited to: ED utilization/boarding, crisis-service utilization, risk of institutional/out-of-home placement, disruption of the home setting, difficulty accessing medical/educational/vocational/behavioral/nutritional resources, lack of adequate natural supports, etc.

Continued Stay Criteria: The beneficiary meets criteria for continued stay if any 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 beneficiary's PCP;
b. The beneficiary continues to be at risk for relapse 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 beneficiary's progress toward goals within the beneficiary's PCP.

This service is intended to be short-term, transitional, and support-focused.

Note: The Family Navigator is expected to coordinate with the Healthy Blue Care Together Care Manager throughout the duration of service and keep the Care Manager informed of discharge and transition planning. Continued stay requests must include documentation demonstrating these care coordination and discharge/transition planning efforts. Submit documentation to indicate how discharge planning is being coordinated with Healthy Blue Care Together Care Manager.

Transition and Discharge Criteria: The beneficiary meets the criteria for discharge if any ONE of the following applies:
a. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to link to identified services and supports;
b. The beneficiary has achieved positive life outcomes that support stable and ongoing needs and is no longer in need of Family Navigator Services;
c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or
d. The beneficiary chooses to withdraw from Family Navigator Services or the legally responsible person(s) chooses to withdraw the beneficiary from services.

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Concurrent/continued stay authorization is based on the member's assessed needs, progress toward individualized goals, and continued medical necessity. The anticipated duration of Family Navigator services is six months; however, authorization decisions are based on the member's individual circumstances and continued need for the service. Continued stay authorization may be supported when the member continues to demonstrate a need for Family Navigator intervention and documentation demonstrates progress toward, or continued need related to, one or more individualized outcomes, including improved access to needed services and supports; increased engagement; improved ability to navigate systems; development or strengthening of natural supports; maintenance of community stability; or reduction of risk for crisis, institutional, or other restrictive service utilization.

Additional Medical Necessity Criteria:
General Criteria Covered: Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:
a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

Service Exclusions, Additional Limitations and Requirements:

Family Navigator services may not be provided during the same authorization period as the following:

1. Child Focused-Assertive Community Treatment Team (CF-ACTT)
2. Assertive Community Treatment Team (ACTT)
3. Community Support Team (CST)

Family Navigator services may not be provided at the same time that the following services are provided:

1. Substance Abuse Intensive Outpatient (SAIOP)
2. Substance Abuse Comprehensive Outpatient Treatment (SACOT)
3. Partial Hospitalization
4. Psychosocial Rehabilitation

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5. Respite

- Family Navigator services may not duplicate other Medicaid-covered services the beneficiary is receiving.
- A beneficiary may receive Family Navigator services from only one provider organization during an active authorization period. A change in provider requires a new authorization request.
- Family members or legally responsible persons may not provide Family Navigator services to the beneficiary.
- Transportation of a beneficiary is not covered as a component for this policy. Any provision of services provided to a beneficiary during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided. This limitation does not impact a beneficiary's ability to access non-emergency medical transportation (NEMT).

Note: Family Navigator service is not a "first responder" service. As documented in the beneficiary's PCP Comprehensive Prevention and Intervention Crisis Plan, the Family Navigator provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response. A documented discharge plan must be discussed with the beneficiary and documented in the service record.

Documentation Requirements: The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, 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 Medicaid. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for the staff member who provided the service.

Contents of a Service Note: 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. Beneficiary's name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (in person, telehealth or telephonic, audio-only communication);

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f. Place of service;
g. Purpose of contact as it relates to the PCP goals:
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, Qualified Professional 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, experimental, or investigational.
2. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements:
1. If the service, product, or procedure requires prior approval, the fact that the beneficiary

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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.

Program Requirements

The Family Navigator service encompasses three primary service areas, each offering a range of functions tailored to the individualized needs of members and families: Family/Self-Advocacy, Outreach and Information, and Community Connections and Natural Supports.

1. Family/Self Advocate Skills

- Assist members and families during life transitions by educating them about systems, processes, and resources, as well as how to navigate them.
- Support, when needed, communication between families/members and providers to ensure needs are adequately met in a timely fashion.
- Provide resources for members and their families to reduce isolation and address feelings of stigma, blame, and hopelessness.
- Assist members and families in identifying and contacting service providers with expertise in working with individuals with intellectual/developmental disabilities (I/DD).
- Help members and families prepare for meetings and accompany them when needed.

2. Outreach and Information

- Provide outreach and education to members and families about various funding sources available to them.
- Answer “Warm Line” calls from members and families seeking information.
- Supply resource materials and directories to help members and families identify relevant services and resources.
- Conduct outreach and engage with members and families to ensure provided information meets their needs and supports progress.
- Inform members and families about grievance and appeals processes for specific agencies.
- Perform outreach within the community to raise awareness, reduce stigma, and encourage member/family engagement with services.

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3. Community Connections and Natural Supports

- Facilitate meetings and connections with members and families to promote self-care, strengthen social connections, and decrease isolation.
- Assist members and families with identifying, connecting, and/or reconnecting to natural supports for community participation and integration.
- Encourage connections between members, families, and others with similar life experiences.
- Network and collaborate with community partners to create resources that address unmet needs.
- Support families and/or self-advocates in identifying and participating in leisure and recreational activities in their communities

Important Note: The specific Family Navigator functions authorized and delivered must be individualized to the member's assessed needs and identified goals. A member is not required to receive services within all three service areas.

Family Navigator Services are designed as a short-term (6 months) outreach and engagement service targeted to populations or specific member circumstances that prevent the individual from fully participating in needed care for intellectual or developmental disability or traumatic brain injury.

Many individuals in need of Family Navigator services are waiting for funding for Innovations Waiver services or who reside in an institutional setting or who are unable to navigate systems to gain adequate access to medical, educational, vocational, behavioral, nutritional or other entitlements without the lived experience of a family navigator to support and assist them.

These individuals have a higher-than-average potential to go into crisis and long-term care settings because of not receiving an adequate level of services and supports despite having Medicaid. These members will likely experience one or more of the following:

- Present at a local emergency department with a high level of needs with no other services available resulting in ED boarding for extended periods of time.

- Creates a disruption in the home setting without adequate supports, for children this often leads to foster care placement.

- Contact crisis services such as NC START, mobile crisis or emergency services for

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assistance on an ongoing basis.

- Be placed under an IVC or admitted to an inpatient hospital setting either at a community-based hospital or a state psychiatric hospital and have nowhere to return if discharged.

- Adults often end up living in adult care homes, nursing homes or family care homes at a very young age due to lack of services and support. Family Navigator's network and collaborate with community partners to create resources that address unmet needs.

Provider and Staffing Requirements

Family Navigator Provider Requirements:

- Provider Agencies must be approved and contracted with Healthy Blue Care Together.
- To be eligible to bill for the service described in this policy, the provider(s) shall:
    1. Meet Medicaid qualifications for participation.
    2. Have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
    3. Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.
- Direct care providers shall meet the competencies and supervision requirements as specified in 10A NCAC 27G .0202 and .0204.

Family Navigator Provider Qualifications and Exclusions:

Qualifications: The Family Navigator Service must be delivered by Family Navigators. To be eligible as a Family Navigator, the applicant must:

- Have personal experience providing care to a loved one with I/DD or TBI or be a person with lived experience with Intellectual or Developmental Disability or TBI.
- Have a high school diploma or GED
- Complete the approved training for the Family Navigator Role from an authorized training source
- Provide services based on their training and their unique qualifications to work with individuals and families.

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Provider Exclusions:

- The applicant cannot work for the same agency/organization they are currently receiving services from.
- The applicant cannot provide services to self, their child(ren) and/or a family member.
- The applicant cannot currently be receiving Family Navigator services.

Note: Providers of Family Navigator services must comply with the current NC Medicaid/DHHS Clinical Coverage Policy 8G, Peer Support Services applicable telehealth, telephonic service delivery, and documentation requirements. Upon promulgation and effective date of an amended CCP 8G, providers must comply with the applicable telehealth, telephonic service delivery, and documentation requirements of the amended policy.

Credentialing Requirements

Provider organizations are responsible for:

- Completing primary-source verification of the Family Navigator's education and verifying applicable experience.
- Making the final determination of whether the individual qualifies as a paraprofessional, associate professional, or qualified professional, as applicable.
- Following all applicable agency policies and procedures and North Carolina General Statutes.
- Ensuring Family Navigator staff possess the knowledge, skills, and abilities required to serve the applicable population and age group.

Clinical Supervisor Requirements

Supervisors of Family Navigators must:

- Meet the qualifications of a **Qualified Professional (QP)**.
- Have documented lived experience as a family member of an individual with I/DD or TBI, **or** be a QP with lived experience with I/DD.

Administrative Supervision Requirements

- All Family Navigator team members must receive ongoing clinical and administrative supervision from team leadership, with the **Team Leader serving as the primary clinical supervisor**.

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- The frequency and type of supervision will be based on the staff member's licensure and applicable supervision requirements.
- **Non-licensed staff must receive scheduled individual or group supervision at least biweekly.**

Training Requirements

Family Navigators must complete:

- **Family Partner 101**, provided by **NC Families United — 24 hours**.
- **24 total hours of initial training**.
- An additional **16 hours of Peer-to-Peer Training six months after hire**.
- Any additional training required by the provider agency or other applicable entities, as appropriate, to fulfill the duties and responsibilities of the position.

Coding			
Procedure Code	**Service Description**	**Rate**	**Billing Frequency**
T2041 U5	Family Navigator	Based on Fee Schedule or Contract	1 unit = 15 min

Discussion/General Information

Healthy Blue Care Together recognizes that individuals with Intellectual/Developmental Disabilities (I/DD) and Traumatic Brain Injury (TBI) experience significant health disparities and inequities due to stigma, marginalization, and systemic barriers to care. These inequities often result in delayed or limited access to medically necessary, clinically appropriate services, leading to poorer health outcomes and increased reliance on crisis and institutional services.

Healthy Blue Care Together is committed to advancing health equity by ensuring that the Family Navigator In Lieu of Service (ILOS) is designed and implemented in a manner that reduces disparities, addresses social drivers of health, and promotes equitable access and outcomes for all members.

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By embedding health equity principles into the design and delivery of the Family Navigator ILOS, we will reduce systemic barriers, advance culturally responsive care, and ensure that members with I/DD and TBI receive equitable opportunities to achieve their highest level of health and well-being.

Data-Driven Identification of Disparities

- Healthy Blue Care Together will stratify data by race, ethnicity, geography, language, disability status, and social determinants of health to identify inequities in access, service utilization, and outcomes for members with I/DD and TBI.
- Findings will inform targeted outreach and interventions to address gaps in care.

Equitable Access and Outreach

- Outreach will specifically target historically marginalized populations, including rural residents, racial/ethnic minorities, and non-English-speaking households, to ensure equitable engagement.

Anticipated Outcomes:

Members are expected to achieve one or more of the following outcomes:

- Members become engaged and involved through increased effective access to all community systems of support (i.e. access to health care, access to education, access to vocational services, access to benefits, etc.)
- Members develop and/or maintain meaningful engagement in services that meet their needs.
- Member's use of hospital services (inpatient/ED) is avoided or reduced in frequency and duration.
- Member's use of crisis services (mobile crisis) is avoided or less frequent.
- Member's need for out-of-home residential or treatment services is avoided.
- Member's access to medical services and annual physical and dental exams are increased.

Reason the service is needed/Gap service intends to fill:

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There is a gap in access to care for this population (I/DD and TBI) who have complex needs. Family Navigator can provide outreach and promote member engagement to reduce the need for crisis services and stop the cycle of admission and re-admissions to Emergency Departments and to higher levels of care or out of home services in residential or institutional restrictive settings.

How is the service different than any State Plan Service?

This service is different than State Plan services because its central component is to maintain continuity of care for individuals with I/DD and TBI. This in turn serves to reduce admission to institutional and other out-of-home placements. Significant improvement in coping skills and quality of life results. Individuals who experience I/DD and TBI also present unique and individualized challenges that the Family Navigator service seeks to mitigate.

Definitions

Intellectual or Developmental Disability (I/DD): A severe, chronic disability attributed to a cognitive or physical impairment, or a combination of cognitive and physical impairments diagnosed or that manifests before 22 years of age. The condition is likely to continue indefinitely and substantially impact the beneficiary's functioning in three or more of the following areas of major life activity:
a. Self-care;
b. Receptive and expressive language;
c. Learning;
d. Mobility;
e. Self-direction;
f. Capacity for independent living; or
g. Economic self-sufficiency.

Traumatic Brain Injury (TBI): An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all of the following criteria:
a. involves an open or closed head injury;
b. resulted from a single event or resulted from a series of events which many include multiple concussions;
c. occurs with or without a loss of consciousness at the time of injury;

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d. results in impairments in one or more areas of the following functions: cognition, language, memory, attention, reasoning, abstract thinking, judgement, problem solving, sensory, perceptual, and motor abilities, psychosocial behavior, physical functions, information processing, and speech; and
e. does not include brain injuries that are congenital or degenerative.

In Lieu of Services (ILOS): Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

Acronyms

ILOS: In Lieu of Services
CCP: Clinical Coverage Policy
CCA: Comprehensive Clinical Assessment
PCP: Person Centered Plan
TBI: Traumatic Brain Injury
I/DD: Intellectual/Developmental Disability

References

Centers for Medicare & Medicaid Services. (n.d.). *In Lieu of Services and Settings (ILOS).* Federal guidance pursuant to 42 C.F.R. § 438.3(e)(2) and 42 C.F.R. § 438.6.NC

NC Medicaid/DHHS Clinical Coverage Policy 8G- Peer Support Services (Amended Date: January 1, 2025).

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C

DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) Items 1 through 12, under Contents of a Service Note, Chapter 7 of the RMDM.

Websites for Additional Information

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NC Tracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

History

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Draft	08/10/2026	Revised
Approved	09/24/2026	Approved by Medical Operation Committee (MOC)

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