Subject: ILOS – Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH Diagnosis

Current Effective Date: 02/10/2026

Status: Active

Last Review Date: 02/10/2026

Description

Residential Services for Individuals with Complex Needs provides short-term residential treatment for children with intellectual and developmental disabilities (IDD) and co-occurring mental health (MH) conditions. These services focus on treating individuals with complex presentations using a multi-disciplinary approach by staff trained to manage IDD, mental health issues, and severe behaviors. Eligible candidates are children and young adults, ages 5 to 21, with either a primary MH diagnosis alongside an IDD diagnosis or borderline intellectual functioning, or a primary IDD diagnosis with a co-occurring MH condition.

A current Comprehensive Clinical Assessment must indicate that residential care is necessary, as home or office-based therapies have been ineffective or inappropriate. The individual's symptoms and behaviors in settings such as home, school, or the community must be due to their MH or IDD condition, exhibiting moderate to severe issues that require intensive clinical interventions. The beneficiary must demonstrate issues in at least two major life areas, affecting their behavioral health needs, such as housing stability, education continuity, employment retention, social skills, significant aggression, or safety risks at home.

Additionally, involvement with the Department of Social Services, Department of Juvenile Justice, or the Exceptional Children's Program may also indicate eligibility. Imminent risk of out-of-home placement and recent access to crisis services are further considerations. Lastly, there should be no evidence that alternative interventions, based on North Carolina's community practice standards and best practice guidelines, would be equally or more effective.

Residential Services – Complex Needs aim to provide integrated treatment interventions within a Residential Level III group home setting, supported by a team specializing in individuals with IDD and co-occurring mental health diagnoses. The treatment is personalized, incorporating behavioral plans and actively engaging families or caregivers to apply strategies at home. Comprehensive coordination with schools, employers, and healthcare providers ensures a holistic approach. The focus is on strategic planning and enhancing natural support structures to sustain progress beyond residential care. Emphasis is placed on education, vocational development, and community involvement, while adopting a trauma-informed approach to foster positive treatment experiences, considering the past

experiences of individuals.

- Must have NC Medicaid coverage
- Must have dual diagnoses (Intellectual/Developmental Disability and Mental Health) with high-level behavioral needs.
- Must have experienced multiple placements AND
- Must have difficulty functioning in community settings.

Clinical Indications

Residential – Complex Needs is an In Lieu Of Service (ILOS) for individuals ages 5–21 with significant behavioral health or developmental challenges, requiring structured residential treatment and intensive support. This service is reimbursed on a per diem basis and adheres to plan-specific utilization management and medical necessity criteria.

The anticipated outcomes include reducing behaviors that necessitate this care level, improving skill development, decreasing crisis episodes and mental health symptoms, and transitioning back to family or less restrictive settings within six months. Progress is also expected in standard outcome measures during and after treatment, as well as in school or work, as evidenced by progress notes and reviews.

Entrance Criteria: Individuals ages 5–21 with a behavioral health disorder or intellectual developmental disability showing high complexity must require 24/7 supervised residential care when less intensive services are inadequate. Medical necessity must be supported by a Comprehensive Clinical Assessment (CCA), an active crisis plan, and a Person-Centered Plan (PCP) outlining goals and transition planning. Family and cultural interventions are involved as appropriate.

Continued Stay Criteria: Members must still meet the entrance criteria and require residential care, showing documented progress towards PCP goals or justified adjustments if progress is limited. Continuous risk factors need residential care, with active discharge planning detailing step-down criteria and community reintegration measures. All documentation must remain current.

Discharge Criteria: Substantial goal achievement with stable function allows for transition to less

intensive care. The service is deemed unnecessary or a different care level is suitable, or the member disengages after outreach efforts. Additionally, discharge may occur due to loss of eligibility or persistent nonresponse prompting alternative care.

Pre-Authorization/Entrance Requirements:

- Authorization: Required from day 1 for an initial period of up to 60 days.

- Documentation: Submit the following:
  - Complete Service Authorization Request (SAR)
  - Comprehensive Clinical Assessment (CCA) justifying medical necessity and structured residential treatment, including a crisis/safety plan.
  - Recent Psychological Evaluation with intellectual and adaptive behavior assessments.
  - Person-Centered or Care Plan with measurable goals, schedule, and discharge planning from day 1.
  - Service Order signed by a qualified healthcare provider.
  - Crisis/Safety Plan.

- Assessments within First 30 Days:
  - Checklist of Adaptive Living Skills (CALS) assessment
  - Functional behavior and preference assessments
  - Additional required assessments

Continued Stay/Re-Authorization Requirements:

- Reauthorization: Up to an additional 60 days.
- Documentation: Submit the following:
  - Updated SAR, PCP, and CCA (if significant changes).
  - Recent CALS, functional behavior, and preference assessments.
  - All completed assessments.
  - Service notes as per RMDM 45-2.
  - Updated Crisis and Discharge plans

Note: Service duration targets 120 days.

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Concurrent Services:

This service is designed to be comprehensive, eliminating the need for additional services until 60 days before discharge. However, certain services may be authorized concurrently by the Utilization Management team if clinically appropriate and coordinated in the plan.

Outpatient Services:

- **Psychiatric Services**: Established psychiatric providers may continue if a transfer is contraindicated.
- **Outpatient Therapy**: Residential services primarily provide therapy, but specialized therapy may be approved based on individual needs.
- **Psychological Testing**: If needed, updated testing can be billed separately, excluding routine screenings and ongoing assessments expected during psychologist involvement.

Crisis Services:

- **Mobile Crisis Management**: Licensed clinicians must provide initial assessments. If further help is needed, mobile crisis teams can assist in diverting from inpatient care.
- **Inpatient Admission**: Although proactive strategies aim to reduce inpatient needs, this service is available if the member poses an imminent risk to self or others and other interventions have failed.

Documentation:

These services shall be properly and contemporaneously documented in accordance with this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM).

Providers shall make all documentation supporting claims for services reimbursed available to Healthy Blue Care Together, NCDHHS and CMS upon request.

A complete service note is required for every contact or intervention, such as individual sessions or crisis responses, in accordance with APSM 45-2. Each note must include: the member's name,

service record number, Medicaid ID (if applicable), service name, full date and place of service, type of contact, purpose related to care plan goals, description of interventions, duration, assessment of intervention effectiveness or progress, and the signature and credentials of the service provider. From admission, all discharge planning and transition activities should be documented with the youth, family, and care team. A discharge plan must be discussed with the individual and included in the service record.

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 is under 21 years of age does **not** eliminate the requirement for prior approval.

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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

Provider Organization Requirements: Providers must be enrolled in NC Tracks and is provided by organizations accredited and have a NCDHSR license as a small group home provider, .1700, 5600b, or 5600c and have an active contract to provide the service with Healthy Blue Care Together.

The staffing requirements by age/disability for residential services outline that there must always be at least one Qualified Professional and an additional Associate or Paraprofessional with two years of experience with the population available. Training in a standardized program for working with individuals with dual diagnoses must be completed within six months of operation. Two awake staff members must be present whenever two or more individuals are in the home, including during sleep hours. A Licensed Clinician must be on hand for crisis response and can call on a Doctoral Level Psychologist if needed. The psychologist must be available by phone for consultation and can follow up in person within 24 hours.

Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline. Psychiatric assessments by a Child and Adolescent Psychiatrist or a qualified MD/DO are required for all members. Residential providers must coordinate these assessments and maintain continuity with existing psychiatric providers, employing a psychiatrist or experienced physician for consultation as necessary. Staff must be trained in a standardized program for working with individuals with dual diagnoses within six months. Supervision must comply with NCAC regulations and relevant licensing boards.

Residential Services – Complex Needs is provided in small group homes with structured support from a skilled team, including psychologists and licensed clinicians, to develop behavioral intervention plans and respond to crises. A psychiatrist or experienced physician is available for

consultation, ensuring coordination with outpatient psychiatric care. The services are tailored to individual needs with behavioral plans for all members.

Family involvement is key, with coaching to replicate successful strategies at home and in the community. Care coordination includes collaboration with schools, employers, and primary care providers to build strong natural support networks.

Family therapy or support is offered at least twice a month, increasing before discharge to facilitate transitions back home. Efforts are made to connect members to local activities, ensuring continuity of support.

Educational and vocational support are integral, with cooperation between residential providers and schools to maintain consistency in behavior plans. Vocational interests are assessed, with opportunities provided for engagement in employment through formal or informal community connections.

A trauma-informed approach is essential, incorporating evidence-based interventions like TF-CBT and Motivational Interviewing to address past experiences while accommodating any cognitive challenges.

Coding			
Procedure Code	**Service Description**	**Rate**	**Billing Frequency**
H0018 HA	ILOS – Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH Diagnosis	Based on Fee Schedule or Contract	Daily/per diem

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Discussion/General Information

Reason the service is needed/Gap service intends to fill: Currently, individuals are placed in in-patient hospitals, waiting for lengthy periods of time in emergency departments, in state institutions, PRTF, or other similar residential settings. Members remain in a cycle of inpatient, ED and non-sustainable community placements primarily due to the lack of a multidisciplinary approach, which assists member and family/supports learn the best long-term supports and outcomes. Higher levels of care are often far too restrictive, lead to unnecessary trauma, are some of the costliest levels of care in the state, and do not offer opportunities for individuals to have the life they choose, particularly youth approaching adulthood.

How is the service different than any State Plan Service? This service is provided with a multidisciplinary approach, with service provision from specially trained staff and a provider support network of clinical professionals. At a minimum, providers are required to have access within their own agencies to Qualified Professionals, Licensed Clinical Staff, Psychologists and medication prescribers. Based on the members' individual needs, other services (such as Nursing Services, Occupational Therapy and Physical Therapy) also may be utilized as adjuncts to treatment. The level of involvement of these additional services will be based on the comprehensive clinical assessment and psychiatric assessments of the members and adjusted throughout treatment. Routine nursing may be a standard part of the Residential program, if indicated based on the population served.

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Description of Monitoring Activities

Healthy Blue Care Together will monitor admissions and concurrent stay through Utilization Management and Review processes. Healthy Blue Care Together care management will also monitor the individual's progress in the service, the quality of the service and maintain the care plan as outlined in the Healthy Blue Care Together Care Management Program. HBCT network management will monitor individuals receiving Residential-complex needs at a minimum annually for compliance. Ongoing monitoring of complaints, incident reports, quality of care reviews, audits etc. will occur annually or as needed.

Definitions

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
CALS: Checklist of Adaptive Living Skills assessment
SAR: Service Authorization Request

References

Government Agency, Medical Society, and Other Authoritative Publications:

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 8D-2 — Residential Treatment Services (Amended Jan 1, 2025).

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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.

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].

Websites for Additional Information

NC Tracks Provider Claims and Billing Assistance Guide:
Provider Policies, Manuals, Guidelines and Forms (nc.gov)

EPSDT provider page:
NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children (nc.gov)

History

Status	Date	Action
Draft	11/25/2025	DRAFT
Approved	02/10/2026	Approved by the Medical Operations Committee (MOC)