Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Initial Level of Care Eligibility Determination NC Innovations

☐ **PRIOR APPROVAL** (INITIAL/RE-INSTATEMENT REQUEST) ☐ **UTILIZATION REVIEW** (CONTINUED NEED REVIEW)

Name _____
Last *First* *Middle*

Address _____
Street

_____
City State Zip Code

Date of Birth _____ Gender _____ County of Medicaid Eligibility _____

MID# _____ Member Record # _____

Legally Responsible/ Guardian _____

Phone # _____ Address _____

1. **Living in ICF-IID Facility** ☐ Yes ☐ No

2. **Diagnosed condition(s) that establish(es) the individual's developmental disability diagnosis:**

Intellectual/Developmental Disability (Diagnosis/Diagnostic Code): _____

Medical Condition: _____

Related Condition _____

3. **The Intellectual Disability manifested prior to the age of 18 years? If Yes, Note Evaluations Reviewed (Date of evaluation, evaluator/source)** ☐ Yes ☐ No

4. **The medical or related condition manifested prior to age of 22 years? If yes, Note Clinical/Evaluations Reviewed (Date of evaluation, evaluator/source** ☐ Yes ☐ No

5. Is the disability likely to continue indefinitely? ☐ Yes ☐ No

- Self-Care ☐ Yes ☐ No
- Understanding/Use of Language ☐ Yes ☐ No
- Capacity for independent Living ☐ Yes ☐ No
- Mobility ☐ Yes ☐ No
- Self-Direction ☐ Yes ☐ No
- Learning ☐ Yes ☐ No

☐ The individual could benefit from services and supports to promote the acquisition of skills, and to decrease or prevent regression

6. Level of Care Certification ☐ Eligible ICF-IID ☐ Not Eligible ICF-IID

Psychologist/LPA or Physician Signature and Credentials	**Print Name**	**Date**

*****Note: LOC determination based on Intellectual Disability assessment should be completed by a licensed psychologist or LPA.**

LOC based on Medical ID and Conditions Related to Intellectual Disability should be completed by a physician.

(MCO USE ONLY) Level of Care Recommendation

ICF-IID Level of Care ☐ Approved ☐ Denied

LOC Effective Date _____ Prior Approval Number _____

UM Care Manager Signature _____ Date _____

Medical Director Signature (if applicable) _____ Date _____

MEDICAL ASSESSMENT

For Physician's Only

I. System Disorder/Name of Condition	Check One:	
a. Respiratory	☐ Yes	☐ No
b. Cardiovascular	☐ Yes	☐ No
c. Gastro-Intestinal	☐ Yes	☐ No
d. Genito – Urinary	☐ Yes	☐ No
e. Neurological	☐ Yes	☐ No
f. Other:_____	☐ Yes	☐ No

II. History of Seizures (Type)	Check One:	
Simple Partial (Simple motor movements/no awareness loss)	☐ Yes	☐ No
Complex Partial (Loss of Awareness)	☐ Yes	☐ No
Generalized – Absence (petit mal)	☐ Yes	☐ No
Controlled with medication	☐ Yes	☐ No

Other: _____

Seizure Frequency per month: _____

III. Disability	Check One:	
Cerebral Palsy	☐ Yes	☐ No
Mental Illness	☐ Yes	☐ No

Other Related Condition:

_____

IV. Sensory/Motor Limitation	Check One:	
Hearing	☐ Yes	☐ No
Vision	☐ Yes	☐ No
Ambulatory	☐ Yes	☐ No
Fine Motor Deficit	☐ Yes	☐ No
Major Motor Deficit	☐ Yes	☐ No
Communication	☐ Yes	☐ No

V. Treatment Modality	Check One:	
Physical Therapy	☐ Yes	☐ No
Occupational Therapy	☐ Yes	☐ No
Speech Therapy	☐ Yes	☐ No
Special Diet Type:	☐ Yes	☐ No
Other (IV, Tube Feed, O2, Catheter, etc.)	☐ Yes	☐ No

Supportive Protection Devices:_____

VI. Medications

Individual can self-medicate: ☐ Yes ☐ No

Medication	Dosage/Route/Frequency	Related Diagnosis

VII. Physician Orders:

VIII. Physician Signature

Physician Signature **Physician Name Print** **Date**

NC Innovations Waiver

Instructions for Level of Care Determination

This form is to be used for prior approval and utilization review of ICF-IID level of care.

Demographics

1. **Name:** Print last name, first name, middle initial. If no middle name or initial, use NMN**.**
2. **Address:** Enter the complete address where the person lives.
3. **Date of Birth:** Enter the month, day and year.
4. **Gender:** Enter a capital F to indicate Female or a capital M to indicate Male.
5. **County of Medicaid Eligibility:** List the county from which the person's Medicaid originates per the SIPPS system.
6. **Medicaid Number:** Enter the Medicaid Number assigned to the person.
7. **Member Record Number:** Trillium's assigned record number.
8. **Legally Responsible Person/Guardian:** List the name of the person who is the legal guardian or responsible person for the individual who is being reviewed.
9. **Address of Legally Responsible Person/Guardian:** Enter the complete address where the Legal Guardian/Responsible person lives.

Living in ICF-IID Facility

- Place a check in the space indicating whether or not the person lives in an ICF-IID residential facility for the purpose of this level of care.

Diagnostic Information

Check all of the disability areas that apply based on the documented disability.

- If the person has Intellectual Disability based on the documented assessment, document the diagnosis and/or diagnostic code.
- If the person has a Medical Condition or related condition based on documented assessment, document the diagnosis and/or diagnostic code. If no diagnosis, list NA.

Was the Intellectual Disability manifested prior to the age of 18 years?

Based on documented evaluations, specify evaluations reviewed with date, evaluator and/or source.

Please check the correct box.

Was the Disability manifested before the age of 22?

Based on documented assessment, specify assessments or evaluations reviewed with date, evaluator and/or source. Please check the correct box.

Is the Disability likely to continue indefinitely?

Based on documented assessment, specify assessments or evaluations reviewed with date, evaluator and/or source.

Please check the correct box.

Current Substantial Functional Limitations

Place a check in the Yes box for each substantial functional deficit the individual has based on documented assessment. If the individual does not have substantial functional deficits in a specified area then check No.

Skill Acquisition

Check the appropriate box to address if the person could benefit from Skill Acquisition.

Level of Care Certification

Based on assessment, check the appropriate box to designate if the person meets the ICF-IID level of care. The signature and printed name of the evaluator (licensed psychologist/psychological associate, or physician) who completed the assessment is required.

*****Note: LOC determination based on Intellectual Disability assessment should be completed by a licensed psychologist or LPA.**

LOC based on Medical ID and Conditions Related to Intellectual Disability should be completed by a physician.

Return to:

By mail:
Trillium Health Resources I/DD Care Coordination Department
201 W 1st St, Greenville, NC 27858 OR
By Fax:
252.215.6870
Questions:
Toll Free Administrative & Business Line 1-866-998-2597

MCO Level of Care Recommendation

1. Based on review of information, check approved or denied for ICF-IID Level of Care
2. List the month/day/year that the Level of Care became effective.
3. Document the Prior Approval Number.
4. Get the signature of the UM Care Manager and date of signature.
5. Get the signature of Medical Director and date of signature if needed.

NC INNOVATIONS

Intermediate Care Facilities for Individual with Intellectual Disabilities (ICF-IID)

ICF-IID Level of Care Criteria

Clinical Coverage Policy 8E

To be Medicaid certified at the ICF-IID level-of-care, the individual must:

Require active treatment necessitating the ICF-IID level of care. (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include service to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.)

AND

Have a diagnosis of Intellectual Disability, or a condition that is closely related to Intellectual Disability.

1. Intellectual Disability is a disability characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, practical and social skills. The condition originates before the age of 18.
2. Persons with closely related conditions refer to individuals who have a severe, chronic disability that meets ALL of the following conditions:
   1. Is attributable to:
      a. Cerebral palsy or epilepsy or
      b. Any other condition, other than mental illness, that is closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons;
   2. It is manifested before the person reaches age 22;
   3. Is likely to continue indefinitely; and
   4. It results in substantial functional limitations in three or more of the following areas of major life activity:
      a. Self-care (the ability to take care of basic life needs for food, hygiene, and appearance)
      b. Understanding and use of language (the ability to both understand others and to express ideas or information to others either verbally or nonverbally)
      c. Learning (the ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
      d. Mobility (ambulatory, semi-ambulatory, non-ambulatory)
      e. Self-direction (managing one's social and personal life and have the ability to make decisions necessary to protect one's self)
      f. Capacity for independent living (age appropriate ability to live without extraordinary assistance).