

## **Table of Contents**

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions .....	1
2.0	Eligibility Requirements .....	1
2.1	Provisions.....	1
2.1.1	General.....	1
2.1.2	Specific .....	1
2.2	Special Provisions.....	2
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age .....	2
2.2.2	EPSDT does not apply to NCHC beneficiaries .....	3
2.2.3	Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age .....	3
2.3	Limitations .....	3
3.0	When the Procedure, Product, or Service Is Covered.....	3
3.1	General Criteria Covered .....	3
3.2	Specific Criteria Covered.....	3
3.2.1	Specific criteria covered by both Medicaid and NCHC .....	3
3.2.2	Medicaid Additional Criteria Covered.....	3
3.2.3	NCHC Additional Criteria Covered .....	4
4.0	When the Procedure, Product, or Service Is Not Covered.....	4
4.1	General Criteria Not Covered .....	4
4.2	Specific Criteria Not Covered.....	4
4.2.1	Specific Criteria Not Covered by both Medicaid and NCHC.....	4
4.2.2	Medicaid Additional Criteria Not Covered.....	4
4.2.3	NCHC Additional Criteria Not Covered.....	4
5.0	Requirements for and Limitations on Coverage .....	5
5.1	Prior Approval .....	5
5.2	Prior Approval Requirements .....	5
5.2.1	General.....	5
5.3	Specific .....	5
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service .....	5
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	5
6.2	Provider Certifications .....	6
7.0	Additional Requirements .....	6
7.1	Compliance .....	6
7.2	Documentation.....	6
8.0	Policy Implementation/Revision Information.....	6

Attachment A: Claims-Related Information .....	8
A. Claim Type .....	8
B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10- CM) and Procedural Coding System (PCS).....	8
C. Code(s).....	8
D. Modifiers.....	9
E. Billing Units.....	9
F. Place of Service .....	9
G. Co-payments .....	9
H. Reimbursement Rate.....	9

## 1.0 Description of the Procedure, Product, or Service

Maternal care skilled nurse home visits assess and treat pregnant women who have one or more of the high-risk medical conditions specified below.

### 1.1 Definitions

None Apply.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

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

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

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
NCHC beneficiaries are not eligible for maternal care skilled nurse home visit.

## 2.2 Special Provisions

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

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed 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, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

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

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

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

#### b. EPSDT and Prior Approval Requirements

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

*NCTracks Provider Claims and Billing Assistance Guide:*  
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

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

### **2.2.2 EPSDT does not apply to NCHC beneficiaries**

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

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

## **2.3 Limitations**

Pregnant women who receive Medicaid and have one or more of the high-risk medical conditions listed below are eligible for this service.

## **3.0 When the Procedure, Product, or Service Is Covered**

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

### **3.1 General Criteria Covered**

Medicaid and NCHC 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.

### **3.2 Specific Criteria Covered**

#### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

None Apply.

#### **3.2.2 Medicaid Additional Criteria Covered**

Maternal care skilled nurse home visits are covered when a client has one or more of the following high-risk medical conditions or diagnoses:

- a. preterm labor;
- b. hypertension;
- c. pre-eclampsia;
- d. diabetes;
- e. suspected fetal growth retardation;
- f. multiple pregnancy, renal disease;
- g. HIV infection/AIDS;

- h. perinatal substance abuse; OR
  - i. other high-risk medical conditions.
- The beneficiary must be referred by their prenatal care physician or physician extender (certified nurse midwife, nurse practitioner, physician assistant).

### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

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

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

### **4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

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

### **4.2 Specific Criteria Not Covered**

#### **4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

None Apply.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.3 NCHC Additional Criteria Not Covered**

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

## **5.0 Requirements for and Limitations on Coverage**

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

### **5.1 Prior Approval**

Medicaid and NCHC shall not require prior approval for maternal care skilled nursing home visit.

### **5.2 Prior Approval Requirements**

#### **5.2.1 General**

None Apply.

### **5.3 Specific**

A maternal care skilled nurse home visit must be a one-on-one, face-to-face visit conducted in the client's home.

Maternal care skilled nurse home visits include the following components that must be performed:

- a. Previsit preparation: review of prenatal, Pregnancy Care Management services, and other records to identify special problems and needs that may require follow-up.
- b. Home visit.
- c. assessment of the high-risk condition(s).
- d. treatment in the home as outlined in the referral from the medical care provider.
- e. Referral/documentation.
- f. referrals made to Pregnancy Care Manager, Women, Infant, and Children (WIC) Special Supplemental Nutrition program, and other providers if needed.
- g. written findings of the home visit sent to the medical provider.
- h. Consultation: consultation between the registered nurse (RN) and the Pregnancy Care Manager before and after the home visit, when the RN is not the Pregnancy Care Manager.

## **6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

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

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

- a. Local health departments are eligible to provide this service.
- b. The service must be rendered by a registered nurse (RN) skilled in maternity care.

## 6.2 Provider Certifications

None Apply.

## 7.0 Additional Requirements

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

### 7.1 Compliance

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

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

### 7.2 Documentation

At a minimum, the client's record must include the following documentation:

- a. Beneficiary's name and date of birth.
- b. Beneficiary's Medicaid identification number (MID).
- c. Dates of service.
- d. Referral from the prenatal care physician or physician extender.
- e. Plan of treatment/care and outcome.
- f. Name and title of person performing the service.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** October 1, 2002

### Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	Text stating that providers must comply with Medicaid guidelines was added to Section 8.0 (now Attachment A).
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 4	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 4	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
3/1/11	Throughout	Updated policy with standard DMA template language and format
03/1/11	Subsection 5.2	Updated to reflect transition from Maternity Care Coordination Program to Pregnancy Care Management and Child Service Coordination Program to Care Coordination for Children
03/1/11	Attachment A	Updated to reflect transition from Maternity Care Coordination Program to Pregnancy Care Management and Child Service Coordination Program to Care Coordination for Children
03/3/11	Attachment A	Revised to enhance integration with Pregnancy Medical Home/Pregnancy Care Management and Care Coordination with Children services
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/15	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

**Attachment A: Claims-Related Information**

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

**A. Claim Type**

Professional (CMS-1500/837P transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-CM Code(s)		
O09.01	O09.41	O09.891
O09.02	O09.42	O09.892
O09.03	O09.43	O09.893
O09.11	O09.511	O09.91
O09.12	O09.512	O09.92
O09.13	O09.513	O09.93
O09.211	O09.521	Z33.1
O09.212	O09.522	Z34.01
O09.213	O09.523	Z34.02
O09.291	O09.611	Z34.03
O09.292	O09.612	Z34.81
O09.293	O09.613	Z34.82
O09.31	O09.621	Z34.83
O09.32	O09.622	
O09.33	O09.623	

**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.

CPT Code(s)
T1001

**Unlisted Procedure or Service**

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

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

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Two visits per month.

**F. Place of Service**

Beneficiary's home.

**G. Co-payments**

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

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement Rate**

Providers must bill their usual and customary charges.

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

Maternal care skilled nurse home visits are reimbursed up to two visits per month. Claims for additional units will be considered for reimbursement through the adjustment process only when conditions of coverage are met and documentation supports medical necessity.

A maternal care skilled nurse home visit must be billed per date of service.

**Note:** Pregnancy Care Management and Care Coordination for Children providers must follow all applicable guidelines pertaining to per member per month reimbursement model (PMPM).