

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1H: Telehealth, Virtual Communications, and Remote Patient Monitoring

1.0 Description of the Procedure, Product, or Service

Childbirth education is a series of classes designed to help pregnant women and their support person to understand the changes experienced during pregnancy, to prepare for the labor and delivery experience, and to understand the postpartum period, including, but not limited to, the importance of proper postpartum care for the mother and the child. These classes are based on the goals and objectives approved by NC Medicaid, which are listed in **Subsection 5.2, Class Requirements**.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*;
- b. Provider(s) shall verify each Medicaid 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.

2.1.2 Specific

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

- a. **Medicaid**
None Apply.

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: <https://medicaid.ncdhhs.gov/>

2.3 Limitations

Pregnant women who receive Medicaid 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 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.

3.1.1 Telehealth Services

As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring*.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Childbirth education is covered during pregnancy.

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 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 Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Prior approval is not required for Medicaid beneficiaries.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Class Requirements

Childbirth education includes a series of classes that meet for 1 or 2 hours each session, for a total of 10 hours of instruction. The classes shall be based on a written curriculum that outlines mandatory course objectives and the specific content covered in each class. Whether a nationally recognized curriculum is used or a curriculum is newly developed, content must include, but is not limited to, the following:

5.3.1 Pregnancy

- a. Physical and emotional changes during pregnancy and childbirth.
- b. Physical activity and exercise during pregnancy.
- c. Nutritional needs of mother and fetus.
- d. Avoidance of harmful practices and substances including alcohol, drugs, non-prescribed medications and nicotine.
- e. Consumer advocacy.
 1. Informed decision making for childbearing women.
 2. Communication and negotiating skills with healthcare providers.
 3. Birth plans.

5.3.2 Labor and Delivery

- a. The process of labor, including stages and phases as well as warning signs of preterm labor.
- b. Non-pharmacological comfort measures such as breathing and relaxation techniques, touch, massage, and hydrotherapy, in addition to emotional and physical support of the mother.
- c. Role of doulas, elders, or other support persons during labor and birth.
- d. Types of deliveries.
- e. Complications and relevant interventions such as an episiotomy or induction.
- f. Obstetrical analgesia and anesthesia.
- g. Education about hospital routines and the importance of touring the hospital or birthing center.

5.3.3 Postpartum Care

- a. Postpartum physical and emotional changes, including depression.
- b. Postpartum physical activity and exercise.
- c. Postpartum sexuality.
- d. Family planning.
- e. Breastfeeding issues/support.

5.3.4 Infant Care

- a. Normal newborn procedures.
- b. Normal newborn appearances.
- c. Preparation for breastfeeding.
- d. Safe sleep positions.

5.3.5 Other Topics

Participants must be introduced to the following topics. If follow-up is needed, participants shall be informed of where additional information can be obtained.

- a. Infant feeding.
- b. Infant car seat use.
- c. Importance of well-childcare.
- d. Family attachment to the newborn.
- e. Potential stress within the family.
- f. Family planning methods and referral, e.g., referral to medical provider or DSS family planning social worker; the *“Be Smart” Family Planning Medicaid*.

5.4 Class Presentation

Classes should be taught in the language of the beneficiary or in a means to ensure understanding by the beneficiary. Curriculum and educational materials should be culturally appropriate and reflect average readability (6th–8th grade reading level). A variety of materials, including videos, charts, and other teaching aids may be used.

5.5 Class Schedule

Childbirth education classes are usually held in the second half of the pregnancy. They should be held when the support person can attend.

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 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.

All Medicaid-enrolled providers (local health departments, physician or medical diagnostic clinics, outpatient hospitals, physicians, nurse practitioners, physician assistants and nurse midwives) who employ certified childbirth educators are eligible to bill for this service.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

To qualify for reimbursement for childbirth education classes, a provider must

- a. be certified as a childbirth educator by a nationally recognized organization for childbirth education or meet State-approved childbirth education program requirements; and
- b. be a licensed practitioner operating within the scope of his or her practice as defined under State law; or
- c. be under the personal supervision of an individual licensed under State law to practice medicine.

6.2 Staff Qualifications

It is the responsibility of the provider agency to verify all staff qualifications for their staff's provision of service. A copy of this verification must be maintained by the provider agency.

Childbirth education services must be rendered by a childbirth educator who meets one of the following criteria:

- a. Certification from a nationally recognized organization for childbirth education, such as the International Childbirth Education Association (ICEA), Lamaze International, or other national organizations as approved by NC Medicaid.
- b. Verification of meeting State-approved childbirth education program requirements.

6.3 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries 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 NC Medicaid'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).
- c. Copies of records must be furnished upon request.

7.2 Documentation

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

- a. Client's name and date of birth.
- b. Client's Medicaid identification number (MID).
- c. Dates of service.
- d. Total service time component (ex: 1 hour = 1 unit).
- e. 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
12/1/05	Section 2.3	The web address for DMA's EPSDT policy instructions was added to this section
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
8/1/08	Section 1.0	The description of the service was redefined.
8/1/08	Section 4.0	The criteria for when the service is not covered were expanded.
8/1/08	Section 5.0	This section was revised to reflect new curriculum requirements.
8/1/08	Section 5.2	The maximum number of billable hours of instruction was increased from eight to ten.
8/1/08	Section 6.0	Provider qualification and staff qualifications were redefined.
8/1/08	Section 7.0	Plan of treatment/care and outcome removed from the policy as required documentation.
8/1/08	Section 8.0	The billing guidelines were reformatted as Attachment A.
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
07/01/2016	Attachment A	Added ICD-10 code Z32.2
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/20/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/20/2019	Attachment A	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan

Date	Section Revised	Change
		(PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
12/01/2020	Section 5.3.5	Deleted Family Planning Waiver language and updated it with “Be Smart” Family planning Medicaid.
12/01/2020	Section 6.2	Contact information for the Baby Love Program Manager was deleted.
12/01/2020	Added Subsection 3.1.1	As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring.
12/01/2020	Attachment A, letter C	Added column to childbirth education code indicating if the services were eligible for telehealth along with the following language: Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy. Maximum beneficiaries (excluding partners) in both telehealth and non-telehealth group classes is limited to 10. For telehealth group classes, the provider is responsible for making the beneficiary aware of the public nature of online classes.
12/01/2020	Attachment A, letter C	Deleted CPT reference.
12/01/2020	Attachment A, letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.
12/01/2020	Attachment A, letter F	Added language indicating telehealth codes should be filed with the provider’s usual place of service code(s)
12/01/2020	Added beginning of Policy	Added the language “This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect.”

Date	Section Revised	Change
8/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

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.

ICD-10-CM Code(s)		
O09.01	O09.33	O09.622
O09.02	O09.41	O09.623
O09.03	O09.42	O09.891
O09.11	O09.43	O09.892
O09.12	O09.511	O09.893
O09.13	O09.512	O09.91
O09.211	O09.513	O09.92
O09.212	O09.521	O09.93
O09.213	O09.522	Z32.2
O09.291	O09.523	Z33.1
O09.292	O09.611	Z34.01
O09.293	O09.612	Z34.02
O09.31	O09.613	Z34.03
O09.32	O09.621	Z34.81
		Z34.82
		Z34.83

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)	Telehealth Eligible Service
S9442	Yes

Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

Maximum beneficiaries (excluding partners) in both telehealth and non-telehealth group classes is limited to 10.

For telehealth group classes, the provider is responsible for making the beneficiary aware of the public nature of online classes.

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

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Childbirth education is reimbursed per class. Each class can be either one hour or two hours.

The childbirth education provider may submit claims for reimbursement only for classes that the beneficiary attends. A maximum of 4 hours of instruction (four 1-hour classes or two 2-hour classes) may be provided per day and a maximum of 10 hours of instruction (ten 1-hour classes or five 2-hour classes) may be billed for reimbursement per pregnancy. A complete childbirth education series consists of ten hours of instruction.

Childbirth education must be billed per date of service.

F. Place of Service

Outpatient facility or Office

Telehealth claims should be filed with the provider's usual place of service code(s).

Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

G. Reimbursement

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

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>