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1.0 Description of the Procedure, Product, or Service

A home visit for newborn care and assessment delivers health, social support, and/or educational services directly to families in their homes. A home visit for newborn care and assessment is a means to follow up on the infant's health; to counsel on infant care; to follow up on newborn screening; and to arrange for additional appointments for the infant.

The goals of the home visit for newborn care and assessment are:

- a. to provide a key mechanism for reaching families early with preventive and anticipatory services;
- b. to provide opportunities for timely referral of problems; and
- c. to provide a link with children's preventive health services.

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 home visit for newborn care and assessment.

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

Infants aged birth to 60 days 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 Medicaid Beneficiaries 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

A home visit for newborn care and assessment is covered within two or three weeks following discharge from the hospital, but no later than 60 days after delivery.

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 Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for home visit for newborn care and assessment.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.3 Home Visits

A home visit for newborn care and assessment must be a one-on-one, face-to-face visit conducted in the client's home. This includes, but is not limited to, assessment, counseling, teaching, and referral to other service providers for additional services. A home visit for newborn care and assessment must follow the curriculum requirements outlined on the Newborn Home Visit form (DEHNR T774 Rev. 3/93).

5.4 Other Requirements

An RN who is not a Pregnancy Care Manager or Care Coordination for Children Care Manager is required to coordinate services, when applicable. The RN making a home visit for newborn care and assessment must:

- a. discuss the past and current medical history of the mother and child with the Pregnancy Care Manager and/or Care Coordination for Children Care Manager;
- b. discuss the plan of care or service coordination goals with the Pregnancy Care Manager and/or Care Coordination for Children Care Manager prior to the home visit, so that tasks listed in the plan of care can be addressed during the home visit; and
- c. contact the family to schedule a convenient time for the home visit and to explain its purpose.

Following the home visit for newborn care and assessment, the RN must:

- a. document findings in the mother's record and in the child's record as they apply;
- b. discuss observations with the Pregnancy Care Manager and/or Care Coordination for Children Care Manager; and
- c. update the Pregnancy Care Management and/or Care Coordination for Children plan of care, as applicable.

When a child is not eligible for Care Coordination for Children and the mother is receiving Pregnancy Care Management, the RN making a home visit for newborn care and assessment must

- a. review available records from the referral contact;
- b. review prior medical records of the mother (and/or the child) prior to the home visit; and
- c. contact the client to schedule a time for the home visit and to explain its purpose.

Following the home visit for newborn care and assessment, the RN must:

- a. document findings in the appropriate records; and
- b. make referrals to other agency and community resources as indicated by the findings and as agreed to by the family.

An RN who is the family's Pregnancy Care Manager and/or Care Coordination for Children Care Manager may make a home visit for newborn care and assessment in lieu of—or in addition to—regularly scheduled Pregnancy Care Management and/or Care

Coordination for Children activities. Coordination between the Pregnancy Care Management and Care Coordination for Children programs is required.

Coordination of care strategies must be identified by all caregivers to avoid duplication of services.

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. Federally Qualified Health Centers, local health departments, and Rural Health Clinics are eligible to provide this service.
- b. The service must be rendered by a registered nurse (RN).

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).

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
9/1/10	Sections 2 and 7	EPSDT language updated
9/1/10	Attachment A	Billing Guidelines moved from Section 8 to Attachment A: Claims Related Information
9/1/10	Attachment A	Maternal Outreach Worker information removed from policy.
9/1/10	Attachment A	Additional standard policy language added
3/1/11	Throughout	Updated standard DMA template language
3/1/11	Subsection 5.3	Updated to reflect transition from Maternity Care Coordination Program to Pregnancy Care Management and Child Service Coordination Program to Care Coordination for Children
3/1/11	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
3/3/11	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)	
Z00.110	Z00.121
Z00.111	Z00.129

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)
99502

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

One visit – once per lifetime of newborn beneficiary.

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

H. Reimbursement

Providers shall bill their usual and customary charges.

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

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for beneficiaries enrolled in the Medicaid managed care programs.

A home visit for newborn care and assessment is reimbursed once per lifetime. An infant cannot receive both the home visit for newborn care and assessment and the EPSDT home visit for newborn care and assessment.

A home visit for newborn care and assessment must be billed per date of service. A home visit for newborn care and assessment and a home visit for postnatal assessment and follow-up care can be reimbursed when provided on the same 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).