

North Carolina Medicaid Special Bulletin

*An Information Service of the Division of Medical
Assistance*



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Number IV

August 2002

Attention:
Health Departments
Federally Qualified Health Centers
Rural Health Clinics
Developmental Evaluation Centers
Physicians
and
Other Maternity Care Providers

HIPAA Code Conversion

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New Codes for the Oral Screening Preventive Package for Use in Primary Care Physician Offices

Effective with date of service October 1, 2002, procedure codes W8002 and W8003 (Oral Screening Preventive Package) will be end-dated and replaced by American Dental Association (ADA) dental codes to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Procedure code W8002 (Initial Oral Screening) will be replaced with the following procedure codes:

Procedure Code	Description
D0150	Comprehensive oral evaluation
D1203	Topical application of fluoride (prophylaxis not included) - child
D1330	Oral hygiene instructions

The following criteria apply for the Initial Oral Screening:

- Includes early caries screening and detection of other notable findings in the oral cavity.
- Includes prevention and dietary counseling.
- Includes prescribing a fluoride supplement, if indicated.
- Includes application of fluoride varnish.
- Medicaid will only allow reimbursement for this oral screening when teeth are present and fluoride varnish is applied to the teeth.
- Limited to recipients under 3-years-old.
- Allowed once per provider for each recipient.
- Periodic oral screening is recommended 4 to 6 months after the initial oral screening.
- Exempt from third party liability.

Procedure code W8003 (Periodic Oral Screening) will be replaced with the following procedure codes:

Procedure Code	Description
D0120	Periodic oral evaluation
D1203	Topical application of fluoride (prophylaxis not included) - child
D1330	Oral hygiene instructions

The following criteria apply for the Periodic Oral Screening:

- Includes early caries screening and detection of other notable findings in the oral cavity.
- Includes prevention and dietary counseling.
- Includes application of fluoride varnish.
- Medicaid will only allow reimbursement for this oral screening when teeth are present and fluoride varnish is applied to the teeth.
- Limited to recipients under 3-years-old.
- Periodic oral screening is recommended 4 to 6 months after the initial oral screening.
- Periodic oral screening and fluoride varnish application are recommended two times per year at 4 to 6 month intervals for the same or different provider.
- Exempt from third party liability.

Claims Filing Process

Prior approval is not required for these services. These services are billed on the CMS-1500 claim form or electronically through ECS. Refer to the claim examples on pages 3 through 5. Refer to the Basic Medicaid handout for additional billing instructions.

For health departments, these services are billed through HSIS. Refer to the HSIS screen entry examples on page 6.

Note: Medicaid will only allow reimbursement of these ADA codes if all three procedures are billed on the same claim for the same date of service.

Note: These procedure codes all begin with an alpha “D” character followed by four numeric characters.

PLEASE
DO NOT
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AREA



Example 1:
Periodic Oral Screening as a
Separate Procedure

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) **998765432A**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Smith, Barbie**

3. PATIENT'S BIRTH DATE MM DD YY **05 10 01** SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) **123 Any Street**

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY **City** STATE **NC**

8. PATIENT STATUS Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE **1234567**

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. LINE	A DATE(S) OF SERVICE		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/PCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSTD Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY										
1	11 15 YY	11 15 YY	11	01	D0120		23 07	1				
2	11 15 YY	11 15 YY	11	01	D1203		15 44	1				
3	11 15 YY	11 15 YY	11	01	D1330		15 00	1				
4												
5												

25. FEDERAL TAX I.D. NUMBER SSN EIN **098788**

26. PATIENT'S ACCOUNT NO. **098788**

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE \$ **53 51**

29. AMOUNT PAID \$

30. BALANCE DUE \$ **53 51**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # **James Medical Center**
123 Any Street
City, State 29999

SIGNED **Bill James, MD** DATE **11-15-00**

PIN# **8900000** GRP# **8901000**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM CWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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Example 2: Initial Oral Screening in Conjunction with an office visit

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Patty, Peppermint**

3. PATIENT'S BIRTH DATE MM/DD/YY **05/10/01** SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) **123 Any Street**

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS
Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? YES NO PLACE (State)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____ DATE _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM/DD/YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM/DD/YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. **L 382.9** 3. _____
2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSTD Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
11/15/YY - 11/15/YY	11	01	99212		80.00	1				
11/15/YY - 11/15/YY	11	01	D0150		31.46	1				
11/15/YY - 11/15/YY	11	01	D1203		15.44	1				
11/15/YY - 11/15/YY	11	01	D1330		15.00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. **09878B**

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE \$ **141.90**

29. AMOUNT PAID \$

30. BALANCE DUE \$ **141.90**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)
SIGNED **Bill Jones, MD** DATE **11-15-00YY**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Jones Medical Center
123 Any Street
City, State 29999
PIN# **8900000** GRP# **8901000**

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Example 3:
Initial Oral Screening in
Conjunction with a Health Check Screening

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/>	MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/>	CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/>	CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/>	GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>	FECA BLK LUNG (SSN) <input type="checkbox"/>	OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123456789A				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Brown, Charlie			3. PATIENT'S BIRTH DATE MM DD YY 05 10 01		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No. Street) 123 Any Street			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street)						
CITY City		STATE NC	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE				
ZIP CODE 29999	TELEPHONE (Include Area Code) (919) 555-5555		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	TELEPHONE (INCLUDE AREA CODE) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY						
c. EMPLOYER'S NAME OR SCHOOL NAME	d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 12 15 01	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. RESERVED FOR LOCAL USE 1234567	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. L V20.2	22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.						
2. _____	3. _____	4. _____	23. PRIOR AUTHORIZATION NUMBER	24. TABLE OF SERVICES							
A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPST/ Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE	
1 11 15 YY 11 15 YY	11	01	99392 EP		80 33	1					
2 11 15 YY 11 15 YY	11	01	D0150		31 46	1					
3 11 15 YY 11 15 YY	11	01	D1203		15 44	1					
4 11 15 YY 11 15 YY	11	01	D1330		15 00	1					
5											
6 25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO. 09878B	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 142.23	29. AMOUNT PAID \$	30. BALANCE DUE \$ 142.23					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <i>Bill Jones, MD</i> DATE 11-15-01			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Jones Medical Center 123 Any Street City, State 29999 PIN# 8900000 GRP# 8901000						

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0838-0008 FORM CMS-1500 (12-80), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Screen Entry Examples of the Services Screen (Option 65) for Local Health Department's That Use the N.C. Health Services Information System (HSIS)

Example #1 - Periodic Oral Screening as a Separate Procedure

NEXT RECORD: COUNTY 999 SCREEN 65 ID 444444444 DATE 120902 ACTION A
MESSAGE:

NAME: Smith, Barbie POST-OP FROM DT: _____
SERVICE GROUP: THRU DT: _____
DIAG CODES A: **V72.2_** B: C: D: E: F: G:
H: I: J: K: HLTH CHK/EPST REFERRAL: _

B/
R/

D	PGM	CPT	M1	M2	M3	DIAG	1	2	3	4	SVC	PROV	UNITS	POS	ATN	TYP	REF	POST	SITE
B	CH	D0120	__	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999
R	CH	D1203	__	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999
R	CH	D1330	__	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999

Example #2 – Initial Oral Screening in Conjunction with an Office Visit

NEXT RECORD: COUNTY 999 SCREEN 65 ID 333333333 DATE 120902 ACTION A
MESSAGE:

NAME: Patty, Peppermint POST-OP FROM DT: _____
SERVICE GROUP: THRU DT: _____
DIAG CODES A: **382.9_** B: C: D: E: F: G:
H: I: J: K: HLTH CHK/EPST REFERRAL: R

B/
R/

D	PGM	CPT	M1	M2	M3	DIAG	1	2	3	4	SVC	PROV	UNITS	POS	ATN	TYP	REF	POST	SITE
B	CH	99212	__	__	__	A	__	__	__	__	RN	__	01	71	_____	__	_____	__	99999
B	CH	D0150	__	__	__	A	__	__	__	__	RN	__	01	71	_____	__	_____	__	99999
B	CH	D1203	__	__	__	A	__	__	__	__	RN	__	01	71	_____	__	_____	__	99999
B	CH	D1330	__	__	__	A	__	__	__	__	RN	__	01	71	_____	__	_____	__	99999

Example #3 – Initial Oral Screening in Conjunction with a Health Check Periodic Screening

NEXT RECORD: COUNTY 999 SCREEN 65 ID 222222222 DATE 103102 ACTION A
MESSAGE:

NAME: Brown, Charlie POST-OP FROM DT: _____
SERVICE GROUP: THRU DT: _____
DIAG CODES A: **V20.2_** C: D: E: F: G:
H: I: J: K: HLTH CHK/EPST REFERRAL: _

B/
R/

D	PGM	CPT	M1	M2	M3	DIAG	1	2	3	4	SVC	PROV	UNITS	POS	ATN	TYP	REF	POST	SITE
B	CH	99392	EP	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999
B	CH	D0150	__	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999
B	CH	D1203	__	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999
B	CH	D1330	__	__	__	A	__	__	__	__	ROS	__	01	71	_____	__	_____	__	99999

Conversion of Refugee Health Assessment Code, STD Control Treatment Code, and TB Control Treatment Code

Effective with date of service September 30, 2002, procedure codes Y2034, Y2013, and Y2012 will be end-dated. Health departments will follow new billing guidelines beginning with date of service October 1, 2002.

TB Control and Treatment Provided in Health Departments

1.0 Description of the Service

This service refers specifically to TB control and treatment in the local health department setting. Service includes medical history on initial visit, update of history on follow-up visits, diagnostic exam, which may include x-rays and laboratory tests, evaluation of current status, treatment for disease and/or prevention, and referral as appropriate.

2.0 Eligible Recipients

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

3.0 When Service is Covered

Services are covered when they are medically necessary.

4.0 When Service is Not Covered

- Service is not covered when it is not medically necessary.
- TB skin testing is not covered for job or college requirements.
- Services of an experimental nature or part of a clinical trial are not covered.

5.0 Policy Guidelines

Limitations are listed in **Section 8.0, Billing Guidelines**.

6.0 Eligible Providers

The following providers in a local health department setting are eligible to perform this service.

- physicians
- nurse practitioners
- physician assistants
- public health nurses who have completed the *Introduction to Tuberculosis Management* course

7.0 Additional Requirements

Documentation must include:

- medical necessity
- all components of service
- service time component

8.0 Billing Guidelines

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

Providers must bill the most specific diagnosis to support medical necessity.

Procedure Code(s)

Public health nurses use HCPCS code T1002 - "RN services up to 15 minutes." This code is billable when all of the service components are provided. A maximum of 4 units per day may be billed.

Reimbursement for additional units is considered when documentation supports medical necessity. When additional units deny, request an adjustment using the Medicaid Claim Adjustment Request form (see page 55) and include the medical indication (allergic reaction to treatment, STD and TB visit for the same client on the same date of service, history of false positive complicating treatment, comorbid conditions) with documentation. A corrected claim should not be submitted. EDS will perform the adjustment using the adjustment form and the original claim.

T1002 cannot be billed with a preventive medicine, prenatal or treatment code. When another health department provider sees the recipient on the same date of service for a separately identifiable medical condition, the health department may bill the appropriate E/M code. The diagnosis on the claim form must indicate the separately identifiable medical condition. Modifier 25 must be appended to either the E/M code or T1002.

Bill laboratory codes for laboratory tests done on site.

All other providers billing for these services when provided in health departments must use appropriate E/M codes.

Sexually Transmitted Disease Treatment Provided in the Health Department

1.0 Description of the Service

This service refers specifically to the treatment of sexually transmitted diseases (STD) provided in the local health department setting. Service includes medical history, diagnostic examinations for sexually transmitted diseases, laboratory tests as medically indicated, treatment as indicated, and referral as appropriate.

2.0 Eligible Recipients

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

3.0 When Service is Covered

Services are covered when they are medically necessary.

4.0 When Service is Not Covered

- Service is not covered when it is not medically necessary.
- STD testing is not covered for job requirements or insurance.
- STD testing is not covered for routine health screening.
- Services of an experimental nature or part of a clinical trial are not covered.

5.0 Policy Guidelines

Limitations are listed in **Section 8.0, Billing Guidelines**.

6.0 Eligible Providers

The following providers in a local health department setting are eligible to perform this service.

- physicians
- nurse practitioners
- physician assistants
- public health nurses who have completed the *Physical Assessment of Adults* course and *STD Nurse Clinician Training*

7.0 Additional Requirements

Documentation must include:

- medical necessity
- all components of service
- service time component

8.0 Billing Guidelines

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

Providers must bill the most specific diagnosis to support medical necessity.

Procedure Code(s)

Public health nurses use HCPCS code T1002 - "RN services up to 15 minutes." This code is billable when all of the service components are provided. A maximum of 4 units per day may be billed.

Reimbursement for additional units is considered when documentation supports medical necessity. When additional units deny, request an adjustment using the Medicaid Claim Adjustment Request form (see page 55) and include the medical indication (allergic reaction to treatment, STD and TB visit for the same client on the same date of service, history of false positive complicating treatment, comorbid conditions, multiple STDs) with documentation. A corrected claim should not be submitted. EDS will perform the adjustment using the adjustment form and the original claim.

T1002 cannot be billed with a preventive medicine, prenatal or treatment code. When another health department provider sees the recipient on the same date of service for a separately identifiable medical condition, the health department may bill the appropriate E/M code. The diagnosis on the claim form must indicate the separately identifiable medical condition. Modifier 25 must be appended to either the E/M code or T1002.

Bill laboratory codes for laboratory tests done on site.

All other providers billing for these services when provided in health departments must use appropriate E/M codes.

Refugee Health Assessments Provided in Health Departments

1.0 Description of the Service

This service refers specifically to refugee health assessments in the local health department setting. The assessment includes medical history, physical examination, review of documents, determination of immunization status/upgrade immunizations, TB skin testing, ova and parasite testing, sexually transmitted disease testing, other lab tests as indicated, and treatment or referral as appropriate.

2.0 Eligible Recipients

Eligible recipients are those documented by the U.S. Immigration and Naturalization Service (INS) on form I-94 who have been in the United States for less than 18 months.

3.0 When Service is Covered

Refugee health assessment is covered when the individual meets the eligibility requirement listed above.

4.0 When Service is Not Covered

Service is not covered when the eligibility criteria listed above are not met.

5.0 Policy Guidelines

Refugee health assessment is allowed once per lifetime.

6.0 Eligible Providers

The following providers in a local health department setting are eligible to perform this service.

- physicians
- nurse practitioners
- physician assistants
- public health nurses who have completed the *Physical Assessment of Adults* course (for refugees 21 years of age or older) or the *Physical Assessment of Children* course (for refugees under age 21 years)

7.0 Additional Requirements

All Medicaid documentation requirements apply. Documentation must also include:

- review of INS documents
- all components of service

8.0 Billing Guidelines

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V70.5 Health examination of defined subpopulations

Procedure Code(s)

Refugees under 21 years old	Follow the Health Check billing guidelines in the July 2002 Special Bulletin III
Refugees 21-39	99385 – <i>Initial comprehensive preventive medicine; 18-39 years</i>
Refugees 40-64	99386 – <i>Initial comprehensive preventive medicine; 40-64 years</i>
Refugees 65 years and older	99387 – <i>Initial comprehensive preventive medicine; 65 years and older</i>

Bill laboratory codes for laboratory tests provided on site.

Termination of Coverage

Effective with date of service September 30, 2002, the following state-created codes will be end-dated: Refresher Childbirth (Y2045), Enhanced Maternity Care Coordination (Y2352), and Enhanced Child Service Coordination (Y2353). The N.C. Medicaid program will no longer cover these services.

New Codes for Maternal and Child Services

Effective with date of service October 1, 2002, Maternity Care Coordination, Maternity Support, Child Service Coordination, and Maternal Outreach Worker services must bill the following CPT or HCPCS codes. The new codes replace the state-created codes listed below, in compliance with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Old Code	Old Description	New Code	New Description
W8201	Maternity Care Coordination Initial	T1017	Maternity care coordination
W8202	Maternity Care Coordination Subsequent		
Y2044	Maternity Care Coordination Home Visit		
W8203	Childbirth Education	S9442	Childbirth education
W8204	Maternal Care Skilled Nurse Home Visit	T1001	Maternal care skilled nurse home visit
Y2046	Postpartum Home Visit	99501	<i>Home visit for postnatal assessment and follow-up care</i>
Y2047	Newborn Home Visit	99502	<i>Home visit for newborn care and assessment</i>
Y2049	Intensive Psychosocial Counseling	96152	<i>Health and behavior intervention</i>
Y2155	Child Service Coordination	T1016	Child service coordination
Y2525	Maternal Outreach Worker Brief	S9445	Maternal outreach worker services
Y2526	Maternal Outreach Worker Standard		
Y2527	Maternal Outreach Worker Extended		

Maternity Care Coordination

1.0 Description of the Service

The Maternity Care Coordination program provides formal case management services to eligible women during and after pregnancy and intervention as early in pregnancy as possible to promote healthy pregnancy and positive birth outcomes. Maternity Care Coordination services must be provided by a qualified care coordinator. The process consists of successful completion of the following activities:

Outreach

Assist potentially eligible clients in applying for Medicaid, develop a strong referral network, and increase community awareness of expanded Medicaid coverage and benefits.

Recruitment

Encourage clients to enroll in the Maternity Care Coordination program. This includes evaluating Medicaid status, explaining Maternity Care Coordination services, and obtaining the client's consent.

Assessment

Determine client's strengths and needs, including psychosocial, nutritional, medical, educational, and financial factors.

Service Planning

Develop an individualized description of what services and resources are needed to meet the needs of the client and provide assistance in accessing those resources.

Coordination and Referral

Assist the client in arranging for appropriate services, ensure that appropriate services are received and that there is continuity of care.

Follow-up and Monitoring

Assess ongoing progress and ensure that services are delivered.

Education and Counseling

Educate and inform the client in preparation for childbirth and parenting. Guide the client and develop a supportive relationship that promotes the plan of care.

2.0 Eligible Recipients

Pregnant and postpartum women who receive Medicaid are eligible for this service.

Note: Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs.

3.0 When Service is Covered

Maternity Care Coordination services are covered during pregnancy and through the end of the month in which the 60th postpartum day occurs.

Maternity Care Coordination services are covered for women who experience a spontaneous abortion (miscarriage), a therapeutic elective abortion, fetal demise or molar pregnancy through the end of the month in which the 60th postpartum day occurs.

4.0 When Service is Not Covered

Maternity Care Coordination services are not covered when the criteria listed above are not met.

5.0 Policy Guidelines

Maternity Care Coordination services include assessment, development, implementation, and evaluation of the plan of care for pregnant and postpartum women.

5.1 Enrollment

Enrollment in the Maternity Care Coordination program must be a one-on-one, face-to-face encounter. Explanation of the services and that the service is voluntary are part of the enrollment process. Enrollment in the Maternity Care Coordination program should be in the client's county of residence. Clients receiving prenatal care in the private sector are also eligible to participate in the Maternity Care Coordination program.

A pregnant or postpartum woman is enrolled in the Maternity Care Coordination program when she has signed the Letter of Agreement (DMA-3004 Rev. 10/99) or the approved equivalent indicating her desire to participate in the program and designating her Maternity Care Coordinator. The Letter of Agreement may also indicate a secondary Maternity Care Coordinator to assist in care coordination in the absence of the primary Maternity Care Coordinator.

Immediately following enrollment in the Maternity Care Coordination program, the Maternity Care Coordinator must complete the Family Strengths/Needs Assessment (DMA 3006 Rev. 5/00) or the approved equivalent.

5.2 Initial Assessment

The goal of the initial assessment is to establish rapport with both the client and care providers; to provide assistance in meeting the service objectives; and to establish a schedule for follow-up assessments that addresses the service objectives and meets minimum program requirements for frequency of client contact. A Maternity Care Coordinator must complete the initial assessment. The components of the initial Maternity Care Coordination assessment are:

- Determine the current status of Medicaid eligibility.
- Explain Maternity Care Coordination services to the client.
 - ◆ Help the client locate providers and services.
 - ◆ Assist the client in planning visits to providers and arranging for transportation when needed.
 - ◆ Develop a plan of care with input from the client and the medical prenatal care provider to help ensure the best possible pregnancy outcome based on the client's needs.
 - ◆ Assist in the completion of forms and paperwork as required for other programs.
 - ◆ Work with the providers, especially prenatal care providers, to make sure the plan of care is followed and revised if necessary.
 - ◆ Listen to the client's needs and concerns and integrate them into the plan of care.
 - ◆ Help the client plan for the continuing health care of her child(ren).

- ◆ Provide information about other services available within the community for the client's use.
- Explain Maternity Support services to the client.
 - ◆ coverage of pregnancy-related medical services
 - ◆ transportation
 - ◆ prescriptions
 - ◆ childbirth and parenting classes
 - ◆ dental care
 - ◆ Maternal Care Skilled Nurse Home Visit
 - ◆ Health and Behavior Intervention
 - ◆ Medical Nutritional Therapy
 - ◆ newborn Medicaid coverage
 - ◆ Home Visit for Postnatal Assessment and Follow-up Care
 - ◆ Home Visit for Newborn Care and Assessment

Note: Enrollment in the Maternity Care Coordination program is not necessary in order to benefit from Maternity Support services.

- Explain the client's responsibilities while receiving Maternity Care Coordination services.
 - ◆ Select a primary care provider and give the name of the Maternity Care Coordinator.
 - ◆ Agree to work with the Maternity Care Coordinator to develop a plan of care based on the client's identified needs.
 - ◆ Agree to follow the plan of care as developed by the client, Maternity Care Coordinator, and the prenatal care provider.
- Obtain the client's signature on the Letter of Agreement.
- Complete the Family Strengths/Needs Assessment form.
- Complete the Women, Infant, and Children (WIC) Special Supplemental Nutrition program referral form.
- Provide client/prenatal education.
 - ◆ Counsel the client about the importance of early and continuous prenatal care.
 - ◆ Assist the client in finding a prenatal care provider, if necessary.
 - ◆ Ensure that the client has received health education materials.
 - ◆ Provide information on childbirth or parenting classes available in the agency or community.
 - ◆ Provide information on tobacco usage, second-hand smoke, and smoking cessation programs.
 - ◆ Provide information on substance/alcohol usage during pregnancy and assist with locating support groups/treatment.
 - ◆ Advise against the use of any drugs/medications during pregnancy unless prescribed by a prenatal care provider.
 - ◆ Encourage the client to adhere to the prenatal care provider's plan of care.

- ◆ Encourage and develop a plan for labor and delivery, which includes a support person and transportation.
- ◆ Assist in obtaining an infant safety seat and advise the client on the infant safety law and seat usage.

Note: The Maternity Care Coordinator has a legal obligation to report situations of clear and imminent danger to the appropriate authority.

5.3 Plan of Care

The purpose of the plan of care is to document the work being done by both the family and the Maternity Care Coordinator. Agencies with Maternal Outreach Worker programs must also document Maternal Outreach Worker duties on the plan of care. Key points in the development of the plan of care include:

- the agreement between the client and the Maternity Care Coordinator on areas to be addressed, including priorities identified by the client
- care coordination goals and activities written in clear, behavioral terms indicating specific responsibilities and time lines for accomplishment/ reassessment
- strengths identified as resources
- modification according to changes in identified needs

5.4 Subsequent Contacts

Maternity Care Coordination subsequent contacts must be one-on-one, face-to-face visits conducted in the clinic, home or a convenient site. The subsequent contact may also be an exchange of information by telephone. Although frequency and duration of services are to be determined by the needs of the client, **a minimum monthly contact is required.**

The Maternity Care Coordinator is responsible for ensuring that mandated follow-up of missed appointments occur.

Subsequent contacts should be individualized and include the following:

- number and complexity of problems
- availability of caregivers within the area
- availability of services within the area
- client's and her family's ability to meet their own needs and use available support systems

During the subsequent contact, the Maternity Care Coordinator must:

- review the Family Strengths/Needs Assessment for new concerns or changes in the status of previously identified concerns
- reassess the priorities of the client
- assess and reassess the family/client relationships
- update and revise the plan of care as needed
- make necessary referrals and follow-up on previous referrals
- discuss the future plans and/or transitions to other programs or services

5.5 Home Visits

Maternity Care Coordination home visits must be one-on-one, face-to-face visits conducted in the client's home. A home visit is determined to be necessary when it is needed to implement the developed plan of care or to prevent the client from discontinuing services. Home visits are considered subsequent contacts and meet the minimum monthly contact requirement.

In addition to the requirements outlined in subsequent contacts, the home visit must also include one or more of the following:

- assessment of the home environment
- monitoring of the client's adherence to their service plan
- education/counseling
- referral and follow-up
- other support services, as needed

5.6 Transfer

The client may elect to obtain Maternity Care Coordination services from another provider. In this case, the transferring Maternity Care Coordinator must coordinate activities by:

- obtaining a signed medical release of information
- updating the plan of care
- notifying appropriate caregivers of status change
- initiating contact with the new Maternity Care Coordinator by letter/telephone to review the client's file and share significant information
- discussing transfer of services with the client and assisting with information regarding the new provider
- transferring a copy of the care coordination record(s) including all required forms

A new Letter of Agreement must be signed by the new Maternity Care Coordinator and the client once the transfer is complete.

5.7 Discontinuation

Maternity Care Coordination services can only be discontinued for the following reason(s):

- services are terminated at the end of the month in which the 60th postpartum day occurs
- client transfers out of the county
- client states she no longer wishes to receive services
- client is lost to follow-up after repeated attempts to locate her
- client expires during the eligibility period
- client is no longer Medicaid-eligible

5.8 Transition

The Maternity Care Coordinator must provide follow-up services to the mother and infant when transitioning the family to the Child Service Coordination program. The transition must include the following:

- Follow-up Services for the Mother:
 - ◆ Assist in locating a medical provider for her ongoing health needs.
 - ◆ Refer and assist in obtaining appropriate family planning services.
 - ◆ Provide and assist with information on community resources.
 - ◆ Provide and assist with information on parenting and well child care.
 - ◆ Refer and arrange for postpartum WIC certification.
 - ◆ Notify the client and caregivers that Maternity Care Coordination services are being discontinued.
 - ◆ Ensure that the Pregnancy Outcome Summary/Report has been completed correctly and has been submitted.
- Follow-up Services for the Infant:
 - ◆ Ensure that the local department of social services has been notified of the infant's birth and that the newborn has received Medicaid certification.
 - ◆ Assist in locating a medical provider for ongoing well child and sick care.
 - ◆ Ensure that the mother has the Health Check program brochure and understands that preventive services are available for children under the age of 21.
 - ◆ Consult with the local Health Check program coordinator regarding medical appointments for the infant and arranging medical transportation.
 - ◆ Refer and arrange for WIC certification for the infant.
 - ◆ Inform and assist the mother on the use of infant/child safety seats.
 - ◆ Coordinate the transition of care coordination services with the Child Service Coordinator.

5.9 Closure

Maternity Care Coordination services must be closed when one of the discontinuation provisions specified in **Section 5.7, Discontinuation**, occur. The Maternity Care Coordinator must:

- provide and assist with information on community resources
- update the plan of care to reflect the final Maternity Care Coordination service status
- notify the client and caregivers that Maternity Care Coordination services have terminated
- document reason for termination

When Maternity Care Coordination services are discontinued at client's request, the Maternity Care Coordinator should:

- consider transferring the case to another Maternity Care Coordinator; or
- follow-up after termination to determine if the client would like to re-enroll.

5.10 Evaluation and Reporting

In order to collect data necessary for measuring the effectiveness of Maternity Care Coordination services, Maternity Care Coordinators are responsible for completing a Pregnancy Outcome Summary/Report for each client upon the completion of care coordination services. The Pregnancy Outcome Summary/Report must be submitted within 30 days of discontinuation of services.

Local health departments must complete the Pregnancy Outcome Summary (DEHNR 3080). This data must be submitted through the Health Services Information System (HSIS).

All other Maternity Care Coordination provider agencies (i.e., Federally Qualified Health Centers, Rural Health Clinics, physicians) must complete the Pregnancy Outcome Report (DMA-3002 Rev. 9/99). This report is submitted to:

Baby Love Program
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

6.0 Eligible Providers

Community and migrant health centers, Federally Qualified Health Centers, local health departments, private practitioners, regional perinatal providers, and Rural Health Clinics are eligible to provide this service.

The caseload size for a full-time Maternity Care Coordinator is 100 clients per year or 60 to 70 clients at any given time.

6.1 Provider Enrollment

1. Provider Application – A signed provider application (DMA-3008) must be on file for each agency that provides Maternity Care Coordination services.
2. Approval – The Division of Public Health and the Division of Medical Assistance must approve the application.
3. Termination – Provider participation can be terminated in accordance with provisions contained within the agreement.

6.2 Staffing Qualifications

This service must be rendered by:

- a registered nurse (RN) who is licensed in the State of North Carolina with a minimum of one year of experience in community health nursing and working with pregnant women and families;
- a Social Worker with a Master’s Degree in Social Work, Bachelor’s Degree in Social Work or employed as a Social Worker meeting state SW II qualifications with a minimum of one year of experience in health and human services and working with pregnant women and families; or

- a Maternity Care Coordinator trainee who is either:
 - ◆ an RN who is licensed in the State of North Carolina; or
 - ◆ a Social Worker with a Master's Degree in Social Work, Bachelor's Degree in Social Work or employed as a Social Worker meeting state SW II qualifications.

When additional years of experience are needed to meet the required number of years for SW II qualifications, the work experience requirement cannot be waived.

The work experience requirement is waived when the trainee is an RN, BSN, BSW or MSW. The trainee must work under the supervision of an experienced Maternity Care Coordinator. The duties and functions of a trainee are the same as outlined for the Maternity Care Coordinator. This includes carrying a caseload and does not require the signature of the supervising Maternity Care Coordinator. The supervising Maternity Care Coordinator must:

- arrange informal weekly conferences with the trainee
- provide timely access for the trainee
- assure supervisor and trainee relationship is defined in the agency policy

6.3 Staffing Requirements

The Maternity Care Coordinator must be:

- employed by a qualified service provider; and
- required to attend state-sponsored "Basic Training" within one year of hire date

Note: Student interns cannot provide Maternity Care Coordination services for Medicaid reimbursement.

7.0 Additional Requirements

Documentation

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

1. signed Letter of Agreement;
2. completed Family Strengths/Needs Assessment;
3. plan of care;
4. dates of client contact/attempt;
5. type of contact (face-to-face, home visit, exchange of information by telephone);
6. actions taken from previous contacts/problems resolved;
7. plan of care concerns addressed during the contact and the actions to be taken by the client and the Maternity Care Coordinator before the next contact;
8. modifications to the original plan of care;
9. next scheduled contact; and
10. signature of the Maternity Care Coordinator.

Documentation of contacts can occur on narrative notes (DMA-3016 Rev. 7/99), care plans (DMA-3007 Rev. 7/93) or Subjective data, Objective data, Assessment, and Plan of Action (SOAP) notes.

When applicable, agencies may opt to develop their own equivalent forms. However, components of the local forms must contain all the elements of the state-created forms and must be approved by the regional social work consultant prior to implementation.

8.0 Billing Guidelines

Maternity Care Coordination services are reimbursed up to six units per month. One unit = 15 minutes. Additional units may be requested through the claims adjustment process. Claims for additional units will be considered for reimbursement only when conditions of coverage are met and documentation supports the following medical necessity factors (or high-risk criteria):

- medical high-risk factors related to pregnancy outcome such as preterm labor, hypertension, preeclampsia, diabetes, suspected fetal growth retardation, multiple pregnancy, renal disease, HIV infection/AIDS, perinatal substance abuse and/or other high-risk medical conditions
- substance abuse (alcohol or drugs) or history of substance abuse with potential negative impact on current pregnancy
- child abuse or family violence with potential negative impact on current pregnancy
- mental impairment/retardation

Maternity Care Coordination services cannot be reimbursed when provided on the same date as the following services:

- Child Service Coordination
- Home Visit for Newborn Care and Assessment
- Home Visit for Postnatal Assessment and Follow-Up Care
- Maternal Care Skilled Nurse Home Visit
- Maternal Outreach Worker services

If a Health and Behavior Intervention home visit is determined to be necessary during a Maternity Care Coordination home visit, bill only one service.

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.4	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida
V23.84	Young multigravida

- V23.89 Other high-risk pregnancy
- V23.9 Unspecified high-risk pregnancy
- V24.0 Immediately after delivery
- V24.2 Routine postpartum follow up

Procedure Code(s)

HCPCS code T1017 – Targeted case management, each 15 minutes

Payment Rate(s)

Providers must bill their usual and customary charge.

Childbirth Education

1.0 Description of the Service

Childbirth education prepares the pregnant woman and her support person for the labor and delivery experience. Various breathing relaxation techniques and comfort measures for all phases of labor are demonstrated, as well as opportunities for return demonstration and repeated practice during classes.

2.0 Eligible Recipients

Pregnant women who receive Medicaid are eligible for this service.

3.0 When Service is Covered

Childbirth education is covered during the pregnancy.

4.0 When Service is Not Covered

Childbirth education is not covered when the criteria listed above are not met.

5.0 Policy Guidelines

Childbirth education includes a series of four classes, which meet for two hours each, for a total of eight hours of instruction. The classes must be based on a written curriculum that outlines course objectives and the specific content covered in each class. Instructions include, but are not limited to:

- important aspects of prenatal care, including danger signs
- signs of preterm labor
- preparation for labor and delivery
- breathing, relaxation, and other comfort measures

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 Eligible Providers

Local health departments, physician or medical diagnostic clinics, physicians, and nurse midwives are eligible to provide this service.

Staff Qualifications

If the childbirth educator is not certified, the agency providing this service must assess the educator's qualifications.

7.0 Additional Requirements**Documentation**

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

1. client's name and date of birth;
2. client's Medicaid identification number (MID);
3. dates of service;
4. plan of treatment/care and outcome; and
5. name and title of person performing the service.

8.0 Billing Guidelines

Childbirth education is reimbursed per class. One class = two hours of instruction. Two classes = four hours of instruction. Four classes = eight hours of instruction. The childbirth education provider can only submit claims for reimbursement for classes that the client attends. A maximum of two classes per day may be provided and a maximum of four classes per pregnancy can be billed for reimbursement.

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

- V22.0 Supervision of normal first pregnancy
- V22.1 Supervision of other normal pregnancy
- V22.2 Pregnant state, incidental
- V23.0 Pregnancy with history of infertility
- V23.1 Pregnancy with history of trophoblastic disease
- V23.2 Pregnancy with history of abortion
- V23.3 Grand multiparity
- V23.4 Pregnancy with other poor obstetric history
- V23.5 Pregnancy with other poor reproductive history
- V23.7 Insufficient prenatal care
- V23.81 Elderly primigravida
- V23.82 Elderly multigravida
- V23.83 Young primigravida
- V23.84 Young multigravida
- V23.89 Other high-risk pregnancy
- V23.9 Unspecified high-risk pregnancy

Procedure Code(s)

HCPCS code S9442 – Birthing classes, non-physician provider, per session

Payment Rate(s)

Providers must bill their usual and customary charges.

Maternal Care Skilled Nurse Home Visit

1.0 Description of the 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.

2.0 Eligible Recipients

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 Service is 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: preterm labor, hypertension, preeclampsia, diabetes, suspected fetal growth retardation, multiple pregnancy, renal disease, HIV infection/AIDS, perinatal substance abuse, and/or other high-risk medical conditions. The client must be referred by their prenatal care physician or physician extender (certified nurse midwife, nurse practitioner, physician assistant).

4.0 When Service is Not Covered

Maternal Care Skilled Nurse Home Visits are not covered when criteria listed above are not met.

5.0 Policy Guidelines

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:

- **Previsit Preparation**
review of prenatal, Maternity Care Coordination services, and other records to identify special problems and needs that may require follow-up
- **Home Visit**
 - ◆ assessment of the high-risk condition(s)
 - ◆ treatment in the home as outlined in the referral from the medical care provider
- **Referral/Documentation**
 - ◆ referrals made to Maternity Care Coordinator, Women, Infant, and Children (WIC) Special Supplemental Nutrition program, and other providers if needed
 - ◆ written findings of the home visit sent to the medical provider
- **Consultation**
consultation between the registered nurse (RN) and the Maternity Care Coordinator before and after the home visit, when the RN is not the Maternity Care Coordinator

6.0 Eligible Providers

Local health departments are eligible to provide this service.

Staff Qualifications

The service must be rendered by an RN skilled in maternity care.

7.0 Additional Requirements:**Documentation:**

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

1. client's name and date of birth;
2. client's Medicaid identification number (MID);
3. dates of service;
4. referral from the prenatal care physician or physician extender;
5. plan of treatment/care and outcome; and
6. name and title of person performing the service.

8.0 Billing Guidelines

Maternal Care Skilled Nurse Home Visits are reimbursed up to two visits per month. Additional visits may be requested through the claims adjustment process. Claims for additional visits will be considered for reimbursement only when conditions of coverage are met and documentation supports medical necessity.

Maternal Care Skilled Nurse Home Visits cannot be reimbursed when provided on the same date as the following services:

- Child Service Coordination
- Home Visit for Newborn Care and Assessment
- Home Visit for Postnatal Assessment and Follow-Up Care
- Maternity Care Coordination

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.4	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida
V23.84	Young multigravida
V23.89	Other high-risk pregnancy
V23.9	Unspecified high-risk pregnancy

Procedure Code(s)

HCPCS code T1001 – Nursing assessment/evaluation

Payment Rate(s)

Providers must bill their usual and customary charges.

Home Visit for Postnatal Assessment and Follow-Up Care

1.0 Description of the Service

Home Visit for Postnatal Assessment and Follow-up Care is designed to deliver health, social support, and/or educational services directly to families in their home. Home Visit for Postnatal Assessment and Follow-up Care is a means for follow-up on the mother's health; to counsel on family planning and infant care; and to arrange for additional appointments for the infant and mother.

The goals of the Home Visit for Postnatal Assessment and Follow-up Care are:

- to provide a key mechanism for reaching families early with preventive and anticipatory services
- to provide opportunities for timely referral of problems
- to promote spacing of subsequent pregnancies
- to provide a link with women's preventive health services

2.0 Eligible Recipients

Postpartum women who receive Medicaid are eligible for this service.

Note: Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs.

3.0 When Service is Covered

Home Visit for Postnatal Assessment and Follow-up Care is covered within two or three weeks following the client's discharge from the hospital, but no later than 60 days after delivery.

4.0 When Service is Not Covered

Home Visit for Postnatal Assessment and Follow-up Care is not covered when the criteria listed above are not met.

5.0 Policy Guidelines

Home Visit for Postnatal Assessment and Follow-up Care must be a one-to-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. Home Visit for Postnatal Assessment and Follow-up Care must follow the curriculum requirements outlined on the Postpartum Home Visit Assessment form (DEHNR T775 Rev. 3/93).

6.0 Eligible Providers

Federally Qualified Health Centers, local health departments, and Rural Health Clinics are eligible to provide this service.

Staffing Qualifications

The service must be rendered by a registered nurse (RN).

7.0 Additional Requirements

An RN who is not a Maternity Care Coordinator or Child Service Coordinator is required to coordinate services, when applicable. The RN making a Home Visit for Postnatal Assessment and Follow-up Care must:

1. discuss the past and current medical history of the mother and child with the Maternity Care Coordinator and/or Child Service Coordinator;
2. discuss the plan of care or service coordination goals with the Maternity Care Coordinator and/or Child Service Coordinator prior to the home visit so that tasks listed in the plan of care can be addressed during the home visit; and
3. contact the family to schedule a convenient time for the home visit and explain its purpose.

Following the Home Visit for Postnatal Assessment and Follow-up Care, the RN must:

1. document findings in the mother’s record and in the child’s record as they apply;
2. discuss observations with the Maternity Care Coordinator and/or Child Service Coordinator; and
3. update the Maternity Care Coordination and/or Child Service Coordination plan of care as applicable.

When a child is not eligible for Child Service Coordination and the mother is receiving Maternity Care Coordination, the RN making a Home Visit for Postnatal Assessment and Follow-up Care must:

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

Following the Home Visit for Postnatal Care Assessment and Follow-up Care, the RN must:

1. document findings in the appropriate records; and
2. make referrals to other agency and community resources as indicated by the findings and as agreed with by the family.

An RN who is the family’s Maternity Care Coordinator and/or Child Service Coordinator may make a Home Visit for Postnatal Assessment and Follow-up Care in lieu of – or in addition to – regularly scheduled Maternity Care Coordination and/or Child Service Coordination activities. Coordination between the Maternity Care Coordination and Child Service Coordination programs is required.

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

8.0 Billing Guidelines

Home Visit for Postnatal Assessment and Follow-up Care is reimbursed once per client per pregnancy. Home Visit for Postnatal Assessment and Follow-up Care and Home Visit for Newborn Care and Assessment can be reimbursed when provided on the same date of service.

Home Visit for Postnatal Assessment and Follow-up Care cannot be reimbursed when provided on the same date as the following services:

- Child Service Coordination
- Maternal Care Skilled Nurse Visit
- Maternity Care Coordination
- Maternal Outreach Worker services

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V24.0 Immediately after delivery

V24.2 Routine postpartum follow up

Procedure Code(s)

CPT code 99501 – *Home visit for postnatal assessment and follow-up care*

Payment Rate(s)

Providers must bill their usual and customary charges.

Home Visit for Newborn Care and Assessment

1.0 Description of the Service

Home Visit for Newborn Care and Assessment delivers health, social support, and/or educational services directly to families in their home. Home Visit for Newborn Care and Assessment is a means for 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:

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

2.0 Eligible Recipients

Infants age birth to 60 days who receive Medicaid are eligible for this service.

3.0 When Service is Covered

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.

4.0 When Service is Not Covered

Home Visit for Newborn Care and Assessment is not covered when the criteria listed above is not met.

5.0 Policy Guidelines

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. Home Visit for Newborn Care and Assessment must follow the curriculum requirements outlined on the Newborn Home Visit form (DEHNR T774 Rev. 3/93).

6.0 Eligible Providers

Federally Qualified Health Centers, local health departments, and Rural Health Clinics are eligible to provide this service.

Staffing Qualifications

The service must be rendered by a registered nurse (RN).

7.0 Additional Requirements:

An RN who is not a Maternity Care Coordinator or Child Service Coordinator is required to coordinate services, when applicable. The RN making a Home Visit for Newborn Care and Assessment must:

1. discuss the past and current medical history of the mother and child with the Maternity Care Coordinator and/or Child Service Coordinator;
2. discuss the plan of care or service coordination goals with the Maternity Care Coordinator and/or Child Service Coordinator prior to the home visit so that tasks listed in the plan of care can be addressed during the home visit; and
3. 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:

1. document findings in the mother’s record and in the child’s record as they apply;
2. discuss observations with the Maternity Care Coordinator and/or Child Service Coordinator; and
3. update the Maternity Care Coordination and/or Child Service Coordination plan of care, as applicable.

When a child is not eligible for Child Service Coordination and the mother is receiving Maternity Care Coordination, the RN making a Home Visit for Newborn Care and Assessment must:

1. review available records from the referral contact;
2. review prior medical records of the mother (and/or the child) prior to the home visit; and
3. 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:

1. document findings in the appropriate records; and
2. make referrals to other agency and community resources as indicated by the findings and as agreed with by the family.

An RN who is the family’s Maternity Care Coordinator and/or Child Service Coordinator may make a Home Visit for Newborn Care and Assessment in lieu of – or in addition to – regularly scheduled Maternity Care Coordination and/or Child Service Coordination activities. Coordination between the Maternity Care Coordination and Child Service Coordination programs is required.

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

8.0 Billing Guidelines

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 Early Periodic Screening Diagnosis Testing (EPSDT) Home Visit for Newborn Care and Assessment.

Home Visit for Newborn Care and Assessment and Home Visit for Postnatal Assessment and Follow-up Care can be reimbursed when provided on the same date of service.

Home Visit for Newborn Care and Assessment cannot be reimbursed when provided on the same date as the following services:

- Child Service Coordination
- Maternal Care Skilled Nurse Home Visit
- Maternal Outreach Worker services
- Maternity Care Coordination

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V20.2 Routine infant or child health check

Procedure Code(s)

CPT code 99502 – *Home visit for newborn care and assessment*

Payment Rate(s)

Providers must bill their usual and customary charges.

Health and Behavior Intervention

1.0 Description of the Service

Health and Behavior Intervention provides intensive, focused counseling for pregnant and postpartum women who have serious psychosocial needs, which include individualized problem-solving, priority setting, instruction, and action planning to effect behavior modification or environmental change. It may include individualized treatment therapies designed specifically to aid in overcoming the identified problems. It may also include the involvement of the woman's significant other or other service providers.

2.0 Eligible Recipients

Pregnant and postpartum women who receive Medicaid and have one or more of the specified intensive psychosocial needs are eligible for this service.

Note: Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs.

3.0 When Service is Covered

Health and Behavior Intervention is covered for pregnant or postpartum women with one or more of the following conditions:

- substance abuse (alcohol or drugs) or history of substance abuse with potential negative impact on the current pregnancy
- child abuse, family violence or severe family dysfunction or history of such problems with potential negative impact on the current pregnancy
- severe emotional crises associated with situations such as loss of job, divorce, homelessness, death, terminal illness
- episodic disorders: severe depression, psychosis, behavior disorders
- suicidal tendencies
- intense negative feelings about the current pregnancy
- intense negative feelings about previous poor pregnancy outcome such as fetal death, stillborn, infant death or congenital abnormalities
- HIV infection/AIDS and other life-threatening medical problems
- pending incarceration during the pregnancy
- major psychological behavioral disorders such as anorexia

4.0 When Service is Not Covered

Health and Behavior Intervention is not covered when the criteria listed above are not met.

5.0 Policy Guidelines

Health and Behavior Intervention services for pregnant and postpartum women should be face-to-face in the home or clinic (not the area mental health center). It can be provided by telephone when life-threatening situations exist.

Health and Behavior Intervention services may be provided in addition to services provided by the area mental health center. The two agencies may not provide the same service for the same reason or criteria. Counseling services must be coordinated to ensure continuity of care.

This short-term service may begin during the pregnancy and continue through the end of the month in which the 60th postpartum day occurs. Long-term counseling needs may necessitate referrals to other providers.

6.0 Eligible Providers

Local health departments are eligible to provide this service.

Staffing Qualifications

This service must be rendered by a licensed clinical social worker.

7.0 Additional Requirements:

Documentation

Initial and subsequent client contacts must be documented. The Intensive Psychosocial Counseling Initial and Subsequent Assessment forms, a narrative note or Subjective data, Objective data, Assessment and Plan of Action (SOAP) note are acceptable forms for documentation. If the narrative note is used, the reason for the referral, presenting problem, summary/impression, treatment plan, and disposition must be included.

Screening tools may be used in conjunction with the assessment tool. The tools are used to help identify and screen specific psychosocial problems such as: alcohol and/or substance abuse, depression, HIV infection/AIDS, domestic violence or suicidal tendencies.

Confidentiality of the records must be maintained.

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

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

1. client's name and date of birth;
2. client's Medicaid identification number (MID);
3. dates of service;
4. documentation of initial and subsequent contacts;
5. plan of treatment/care and outcome; and
6. name and title of person performing the service.

8.0 Billing Guidelines

Health and Behavior Intervention is reimbursed up to four units per day. One unit = 15 minutes with a maximum of 44 units per pregnancy and postpartum. Additional units may be requested through the claims adjustment process. Claims for additional units will be considered for reimbursement only when conditions of coverage are met and documentation supports medical necessity.

Health and Behavior Intervention cannot be reimbursed when provided on the same date as the following services:

- Home Visit for Newborn Care and Assessment
- Home Visit for Postnatal Assessment and Follow-up Care

If a Health and Behavior Intervention home visit is determined to be necessary during a Maternity Care Coordination home visit, bill only one service.

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.4	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida
V23.84	Young multigravida
V23.89	Other high-risk pregnancy
V23.9	Unspecified high-risk pregnancy
V24.0	Immediately after delivery
V24.2	Routine postpartum follow up

Procedure Code(s)

CPT code 96152 – *Health and behavior intervention*

Payment Rate(s)

Providers must bill their usual and customary charges.

Child Service Coordination

1.0 Description of the Service

The Child Service Coordination program provides formal case management services to eligible children at risk or diagnosed with special needs. Child Service Coordination identifies and provides access to needed preventive and specialized support services for children and their families through collaboration. The program is family-centered and family-driven and seeks to respond to the varying concerns of children and their families recognizing that:

- concerns of children and families change over time
- families are the constant in the lives of children
- families have expertise regarding their children

The Child Service Coordination program requirements include:

- outreach
- identification and referral
- enrollment
- assessment of family strengths and concerns and the child's development
- assessment of parent/child interaction
- development of care coordination plan
- follow-up
- evaluation

Through Child Service Coordination, families will have:

- improved access to services, pursuant to federal Child Find initiatives
- the opportunity to reach their maximum potential
- the opportunity to identify concerns and develop or enhance self-reliance skills

2.0 Eligible Recipients

Children age birth to three years who are at risk for the criteria listed below are eligible for this service.

Children age birth to five years who are diagnosed with the criteria listed below are eligible for this service.

3.0 When Service is Covered

Child Service Coordination is covered for children age birth to three years who are at risk for developmental delay or disability, chronic illness or social/emotional disorder.

Child Service Coordination is covered for children age birth to five years who are diagnosed with developmental delay or disability, chronic illness or social/emotional disorder.

4.0 When Service is Not Covered

Child Service Coordination is not covered when the criteria listed below are not met.

5.0 Policy Guidelines

5.1 Identification and Referral

Potentially eligible infants and children may be identified at any time for the Child Service Coordination program. Risk conditions and diagnoses used to identify children are listed on the Identification and Referral form (DHHS 3748), which include definitions to guide the care coordinator.

The Identification and Referral form is a requirement for the Child Service Coordination program and should be completed by professionals. The completed form should be forwarded to the health department in the child's county of residence. The Child Service Coordinator must ensure the completion and validity of the information provided prior to data entry. Federal and state guidelines mandate the collection of the information listed on lines 1 through 9 on the form.

5.2 Child Service Coordination Program Log

The Child Service Coordination Program Log is a listing of all children age birth to five years who are identified for the Child Service Coordination program. The log indicates active or inactive status and the Child Service Coordination agency. The local health department maintains this log.

5.3 Initial Follow-up of the Referral

The following activities should be carried out:

- Review the Identification and Referral form.
- Contact the local health department for verification of the child's enrollment status.
 - ◆ If the child is enrolled, the agency that received the referral indicates the name of the Child Service Coordinator and returns the form to the referring party.
 - ◆ If the child has not been enrolled, the agency that receives the referral contacts the family to explain the enrollment process of the Child Service Coordination program.
 - ◆ If the child has not been enrolled and an agency other than the health department receives the referral, that agency contacts the family to explain the enrollment process of the Child Service Coordination program.

Note: The agency providing Child Service Coordination designates the initial coordinator.

5.4 Enrollment

Enrollment into the Child Service Coordination program should take place within two weeks. The exception is children who are potentially eligible for the North Carolina Infant-Toddler program. Contact must be made within two working days.

Note: Children who are potentially eligible for the North Carolina Infant-Toddler program will have one risk indicator identified in the 401-411 series or any three risk indicators identified in the 100, 200 or 300 series on the Identification and Referral form.

Child Service Coordinators are required to meet face-to-face with the family for enrollment. The tasks to be accomplished are:

- to develop a relationship with the family
- to verify the risk status of the child on the Identification and Referral form
- to explain the Child Service Coordination program and the role of the Child Service Coordinator
- to obtain the family's signature on the Letter of Agreement
- to obtain signed release(s) of information, as needed
- to initiate the family and child strengths/needs assessment process
- to assist the family in deciding priorities
- to prepare the care coordination plan

5.5 Designation of the Child Service Coordinator

The decision regarding designation of the Child Service Coordinator is made by the family and relevant professionals based upon:

- family preference
- potential for continuity of service coordination over time
- match between the specific concerns of the family and the types of services provided by an agency
- geographic accessibility of service coordinator
- ability to provide service coordination for multiple children in the family

A Child Service Coordinator should be designated when:

- a referral is received
- the child is enrolled in the Child Service Coordination program
- the family requests a change in the Child Service Coordinator
- the child is referred for eligibility to the North Carolina Infant-Toddler program

5.6 Letter of Agreement

The Letter of Agreement outlines the responsibilities of the Child Service Coordinator and the family. An agency may elect to develop their own Letter of Agreement or use the recommended form. A child is enrolled in the program when the family signs a Letter of Agreement. A copy of this agreement is maintained in the child's clinical record. The family must receive a copy of the agreement.

A new Letter of Agreement must be initiated with each change in the Child Service Coordinator. If a Child Service Coordinator is not available for an extended period of time (three months), a new Letter of Agreement is required. However, a new Letter of Agreement is not required in a family emergency situation.

5.7 Family and Child Strengths/Needs Assessment

The Family and Child Strengths/Needs Assessment (DMA 3006 Rev. 5/00) or approved equivalent is initially completed at the time of enrollment and at 6-month intervals. Alternative forms must be approved by the regional child nurse consultant.

5.8 Assessment of Parent/Child Interaction

Observation of parent/child interaction is a conscious, required activity that involves being able to observe not only the child and the parent individually, but also the child and parent as a dyad. It must occur at each required 6-month interval. If a face-to-face contact with the parents is not possible, the child may be observed in his/her child care setting and a telephone contact is made with the parent to discuss what was observed, obtain parental input, feedback, and discuss other program requirements.

A formal, standardized assessment tool should be used when there are concerns about the parent/child interaction

The Child Service Coordinator should use the information gained from the assessment of the parent/child interaction to educate parents, to reinforce appropriate expectations for growth and development, and to encourage positive behaviors and strengths.

Documentation of the parent/child interaction requires:

- observed behaviors
- reinforcement of parent's strengths
- developmentally appropriate activities
- community referrals

5.9 Developmental Follow-Up/Intermediate Assessment Process

Developmental monitoring and support services include record reviews, conversations with parents, developmental screenings, consultations, standardized developmental assessments, and intervention follow-up. The intermediate assessment is based on a collaborative relationship involving the child, the family, the Child Service Coordinator, and the Infant-Toddler Specialist.

Intermediate assessments must be offered at the following age intervals:

1. Child's chronological age is 15 to 18 months
 - Consultation
 - ◆ review the child's medical records for height, weight, head circumference, and previous developmental screenings
 - ◆ discuss the family's developmental expectations and concerns
 - ◆ contact the Infant-Toddler Specialist
 - ◆ facilitate decisions and document findings
 - ◆ report completion of intermediate assessment
 - Standardized assessment

2. Child's chronological age is 30 to 36 months
 - Standardized assessment
 - Intermediate assessment, which includes the following components:
 - ◆ physical growth (vision, hearing, height, weight, and head circumference)
 - ◆ gross and fine motor function
 - ◆ receptive and expressive language (articulation if appropriate)
 - ◆ self-help skills
 - ◆ behavioral/social/emotional development
 - ◆ cognitive skills
 - ◆ parental interview
 - ◆ record review
 - ◆ administration of appropriate assessment tools
 - ◆ developmental education and counseling
 - ◆ referrals, as appropriate
 - ◆ documentation

If there are additional concerns on the child's development, the Child Service Coordinator should notify the Infant-Toddler Specialist. The two primary functions of the Infant-Toddler Specialist are:

- to consult with Child Service Coordinators regarding the developmental status of children in their catchment area
- to provide intermediate assessment, as indicated

The Child Service Coordinator should initiate the intermediate assessment process with the family. This includes the following activities:

- discuss with the family their perceptions of the child's development
- refer for intermediate assessments as outlined in the Memorandum of Understanding
- provide support to the family
- document intermediate assessment activities in the child's record and on the Program Status Report (DHHS 3750)
- adhere to the responsibilities outlined in the Memorandum of Understanding

If the family requests developmental follow-up on discontinued services, it is the Child Service Coordinator's responsibility to schedule the intermediate assessment.

5.10 Memorandum of Understanding

The Developmental Evaluation Center must negotiate a Memorandum of Understanding with the local health department. At a minimum, the Memorandum of Understanding must include the following items and designate the responsible agency:

1. Establish an intermediate assessment schedule for the county Child Service Coordination program provider agency based on the number of children enrolled in the county Child Service Coordination program.

2. Assure that an Infant-Toddler Specialist or comparable professional is performing intermediate assessments. This requires identifying back-up personnel for times when the Infant-Toddler Specialist is not available.
3. Establish regular meetings with Child Service Coordination program provider agencies to address the county's intermediate assessment needs.
4. Determine the intermediate assessment process.
5. Identify available space within the county to administer intermediate assessments.
6. Obtain parent/guardian consent prior to the child receiving a formal evaluation.
7. Provide Child Service Coordination agency records to Infant-Toddler Specialists for children scheduled for intermediate assessments.

5.11 Preventive Health Services

Informing families of the importance of preventive health care and assisting them in accessing these services is a requirement of the Child Service Coordination program. Preventive health services may include, but are not limited to:

- well child care
- nutrition
- safety
- dental health
- development
- child care
- immunizations

5.12 Developing the Care Coordination Plan

The initial care coordination plan is developed following the completion of the assessment of family and child strengths and priorities. The care coordination plan is a negotiated agreement between the family and the Child Service Coordinator and is modified based on parent/child interaction and changing family priorities. The care coordination plan is a means to document the work being done by the family and the Child Service Coordinator. While there is no required form, the DMA-3007 may be used to document the care coordination plan. Key points in the development of the care coordination plan include:

- The family and the Child Service Coordinator must discuss and agree on the needs to be addressed, with priorities identified by the family included in the care coordination plan. Needs not currently a priority should be documented as such and revisited at a later time;
- Care coordination goals and activities should be written in clear, behavioral terms, indicating specific responsibilities of the family, Child Service Coordinator, and other providers, with time lines for accomplishment/reassessment.
- Identified strengths should be used as resources in meeting identified priorities.
- New priorities may be identified and the plan modified accordingly.

5.13 Subsequent Contacts

The level of contact and frequency of visits is determined by the family and the Child Service Coordinator based upon:

- family concerns and the activities outlined in the care coordination plan
- number and complexity of the priorities and concerns
- availability of services within the area
- family's ability to address its concerns and use available support systems

Interaction between the family and the Child Service Coordinator may take place through an exchange of letters or telephone calls or through face-to-face contacts at a site convenient to the family and the Child Service Coordinator. A face-to-face follow-up is required when there is no response to letter or telephone contact.

The minimum contact schedule is every three months. The Child Service Coordinator must:

1. review the care coordination plan with the family and make modifications as needed;
2. discuss family satisfaction with service provider(s);
3. determine whether there are new situations or concerns to be added to the plan;
4. complete Program Status form, as appropriate; and
5. make referral for intermediate assessments, as appropriate.

Face-to-face contact is required at least every six months. In addition to the requirements listed above, the Child Service Coordinator must also:

1. update the risk indicators on the Identification and Referral form;
2. review potential eligibility for the North Carolina Infant-Toddler or Preschool programs;
3. observe, document, reinforce, support parent/child interaction; and
4. update Family and Child Strengths and Needs Assessment form.

If the parent is not available, the child may be observed in his/her child care setting. However, the parent must be contacted to discuss what was observed, obtain parental input and feedback, and discuss other program requirements.

5.14 Transition

There are four transitions that the Child Service Coordinator must facilitate:

- the transfer of the child to another Child Service Coordinator
- the referral of the child to the North Carolina Infant-Toddler program or the preschool program
- the termination of the child from the North Carolina Infant-Toddler program
- the eligibility of the child terminates

Transition services/support are not necessarily terminated because clinical services change or end.

Major tasks to be completed by the Child Service Coordinator during transitions are:

- to update the care coordination plan
- to contact the new Child Service Coordinator to review the family file and share significant information, including unresolved concerns/priorities of the care coordination plan, and to provide copies of the records as applicable with parental consent
- to notify the appropriate care givers of the change in status
- to complete and submit the Program Status form to the local health department
- to document the change in the care coordination file

5.15 Transitions to Other Programs

North Carolina Infant-Toddler Program

For a child who is potentially eligible for the North Carolina Infant-Toddler program, a referral is made to the county-based consortium. Refer to the North Carolina Infant-Toddler program manual for additional information.

Preschool Program

For a child who is potentially eligible for the preschool program, the Child Service Coordinator should contact the Exceptional Children's Program Coordinator with the local school system.

5.16 Closure

Closure to the Child Service Coordination program occurs in the following situations:

- family assumes Child Service Coordination responsibilities
- family refuses enrollment
- family discontinues participation
- family is lost to follow-up
- family moves out-of-state
- family moves to another county in the state
- child ages out of the program
- child expires
- risk factors cannot be substantiated

The following tasks must be addressed with the family when there is a change of Child Service Coordinators or at closure:

- Update and document the care coordination plan with current status and any future plan of action for each unresolved concern/priority.
- Document the reason for closure and care coordination status of the child and family.
- Contact the new Child Service Coordinator to review the family file and share significant information, if applicable.
- Notify appropriate caregivers of the change in status.
- Complete the Program Status form.
- Facilitate a new Letter of Agreement signed by the family and the new Child Service Coordinator.

- Inform families that Child Service Coordination can be reopened upon request, if requirements are met.
- Notify the Health Check outreach worker at the time of closure.

Instructions for reopening:

- Update original Identification and Referral form.
- Complete the following items on the Program Status form: 1 through 12, 13e, 15a through 15n, and 17 through 25.

5.17 Health Services Information System Reports

The following reports are helpful in assisting counties in evaluating their efforts on behalf of children enrolled in the Child Service Coordination program. These reports may be generated by local health departments and are available for each county and for the state. The reports are:

- Child Service Coordination Program Identification and Tracking Report XX to XX (CNAE 131)
- Child Service Coordination Program Children Active in Child Service Coordination Thru XX (CNAE 132)
- Child Service Coordination Program Log
- Child Health Activity Summary (HBS 141)

5.18 Waiting Lists

A family may be placed on a waiting list by the Child Service Coordinator if the Information and Referral form or a telephone referral is not received within 14 days.

Note: The decision to place a family on the waiting list cannot be solely based on the information on the Identification and Referral form; the Child Service Coordinator must use clinical judgment.

New referrals for Child Service Coordination services and children already enrolled in the Child Service Coordination program must be screened for potential eligibility for the North Carolina Infant-Toddler program. Agencies must clearly define in writing the policy and procedures for serving children on the Child Service Coordination program waiting list.

Waiting lists can be minimized by:

- use of the Home Visit for Postnatal Assessment and Follow-Up Care/Home Visit for Newborn Care and Assessment or a 2-week newborn check
- annual education of hospital nursery staff and other primary referral sources about the eligibility criteria for the Child Service Coordination program
- use of existing family information for those who receive Maternity Care Coordination or Maternal Outreach Worker services

6.0 Eligible Providers

Developmental Evaluation Centers, Federally Qualified Health Centers, local health departments, Rural Health Clinics, and Sickle Cell agencies are eligible to provide this service.

6.1 Provider Enrollment

Agencies wishing to provide Child Service Coordination services must enroll with the local health department. The health department will obtain a signed formal agreement with each Child Service Coordination provider agency in its county. Provider agencies must update their agreement annually. This agreement must address:

- target population(s) the agency will serve without regard to a child's Medicaid eligibility
- plans for providing service coordination to families
- sharing information between agencies
- designated contact persons in each agency
- projected number of enrolled children
- meeting program requirements
- orientation of Child Service Coordinators

New provider agreements must be sent to:
Division of Public Health
Women's and Children's Health Section
Children and Youth Branch
1916 Mail Service Center
Raleigh, NC 27699-1916

The caseload size for a full-time Child Service Coordinator is 75 families.

6.2 Staffing Qualifications

A qualified Child Service Coordinator should be:

- experienced in working with families and children and with community resources
- participate in standard orientation regarding the Child Service Coordination program and other in-service training relevant to the Child Service Coordination program

The education requirements are:

- a Master's Degree in a human service area such as social work, sociology, special education, child development, counseling, psychology or nursing. The professional should be licensed or certified, as applicable. Experience working with children and families is recommended; or
- a Bachelor's Degree in a human service area that includes the aforementioned disciplines. The professional should be licensed or certified, as applicable. Two years of experience in working with children and their families is required; or
- a registered nurse (RN) in North Carolina with two years of experience working with children and their families.

The work experience requirement may be waived only for a new employee under the following circumstances:

The new employee must work under the supervision of an experienced Child Service Coordinator. Supervision is defined by the following minimum requirements:

1. documentation of regular conferences with the new employee to review the records of clients with complex needs;
2. timely access for consultation with the new employee;
3. providing and/or accessing additional skills-building educational opportunities for the new employee to supplement on-the-job training; and
4. responsibility for the safe and effective provision of care coordination services to all families followed by the new employee.

7.0 Additional Requirements:

7.1 Service Coordination File

The service coordination file for each child/family must contain the following information:

1. a signed Letter of Agreement with the current Child Service Coordinator
2. family identification and demographic information
3. Family and Child Strengths and Needs Assessment form, including documentation of parent/child interaction and other relevant forms
4. a care coordination plan
5. a signed release of information form(s) (use standard agency or applicable interagency form), as needed
6. copies of all correspondence and program forms including Identification and Referral form (DHHS 3748), Program Status Reports (DHHS 3750), and other relevant materials

It is recommended that agencies integrate the required components into existing records to avoid duplication of efforts. Records may be subject to audit for required information. Maintenance of the service coordination file is the responsibility of the Child Service Coordination agency. Information contained in the record may be shared with relevant parties with appropriate consent, such as when the family transfers to another Child Service Coordination agency. Families will have complete access to all information contained in the file within the regulations of specific agencies. Disposition of any client file is subject to standard agency procedures.

7.2 Status Report Requirements

The Child Service Coordination Program Status form must be completed by the Child Service Coordinator according to instructions on the form and sent to the local health department for data entry.

The Program Status form must be completed when a child:

- is determined to be eligible for the North Carolina Infant-Toddler program
- terminates from the North Carolina Infant-Toddler program
- terminates from the Child Service Coordination program
- transfers to a different provider agency

8.0 Billing Guidelines

Child Service Coordination services are reimbursed up to six units per month. One unit = 15 minutes.

Child Service Coordination services cannot be reimbursed when provided on the same date as the following services:

- Home Visit for Newborn Care and Assessment
- Home Visit for Postnatal Assessment and Follow-Up Care
- Maternal Care Skilled Nurse Home Visit
- Maternal Outreach Worker services
- Maternity Care Coordination

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

V11.8	Other mental disorders
V11.9	Unspecified mental disorders
V12.00	Unspecified infectious and parasitic disease
V12.2	Endocrine, metabolic, and immunity disorders
V12.09	Other
V12.49	Other disorders of nervous system and sense organs
V13.61	Hypospadias
V13.69	Other congenital malformations
V13.7	Perinatal problems
V13.8	Other specified diseases
V15.86	Exposure to lead
V15.89	Other
V15.9	Unspecified personal history presenting hazards to health
V17.0	Psychiatric condition
V17.1	Stroke (cerebrovascular)
V17.2	Other neurological diseases
V17.5	Asthma
V17.6	Other chronic respiratory conditions
V18.3	Other blood disorder
V18.4	Mental retardation
V18.8	Infectious and parasitic diseases
V19.0	Blindness or visual loss
V19.2	Deafness or hearing loss
V20.1	Other healthy infant or child receiving care
V20.2	Routine infant or child health check
V21.31	Low birth weight status, 500-999 grams
V21.32	Low birth weight status, 1000-1499 grams
V21.33	Low birth weight status, 1500-1999 grams
V21.8	Other specified constitutional states in development
V21.9	Unspecified constitutional state in development
V23.7	Insufficient prenatal care
V29.0	Observation for suspected infectious condition

V29.1	Observation for suspected neurological condition
V29.2	Observation for suspected respiratory condition
V29.3	Observation for suspected genetic or metabolic condition
V40.0	Problems with learning
V40.1	Problems with communication (including speech)
V40.2	Other mental problems
V40.3	Other behavioral problems
V40.9	Unspecified mental or behavioral problem
V41.0	Problems with sight
V41.2	Problems with hearing
V41.4	Problems with voice production
V41.5	Problems with smell and taste
V41.6	Problems with swallowing and mastication
V41.8	Other problems with special functions
V47.0	Deficiencies of internal organs
V60.0	Lack of housing
V60.1	Inadequate housing
V61.20	Counseling for parent/child problem, unspecified
V61.49	Other health problems within family
V61.8	Other specified family circumstances
V62.81	Other psychological or physical stress, not elsewhere classified
V71.81	Abuse and neglect
V71.89	Other specified suspected conditions
V82.5	Chemical poisoning and other contamination

Procedure Code(s)

HCPCS code T1016 - Case management, each 15 minutes

Payment Rate(s)

Providers must bill their usual and customary charges.

Baby Love Maternal Outreach Worker Program

1.0 Description of the Service

The Baby Love Maternal Outreach Worker program is an enhancement to the Baby Love program and the Child Service Coordination program. Functioning as a part of the Baby Love and Child Service Coordination team, paraprofessionals offer outreach and support services through home visitation to Medicaid-eligible pregnant women and infants up to one year. This community-based program extends support to isolated and alienated women and children who do not typically receive preventive health services.

The goal of the program is to reduce infant deaths in North Carolina. In addressing this goal, the Maternal Outreach Worker program strives to achieve the following outcomes:

- earlier entry and enrollment into Medicaid, prenatal care, Women Infant and Children (WIC) Special Supplemental Nutrition program, Maternity Care Coordination, Child Service Coordination, and other supportive programs
- improved consistency of care and reduction of missed prenatal and child health appointments
- adoption of healthy behaviors and improved parenting skills
- increased time interval for subsequent pregnancies and reduction in the incidence of unplanned pregnancies.

Maternal Outreach Workers provide the following primary services to program participants:

- health education
- emotional support
- direct services
- referral to community and social service programs

2.0 Eligible Recipients

Pregnant and postpartum women who receive Medicaid and Maternity Care Coordination services are eligible to receive this service.

Note: Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs.

Children age birth to one year who receive Medicaid and Child Service Coordination services are eligible to receive this service.

3.0 When Service is Covered

Maternal Outreach Worker services are covered for:

- Pregnant and postpartum women who are enrolled in the Maternity Care Coordination program.
- Pregnant women who experience a spontaneous abortion (miscarriage), a therapeutic elective abortion, fetal demise or molar pregnancy and who are enrolled in the Maternity Care Coordination program.
- Children age birth to one year who are enrolled in the Child Service Coordination program. The child must be enrolled before the end of the month in which the child is 2 months old.

4.0 When Service is Not Covered

Maternal Outreach Worker services are not covered when the criteria listed above are not met.

5.0 Policy Guidelines

Maternal Outreach Worker activities must be carried out under the supervision and documentation of the Maternity Care Coordinator or Child Service Coordinator. Maternal Outreach Worker services must not include performing the professional Maternity Care Coordinator or Child Service Coordinator assessments.

Maternal Outreach Worker services must be a one-on-one, face-to-face visit in a non-clinic setting. For Maternal Outreach Worker services, a non-clinic setting is defined as the home, school or non-clinic location in the community. Although frequency and duration of services are to be determined by the needs of the client, **a minimum monthly contact is required.**

Before any one-on-one activities between the Maternal Outreach Worker and the client can occur, the following must take place:

1. completion of the Baby Love Maternal Outreach Worker Referral (DMA-3013 Rev. 9/00) or approved equivalent, which has been signed and dated by the supervisor and the Maternal Outreach Worker;
2. development and documentation of an individualized plan of care by the Maternity Care Coordinator or Child Service Coordinator outlining one or more service element(s);
3. completion of the Baby Love Maternal Outreach Worker services Letter of Agreement (DMA-3015 Rev. 7/99), which has been signed and dated by the Maternal Outreach Worker and the client (this is a required state form and a copy must be provided to the client); and
4. completion of the Baby Love Maternal Outreach Worker Enrollment section (DMA-3013 Rev. 9/00) or approved equivalent for Maternal Outreach Worker services, which has been signed and dated by the Maternal Outreach Worker.

Maternal Outreach Worker visits must include one or more of the following service elements:

- Health Education
 - ◆ reviewing health education materials
 - ◆ reinforcing healthy behaviors
 - ◆ encouraging the use of health services
 - ◆ responding to questions or referring to clinic staff, as appropriate, regarding health concerns
- Direct Services
 - ◆ accompanying the client to service agencies/medical services
 - ◆ transporting the client for non-Medicaid reimbursable services
 - ◆ obtaining fuel, food, clothing, etc.
 - ◆ helping the client apply for services
- Emotional Support
 - ◆ listening actively
 - ◆ assisting with problem-solving
 - ◆ supporting the client to be more self-reliant

- Referral to Programs
 - ◆ contacting agencies/individuals on behalf of the client
 - ◆ enabling the client to pursue resources, based on information provided by the Maternal Outreach Worker

Maternal Outreach Workers are also required to provide **monthly** community-based outreach at a rate of 25 percent of the total hours worked per month. Outreach is defined broadly to include any activities that promote health services/programs. Outreach activities may include:

- participating in community health fairs
- promoting agency services through the local media (newspaper, radio, TV)
- making presentations to local schools, churches, and civic organizations
- posting and distributing program flyers in the community
- sharing program information with local businesses, community agencies, and health care providers
- participating in neighborhood and door-to-door canvassing
- identifying family members of their clients who are in need of health services and linking them to services
- advising people in the community about services available for family planning, immunizations, Women, Infant, and Children (WIC) Special Supplemental Nutrition, well child care, etc.

6.0 Eligible Providers

Federally Qualified Health Centers, local health departments, and Rural Health Clinics are eligible to provide this service.

6.1 Agency Qualifications

The Division of Medical Assistance is currently not accepting new applications for the Maternal Outreach Worker program. An application is considered “new” when an agency has allowed their existing program to lapse for six months; their Maternal Outreach Worker position(s) have been vacant for six months; or when an agency has never been approved for a Maternal Outreach Worker program.

6.2 Staffing Qualifications

A qualified Maternal Outreach Worker is:

- a paraprofessional with a high school diploma or the equivalent, who meets at least a Grade 54-job classification; and
- required to attend state-sponsored “Basic Training” within one year of hire date.

7.0 Additional Requirements

7.1 Maternal Outreach Worker Supervision

Maternal Outreach Worker supervision includes the following:

- arranging localized training and orientation of new employees, including but not limited to, orientation to the agency, orientation to the community, accompanying Maternal Outreach Worker on home visits, and developing a resource guide
- assuring that Maternal Outreach Worker staff are knowledgeable about the community served
- conducting regularly scheduled meetings to address the following issues: referrals, caseload size, education and ongoing training needs, problem areas, outreach and community activities, and job performance evaluations
- monitoring quality assurance of staff by performing random chart reviews on a regular basis
- facilitating communication between Maternity Care Coordinator/Child Service Coordinator and Maternal Outreach Worker staff to ensure ongoing discussion regarding identified case needs and delineation of roles and responsibilities between the Maternity Care Coordinator/Child Service Coordinator and the Maternal Outreach Worker
- ensuring that the Maternal Outreach Worker has clinical back-up
- monitoring the Maternal Outreach Worker case load for the following: maximum caseload of 25 to 30 participants, Medicaid eligibility, balance of moderate-to-high needs clients, general appropriateness of referral, and safeguarding against referral of clients that can best be served by the Maternity Care Coordinator or Child Service Coordinator
- conducting job performance evaluations
- participating in relevant state and regional trainings
- meeting with regional and state staff periodically
- assuring all necessary program data for the Maternal Outreach Worker program is collected, including:
 - ◆ the Baby Love Maternal Outreach Worker Referral form
 - ◆ the Baby Love Maternal Outreach Worker services Letter of Agreement
 - ◆ the Baby Love Maternal Outreach Worker Contact Record

7.2 Documentation

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

1. a completed Baby Love Maternal Outreach Worker Referral/Enrollment/Closure form (DMA-3013 Rev. 9/00) or approved equivalent;
2. a completed copy of client's plan of care listing issues, interventions (such as referrals to needed community resources), outcomes, and plan of care updates on an ongoing basis;
3. a completed Baby Love Maternal Outreach Worker services Letter of Agreement (DMA-3015 Rev. 7/99) (this is a required form);
4. a completed Baby Love Maternal Outreach Worker Contact Record (DMA-3014 Rev. 9/00) or approved equivalent documenting services provided;
5. case conferencing (e.g., narrative notes, signatures on the plan of care); and
6. documentation of outreach activities including date, type, and duration.

When applicable, agencies may opt to develop their own equivalent forms. However, components of the local forms must contain all of the elements of the state-created form(s) and must be approved by the regional social work consultant prior to implementation.

8.0 Billing Guidelines

Maternal Outreach Worker services are reimbursed up to nine units per month. One unit = 15 minutes.

The following Maternal Outreach Worker activities will not be reimbursed:

- attempted visits and contacts
- telephone, voice mail, e-mail or written communications (these contacts may be recorded in the client contact record under telephone contacts)
- services to clients who are incarcerated or institutionalized (drug treatment facilities and hospitals)

Maternal Outreach Worker services cannot be reimbursed when provided on the same date as the following services:

- Child Service Coordination
- Home Visit for Newborn Care and Assessment
- Home Visit for Postnatal Assessment and Follow-up Care
- Maternity Care Coordination

Claim Type

CMS-1500 (HCFA-1500)

Diagnosis Codes That Support Medical Necessity

- V20.1 Other healthy infant or child receiving care
- V22.2 Pregnant state, incidental
- V24.2 Routine postpartum follow-up

Procedure Code(s)

HCPCS code S9445 – Patient education, not otherwise classified, non-physician provider, individual, per session

Payment Rate(s)

Providers must bill their usual and customary charges.

MEDICAID CLAIM ADJUSTMENT REQUEST
(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:

EDS ADJUSTMENT UNIT
PO BOX _____ (PAYER SPECIFIC)
RALEIGH, NC 27622

**A CORRECTED CLAIM
AND THE APPROPRIATE
RA MUST BE ATTACHED**

EDS USE ONLY

One Step: _____

Provider #: _____ Provider Name: _____
Recipient Name: _____ MID#: _____

**SUBMIT A COPY OF THE
RA WITH REQUEST**

Claim #: [Grid of boxes for claim number]

Date From ____/____/____ Billed Amount: Paid Amount: RA Date:
Of
Service: To: ____/____/____ \$ _____ \$ _____ ____/____/____

Please check (✓) reason for submitting the adjustment request:

- Over Payment
- Under Payment
- Full Recoupment
- Other

Please check (✓) changes or corrections to be made:

- Units
- Procedure/Diagnosis Code
- Billed Amount
- Dates of Service
- Patient Liability
- Further Medical Review
- Third Party Liability
- Medicare Adjustments
- Other

Please Specify Reason for Adjustment Request:

Signature Of Sender: _____ Date: ____/____/____ Phone #: (____) _____ - _____

EDS INTERNAL USE ONLY

Clerk ID#: _____ Sent to: _____ Date sent: ____/____/____

Reason for review: _____

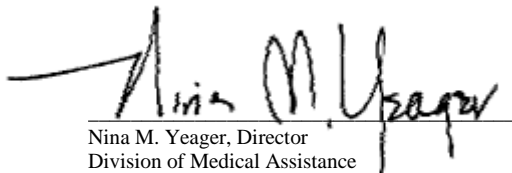
Reviewed by: _____ Date reviewed: ____/____/____


Outcome of review: _____

Date received back in the Adjustment Department: ____/____/____

Revised: 08/21/00

EDS USE ONLY. DO NOT WRITE IN THIS BOX.


Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services


Ricky Pope
Executive Director
EDS

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