NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

GUIDANCE ON IDENTIFYING AND REFERRING PREGNANT TAILORED PLAN MEMBERS TO LOCAL HEALTH DEPARTMENTS

Local Health Departments (LHDs) provide Care Management for High-Risk Pregnancies (CMHRP) to eligible females ages 14-44. This guidance is intended to assist Tailored Plans in identifying pregnant Tailored Plan members and referring those at highest risk to LHDs for CMHRP services.

Tailored Plans are expected to exchange the following data in a standardized format with the LHD Data Platform Vendor, Community Care of North Carolina (CCNC), for the member population eligible for the CMHRP program.

1. **Beneficiary assignment information**, including demographic data and any clinically relevant and available eligibility information. The "LHD BA" File should include all females ages 14-44 years old.
2. **Member claims/encounters data**, including historical physical health (PH), behavioral health (BH), and pharmacy (Rx) claims/encounter data with new data delivered monthly (PH/BH) or weekly (Rx).
3. **Patient Risk List**, including only pregnant members identified as "high" risk for adverse birth outcomes.

This guidance should be used along with the established Data Specifications & Requirements for sharing CMHRP Data to Support Tailored Care Management to ensure accurate exchange of data.

A. Identifying Pregnant Members

This section provides guidance for Tailored plans to determine if a member is pregnant. While the CMHRP program is specifically focused on high-risk pregnancies, Tailored plans must first have a process to recognize any pregnancies within their membership. Refer to the following:

a. Use procedure and diagnosis codes from claims data to identify pregnant members.
b. Relevant diagnosis codes include, but are not limited to:
    i. Z33.1: A billable code for an incidental pregnant state for female patients aged 12–55[1]

[1] Please note the Z33.1 is a standard ICD diagnosis code for members aged 12 to 55, however, the member population eligible for the CMHRP program is females ages 14 to 44.

ii. Z33.3: A code for a gestational carrier
iii. Z34 Series (Z34.00-Z34.93): A code for an encounter to supervise a normal pregnancy
iv. Z34.9: A code for an encounter to supervise an unspecified normal pregnancy
v. Z3A Series (Z3A.00-Z3A.49): A non-billable code for the weeks of gestation of a pregnancy
vi. Z36.0-Z36.9: Encounter for antenatal screening of mother
vii. Z37: Encounter for suspected maternal and fetal conditions ruled out
viii. Z32.01: Encounter for pregnancy test, result positive
ix. O9A: A code for pregnancy, childbirth, and the puerperium

B. Identifying Pregnant Members at Risk of Adverse Birth Outcomes

Tailored Plan eligible members are generally considered high-risk, because the members have more complex health needs and need long-term rehabilitation and care, either in a treatment facility or at home. Tailored Plans should utilize all available data to identify members at risk of adverse birth outcomes. At a minimum, use claims data, care needs screening, comprehensive assessment and the Pregnancy Risk Screening (PRS) form to identify high-risk pregnancies. Additional data sources may include Internal Risk Stratification data, patient medical records, patient interviews, ADT data, and/or provider referrals.

a. CMHRP eligibility includes Medicaid covered pregnant females ages 14 to 44 years identified as being at risk for adverse birth outcomes. The CMHRP target group includes females who have a history or are at risk of:
    i. Preterm birth (<37 completed weeks)
    ii. At least one spontaneous preterm labor and/or rupture of the membranes
    iii. Low birth weight (<2500g)
    iv. Fetal death >20 weeks
    v. Neonatal death (within first 28 days of life)
    vi. Second trimester pregnancy loss
    vii. Three or more first trimester pregnancy losses
    viii. Cervical insufficiency
    ix. Gestational diabetes
    x. Postpartum depression
    xi. Hypertensive disorders of pregnancy: Eclampsia, Preeclampsia, Gestational hypertension, Hemolysis, elevated liver enzymes, low platelet count (HELLP) syndrome
    xii. Multifetal Gestation
    xiii. Fetal complications: Fetal anomaly, Fetal chromosomal abnormality, Intrauterine growth restriction (IUGR), Oligohydramnios, Polyhydramnios
    xiv. Chronic condition which may complicate pregnancy: Diabetes, Hypertension, Asthma Mental illness, HIV, Seizure disorder, Renal disease, Systemic lupus erythematosus
    xv. Current use of drugs or alcohol/recent drug use or heavy alcohol use in month prior to learning of pregnancy
    xvi. Late entry into prenatal care (>14 weeks)
    xvii. Hospital utilization in the antepartum period

xviii. Missed 2+ prenatal appointments
xix. Cervical insufficiency
xx. Vaginal bleeding in 2nd trimester
xxi. Short interpregnancy interval (<12 months between last live birth and current pregnancy)
xxii. Current sexually transmitted infection
xxiii. Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
xxiv. Non-English speaking
xxv. Positive depression screening

Note: This list does *not* represent a comprehensive list of indications for which a member would be referred to LHDs for CMHRP services. **Use other information available for members in claims, care needs screening, comprehensive assessment, etc. on physical health, behavioral health, and health-related social needs to identify high-risk pregnancies.**

b. The ***Weekly CMHRP Member Report File*** can also be leveraged to identify pregnant members as it captures all CMHRP members, has information about the members (including term) and loops in responses to the Pregnancy Risk Screening form. See the data scope and template for the weekly member report here: Data Specifications & Requirements for sharing Care Management for High Risk Pregnancies Data to Support Tailored Care Management.

C. Making Referrals to LHDs for CMHRP

a. Tailored Plans can refer members to LHDs for CMHRP using the following methods:
   i. Identify high-risk pregnant members and designate them as "High" risk in the Patient Risk List (PRL) sent to CCNC. This is the designed and preferred referral method.
   ii. Direct outreach to the LHD may be completed using the CMHRP Referral form. Plan Direct Referrals should be minimal; encompassing only those referrals that need URGENT attention before the next weekly PRL file transmission.
   iii. Tailored Plan Care Manager/Care Coordinator/ Provider Based TCM completes a CMHRP referral form and submits it to the appropriate LHD.
      1. The LHD directory is updated monthly on the Medicaid NCDHHS website at DHHS: DPH: WICWS: Publications and Manuals (ncdhhs.gov).
   iv. It is the Plan's responsibility to ensure all referrals are included on their outgoing PRL regardless of referral method (PRL, Plan direct Referral and CMHRP Referral Form).
b. Reference the Data Specifications & Requirements for sharing Care Management for High Risk Pregnancies Data to Support Tailored Care Management which include information for the Interaction Level Report (ILR).

D. Tailored Plan's Responsibility for High-Risk Pregnant Members when LHDs decline to contract for CMHRP services, contract underperformance, or termination of their contract

a. If an LHD declines to contract or is unable to actively care manage a member due to contract underperformance, staffing, etc., the Tailored Plan will first attempt to contract with another willing LHD for CMHRP services, using the process as outlined in the CMHRP TP Program Guide.
    i. If unable to contract with an alternate LHD, the Tailored Plan will:
        1. Contract with another entity for the provision of local care management services;
        2. Perform the services itself and retain the payment that would otherwise have passed to the LHD.

For more information, please visit the CMHRP TP Program Guide.

Thank you for your attention to these guidelines. Your continued support is crucial in ensuring the effective management and care of our members.