Overview:

The North Carolina Division of Health Benefits (DHB) provides reimbursement to Federally Qualified Health Centers, local health departments, and Rural Health Clinics who provide nursing home visits that follow the requirements outlined in Clinical Coverage Policy No: 1M-5 for the “Home Visit for Postnatal Assessment and Follow-up Care” (CPT code 99501). According to the DHB policy, this home visit is designed to deliver health, social support, and/or educational services directly to families in their homes.

The Care Management for High Risk Pregnanies (CMHRP) Program is available to pregnant and postpartum women who are receiving Medicaid and who are experiencing certain social or medical factors. Examples of potential social or medical factors are below; however, this is not an exhaustive list. Please refer any Medicaid-eligible woman who may benefit from CMHRP services, and the assigned care manager will determine service eligibility. CMHRP services strive to increase positive birth outcomes across the state. Priority risk factors for eligibility can be identified through the completion of a pregnancy risk screening at the initial prenatal visit, to identify these and other risk factors, or through an assessment completed by a Care Manager following a referral to the services.

Priority risk factors include:

- A history of preterm birth
- A history of low birth weight
- Fetal complications
- Chronic conditions which may complicate pregnancy
- Unsafe living environment (homelessness, inadequate housing, violence or abuse)
- Substance use
- Tobacco use

To efficiently and effectively coordinate all services delivered to best meet the needs of each individual patient, it is imperative that individual service providers have communication mechanisms in place to work together collaboratively. Further, it is important to ensure that duplication of services is avoided. To these goals, the DHB Clinical Coverage policy for the Home Visit for Postnatal Assessment and Follow-up Care delineates communication and collaboration between the home visiting RN and the Care Manager, if there is one, in Section 5.4, Other Requirements.
I. Prior to the Home Visit

The RN making the home visit for postnatal assessment and follow-up care must:

- Discuss the past and current medical and psychosocial history of the mother and child with the care manager.
- Discuss the care management plan or service coordination with the Care Manager so tasks listed in the plan of care can address collaborative and mutually supportive activities during the home visit, to best meet patient and family needs.
- Contact the family to schedule a convenient time for the home visit and explain the purpose of the visit.

II. During the Home Visit

The RN making the home visit must:

- Address activities that are relevant to the patient’s care management plan of care and are appropriate for the RN to address in the context of the requirements for the Home Visit for Postnatal Assessment and Follow-up Care.

III. Following the Home Visit

The RN making the home visit must:

- Engage the Care Manager to discuss completed activities and observations.
- Document findings that apply for the mother and child using form DHHS 4151
- Share all appropriate information needed for the Care Manager to update the CMHRP plan of care.
- Discuss completed activities observations with the care manager and develop a plan for referral for other community resources as communicated.

*Note: The receiving Care Manager should document the collaboration and findings in the Interaction Tracker and Comprehensive Needs Assessment OB within the VirtualHealth data platform.*

IV. Considerations When the RN Completing the Home Visit is Also the Care Management for High Risk Pregnancies Care Manager

When the RN completing the Home Visit for Postnatal Assessment and Follow-up Care fee-for-service activity is working part-time, providing this service and part-time providing CMHRP services for the same patient, special considerations exist. In this case, the RN is essentially collaborating with her/himself in the provision of these two distinct and separately funded services that are working in a collaborative model. The RN must complete all the requirements of the Home Visit for Postnatal Assessment and Follow-up Care, including completion of any related forms. The RN must also “share” information with her/himself and then document relevant information in the patient’s care management
record in VirtualHealth, noting that the services were provided when the same individual was completing a “Home Visit for Postnatal Assessment and Follow-up Care”.

If, during the home visit contact, additional care management services were provided which are outside the scope of the Home Visit for Postnatal Assessment and Follow-up Care, and beyond the requirements of this separate service, the care manager should document those activities in Virtual Health as normal care management activities, which were provided in addition to the Home Visit for Postnatal Assessment and Follow-up Care requirements.

**Financing**

Care Management for High Risk Pregnancies services are funded through a monthly per member, per month (pmpm) Medicaid funding allocation, passed from Prepaid Health Plans to the local health department through a contractual relationship.

Care Managers who have their personnel expenses (salary/fringe) covered 100% by the pmpm funding, for care management may not also be providing other Medicaid reimbursable fee-for-service, or other activities or services, (i.e., the Home Visit for Postnatal Assessment and Follow-up Care). If their personnel expenses are covered 100% by the per member, per month funding, all their work activities must be exclusively dedicated to this funding stream, and they cannot also provide other activities or services.

Care Managers who have their personnel expenses (salary/fringe) covered part-time (less than 100%) by the per member, per month funding for care management may provide other Medicaid reimbursable fee-for-service or other activities or services, up to the threshold of available working time that is not allocated to the per member, per month funding for care management. For example, a Care Manager who is allocated for 50% of their personnel expenses covered by the per member, per month funding for care management is expected to spend half of their time providing care management services; the remaining 50% of that individual’s time can be spent in any other activity or service. Individuals who conduct multiple activities or services in this fashion should maintain appropriate records supporting their time allocation accordingly.