



## **Pregnancy Care Management**

*Collaboration guidelines for working with nurses from Federal Qualified Health Centers, local health departments, and Rural Health Clinics who provide the Medicaid reimbursable service –*

***Home Visit for Postnatal Assessment and Follow-up Care (CPT code 99501)***

### **Overview:**

The North Carolina Division of Medical Assistance 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 DMA policy, this home visit is designed to deliver health, social support, and/or educational services.

Pregnancy Care Management services are provided statewide to pregnant and postpartum Medicaid recipients who are determined to be at risk for poor birth outcome. 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 pregnancy care manager following a referral to the services.

Priority risk factors include:

- A history of preterm birth
- A history of low birth weight
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy
- Unsafe living environment (homelessness, inadequate housing, violence or abuse)
- Substance use
- Tobacco use
- Missing two or more prenatal appointments without rescheduling
- Antenatal hospital utilization

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 DMA 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 Pregnancy Care Manager and/or Care Coordination for Children Care Manager, if there is one, in *Section 5.3 – Requirements for and Limitations on Coverage: Other Requirements*.

## **Collaboration Guidelines:**

### **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 with the Pregnancy Care Manager.
- Discuss the care management plan of care goals with the Pregnancy Care Manager, so that collaborative and mutually supportive activities can be addressed during the home visit, to best meet patient needs.

### **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:

- Discuss completed activities and observations with the Pregnancy Care Manager.
- Share all appropriate information needed for the Pregnancy Care Manager to update the Pregnancy Care Management plan of care.

The Pregnancy Care Manager receiving information on the outcome of the Home Visit for Postnatal Assessment and Follow-up Care must:

- Document this collaboration in the patient's care management record in the CCNC Case Management Information System (CMIS), including any progress towards the patient's goals, noting that the services were provided by the RN completing a "Home Visit for Postnatal Assessment and Follow-up Care".

### **IV. Considerations when the RN completing the Home Visit is also the Pregnancy 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 Pregnancy Care Management 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 of 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 CMIS, 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 Pregnancy Care Manager would document those activities in CMIS as normal pregnancy care management activities, which were provided in addition to the Home Visit for Postnatal Assessment and Follow-up Care requirements.

### **Financing:**

Pregnancy Care Management services are funded through a monthly per member, per month (pmpm) Medicaid funding allocation passed from Community Care of North Carolina to the local health department through a contractual relationship.

Pregnancy Care Managers who have their personnel expenses (salary/fringe) covered 100% by the per member, per month 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 of their work activities must be exclusively dedicated to this funding stream, and they cannot also provide other activities or services.

Pregnancy 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 Pregnancy 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.