Targeted Case Management for High-Risk Pregnant Women

PURPOSE

The provision of the Targeted Case Management (TCM) service is to assist high-risk pregnant women in their desire to achieve a healthy birth outcome and additional unintended pregnancies by:

- Reinforcing the need for each woman to receive early, comprehensive and continuous prenatal care;
- Helping each pregnant woman understand their risk factors that could affect birth outcomes and what actions can be taken to lessen those risks; and
- Assisting women in obtaining other necessary support services that will contribute to a healthy birth outcome.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

Targeted case management for high-risk pregnant women can be provided by the enrolled providers as allowed by the scope of their licensure.

Case Managers for pregnant women and their infants up to 6 months of age is limited to providers who:

- Have at least six months experience in delivering services in a community or home setting.
- Demonstrate the ability to coordinate prenatal care services for members, develop relationships with health care and other area agencies in the particular geographical area they are serving, demonstrate experience in assessing the needs of pregnant women and developing case management plans based on the needs of clients and must demonstrate ability to evaluate an at risk pregnant woman's progress in obtaining appropriate medical care and other needed services.
- Ensure case management staff supervisors have a minimum of a degree in

social work, nursing, education, and have at least three years experience in service delivery and supervision.
- Have in place a training process that will ensure that staff have adequate knowledge relating to at risk pregnancy, parenting and other important issues.
- Demonstrate the ability to provide 24-hour, 7 day a week crisis services to eligible women who are in need of emergency case management services.

Individuals performing case management services for this category must meet one of the following criteria:
- Be an individual with a master's degree in social work; or
- A licensed baccalaureate social worker and at least six months of case management experience; or
- A registered nurse licensed in accordance with the North Dakota Nurse Practice Act; or
- A licensed practical nurse licensed in accordance with the North Dakota Nurse Practice Act and has at least six months of case management experience; or
- A health educator with at least a bachelor's degree and at least six months of case management experience; or
- A Licensed Registered Dietitians or Licensed Nutritionists, licensed by the North Dakota Board of Dietetics Practice; or
- If the individual does not have a bachelor's degree, they will be allowed to enroll to provide TCM if they have at least five years of experience working with high risk pregnant women in a supervised, clinical setting.

Individuals enrolled and providing targeted case management prior to July 1, 2020 will be deemed qualified to provide targeted case management, as long as they remain actively providing targeted case management services.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the through the Automated Voice Response System by dialing 1.877.328.7098.

Women who are enrolled in the North Dakota Medicaid Program who have high risk factors that could result in poor birth outcomes are in the target group for this service.

DEFINITION OF HIGH-RISK FACTORS

Women with one or more of the following risk factors are considered to be at high risk of having a problem pregnancy:

- Is age 17 or younger at the time of the assessment.
- Is age 35 or older at the time of the assessment.
- Uses alcohol while pregnant.
- Uses illegal drugs.
- Abuses prescription drugs.
- Previous preterm delivery (before 37 weeks of pregnancy) or low birth weight (less than 5 pounds, 8 ounces).
- Last birth within one year.
- Multi-fetal gestation – more than one fetus in current pregnancy.
- Uses tobacco while pregnant
- Has a developmental disability.
- Has a medical condition such as diabetes, AIDS, HIV, high blood pressure, Polycystic ovary syndrome (PCOS), hemorrhagic conditions, gestational diabetes, kidney disease, autoimmune disease, thyroid disease, obesity, sexually transmitted disease (STD), Zika infection or a heart condition.
- Is currently being treated for a mental health disorder or is currently on any psychotropic drugs.
- Known birth defects or genetic conditions in the fetus.

Women may also qualify for TCM services if **three** or more of the following factors are present.

- Has been diagnosed, within the last five years, with a mental health disorder.
- Psychotropic medication use within the last five years.
- Has had a previous high-risk pregnancy.
- Has a family history of genetic disorders that could be passed on to the child.
- Is currently homeless or has had three different living situations during the current pregnancy.
- Has experienced family violence including spousal abuse, child abuse, and neglect or sexual abuse.
- Has experienced sexual assault within the last two years.
- Is isolated from a network of people who provide an member with practical or emotional support.
- Has not initiated prenatal care and pregnancy is in the second or third trimester.
- Has not graduated from high school or received her GED.
- Has two or more children under the age of five.

- Is residing in any group living arrangement such as a group foster care, residential treatment center or alcohol treatment center.
- First pregnancy.
- Has not visited a dentist in the last year.
- Has been released from a correctional facility within the last six months.

LENGTH OF ELIGIBILITY

Eligibility for TCM services for High-Risk Pregnant Women can begin at the time a pregnancy is confirmed. Eligibility may continue through the month an infant becomes six months of age if the mother remains eligible for Medicaid. All TCM services for High-Risk Pregnant Women are for services provided to the mother; therefore, no services are reimbursable under the child's Medicaid ID.

ELIGIBILITY PROCESS

Providers may begin providing and billing for TCM services after they have completed the assessment form and found that the pregnant woman meets the risk criteria outlined above.

A copy of each assessment must be forwarded to the Department within five business days of completion. The assessment will be reviewed and is subject to denial if the Department finds that the risk criteria were not met. If an assessment is found to **not** meet the criteria, the assessment can still be reimbursed, but no other services will be reimbursed to the provider.

Refer to the Member Eligibility manual for additional information regarding eligibility including information regarding limited coverage categories

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

All of the following services may be reimbursable and can each only be billed once a day and must be available to all high-risk pregnant women who qualify for TCM services:

Code H1000
Assessment identifies a woman's physical, medical, nutritional, psychosocial, financial, developmental and educational status. The information will be used to determine if a pregnant woman meets the risk criteria to receive TCM services.

Providers are required to use the SFN 963 TCM Assessment form. The assessment must be submitted to the Department within five business days or claims for that woman may be denied. If codes for services other than the assessment are billed during the same time as an assessment, documentation must be provided with the assessment in order for ND Medicaid to pay those codes.

If a woman **does not** meet the criteria, TCM services will be denied, and notice will be given to the provider and the woman. The assessment can be reimbursed, but no other services (codes) will be reimbursed to the provider.

In the event that there are two providers in the same area, it is the policy of ND Medicaid that the provider that fills in the assessment and has it signed by the woman first will be the provider that receives payment.

ND Medicaid will only reimburse for one assessment per pregnancy. The number of assessments may be increased based on medical necessity.

Code H1001
Case planning and preparation consists of the identification of the specific needs of each woman and the establishment of goals that will enable the pregnant woman to succeed in her commitment to have a healthy birth outcome. The goals and the means to accomplish them must be included in a written case plan that also reflects the particular resources that are needed to promote the coordination of services for each woman.

To the extent possible, case planning should include the birth father, significant others and other family members when prudent and appropriate. In addition, case planning should be coordinated with other professionals involved in the care of the woman, including medical personnel.

Case monitoring consists of regular contacts between the case manager and the woman to assist the woman in meeting goals that are outlined in the case plan. Monitoring also includes the identification and resolution of problems that occur on an ongoing basis. Ongoing reviews to determine if the case plan and the identified services are meeting the needs of the pregnant woman in her goal to have a positive birth outcome and a healthy start for the infant will be necessary.

Monitoring must include at least two face-to-face contacts in the residence of the woman during pregnancy.

Code H1002
Care coordination consists of identifying those services that will help the woman meet her established goals, assist her in making the appropriate referrals and securing the needed services.

Case evaluation consists of the gathering of information that will be used to ascertain the degree of success realized due to the provision of TCM services.

Case reevaluation is completed prior to discharge from the program and used to determine the progress that has been made toward meeting the goals outlined in the case plan and to identify any unmet needs that should be addressed prior to the woman leaving the program.

Code H1003
Health and parenting education include arranging for educational services that will assist the woman in obtaining knowledge that will enable her to make informed choices regarding health and lifestyle decisions that could affect the birth outcome. Parenting skills will allow the mother to provide for the care of her infant in a positive environment.

Code H1004
This code includes all follow-up home visits after the birth of the baby. TCM must include at least one face-to-face home visit after the child is born. Services are allowed for six months after the birth of the child.

SERVICE AUTHORIZATION REQUIREMENTS

The amount of case management services needed by high-risk pregnant women will vary depending on the individual needs of each woman. Most women will not require

more than 30 units of case management during the pregnancy and after the child is born. If additional case management services are necessary in order to meet the goals outlined in the case plan, providers must request prior authorization from ND Medicaid. Any case management billed in excess of 30 units without ND Medicaid approval will be denied.

The following information will be required when submitting a service authorization when requesting additional case management time.

- A summary of the case management services already provided;
- The number of additional units needed;
- An explanation why the additional units are necessary to meet the goals that were established in the case plan; and
- Appropriate documentation that supports the need for additional units.

ND Medicaid will approve or deny the request for additional units within three business days of receiving the request.

FREEDOM OF CHOICE

Members must be afforded the choice of obtaining TCM services for High-Risk Pregnant Women and infants from any qualified provider within the woman's service area. Members must sign the Freedom of Choice section of the SFN 963 form.

TCM for High-Risk Pregnant women can only be provided by one provider. It is the policy of ND Medicaid that the provider who has completed the assessment form and has it signed by the woman first will be allowed to bill for the service. Claims received from any other providers will be denied.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

TCM does not include, and Federal Financial Participation (FFP) is not available for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible member has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

The target group does not include members between ages 22 and 64 who are served in Institutions for Mental Disease (IMD) or members who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

The following list contains the minimum contents required for the care plan for each member receiving TCM services.

- Name
- Age
- Family composition
- Current residency
- Education level or current educational setting
- Work status/employment
- Placement history (including facility, admission and discharge date)
- Narrative history or background of member
- Presenting concerns
- Diagnosis (if applicable-all Axes)
- Behavioral patterns
- Names of Practitioners that are providing care/services to the member
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)

• Recent medical appointments (if available)

Each member should have a primary point of contact. The primary point of contact should be delineated and easily identifiable in the member's care plan.

Providers delivering and billing for TCM must maintain case records that include the following items to support services billed. TCM activity must be documented as follows:
•The member's name;
• The date of the TCM service;
• Each note or note page must include the provider of the TCM service;
• The nature, content, and time units (total time) of the TCM services received;
• Whether goals specified in the care plan have been or are being achieved;
• The need for and occurrences of coordination with other case managers;
• A timeline for obtaining needed services;
• A timeline for reevaluation of the plan,
• Whether the member has declined services in the care plan.

General Documentation Checklist
• The documentation must link to the eligible member's care plan.
• Abbreviations used are standardized and consistent.
• The narrative supports the units of TCM claimed.
• The documentation supports what has occurred in TCM.
• The activity documented is consistent with the intent of ND Medicaid TCM services.

Reimbursement is based on the factors above. Documentation must be rooted in the official electronic record, if applicable or official record format of the agency.

ND Medicaid or its federal oversight agencies may conduct pre or post payment documentation review to ensure that the above criteria are met. Handwriting on printed documentation is not an accepted practice to fulfill documentation requirements if an audit is done. Such actions could be construed as alteration of a medical record.

Failure to comply with above criteria may result in claim denial and recoupment of Medicaid payment.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

CLAIM FORM

TCM for pregnant women services must be billed using the CMS 1500 claim form or 837p. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

CLAIM REQUIREMENTS

Payment for TCM Services provided to high-risk pregnant women and their infants will be the lower of a provider's actual billed charge or the fee established by ND Medicaid.

A unit of service is defined as a visit. If a case manager provides less than thirty minutes of TCM services in a day, no claim may be submitted for the service.

Providers are only allowed 30 units of service per pregnancy. A provider may bill more than one service in a day but both will count against the maximum allowable units.

ND MEDICAID PROCEDURE CODES

HCPCS Code	Description
H1000	Assessment (only one assessment per pregnancy can be billed)
H1001	Prenatal care, at-risk enhanced service; antepartum management
H1002	Prenatal care, at-risk enhanced service; care coordination
H1003	Prenatal care, at-risk enhanced service; education
H1004	Prenatal care, at-risk enhanced service; follow-up home visit*

*Code can only be used for after the birth of the baby

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

CONTACT

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POLICY UPDATES

July 2025

Section	Summary
	Format changes and clarifications added throughout.