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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.

1.1 Principles

The program is family-centered and family-driven and seeks to respond to the varying concerns of children and their families, recognizing that

- a. concerns of children and families change over time;
- b. families are the constant in the lives of children; and
- c. families have expertise regarding their children.

1.2 Requirements

The Child Service Coordination program requirements include

- a. Outreach
- b. Identification and referral
- c. Enrollment
- d. Assessment of family strengths and concerns and the child's development
- e. Assessment of parent-child interaction
- f. Development of care coordination plan
- g. Follow-up
- h. Evaluation

1.3 Results

Through Child Service Coordination, families will have

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

2.0 Eligible Recipients

2.1 General Provisions

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

2.2 Limitations

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

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

2.3 **EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

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

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

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

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

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 aged 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:

- a. Review the Identification and Referral form.
- b. Contact the local health department for verification of the child's enrollment status.
 1. 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.
 2. 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.
 3. 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: For information on the eligibility requirements for the North Carolina Infant-Toddler Program, refer to the North Carolina Early Intervention Services Web page at <http://www.ncei.org/ei/index.html>.

Child Service Coordinators are required to meet face-to-face with the family for enrollment. If it is impossible to have face-to-face contact with the parents and their child during enrollment, document how the situation is handled. The tasks to be accomplished are as follows:

- a. Develop a relationship with the family
- b. Verify the risk status of the child on the Identification and Referral form
- c. Explain the Child Service Coordination program and the role of the Child Service Coordinator
- d. Obtain the family's signature on the Letter of Agreement
- e. Obtain signed release(s) of information, as needed
- f. Initiate the family and child strengths/needs assessment process
- g. Assist the family in deciding priorities
- h. 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

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

A Child Service Coordinator should be designated when

- a. a referral is received;
- b. the child is enrolled in the Child Service Coordination program;
- c. the family requests a change in the Child Service Coordinator; or
- d. 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

- a. observed behaviors.
- b. reinforcement of parent's strengths,
- c. developmentally appropriate activities, and
- d. 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.

- a. Child's chronological age is 15–18 months
 1. Consultation
 - (a) review the child's medical records for height, weight, head circumference, and previous developmental screenings
 - (b) discuss the family's developmental expectations and concerns
 - (c) contact the Infant–Toddler Specialist
 - (d) facilitate decisions and document findings
 - (e) report completion of intermediate assessment
 - or
 2. Standardized assessment
- b. Child's chronological age is 30–36 months
 1. Standardized assessment
 2. Intermediate assessment, which includes the following components:
 - (a) physical growth (vision, hearing, height, weight, and head circumference)
 - (b) gross and fine motor function
 - (c) receptive and expressive language (articulation if appropriate)
 - (d) self-help skills
 - (e) behavioral/social/emotional development
 - (f) cognitive skills

- (g) parental interview
- (h) record review
- (i) administration of appropriate assessment tools
- (j) developmental education and counseling
- (k) referrals, as appropriate
- (l) 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

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

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

- a. Discuss with the family their perceptions of the child's development.
- b. Refer for intermediate assessments as outlined in the Memorandum of Understanding.
- c. Provide support to the family.
- d. Document intermediate assessment activities in the child's record and at the next Program Status Report (DHHS 3750) interval.
 - 1. Adhere to the responsibilities outlined in the Memorandum of Understanding.
 - 2. 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.

- a. 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.
- b. 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.
- c. Establish regular meetings with Child Service Coordination program provider agencies to address the county's intermediate assessment needs.
- d. Determine the intermediate assessment process.
- e. Identify available space within the county to administer intermediate assessments.
- f. Obtain parent/guardian consent prior to the child receiving a formal evaluation.
- g. 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, the following:

- a. Well-child care
- b. Nutrition
- c. Safety
- d. Dental health
- e. Development
- f. Child care
- g. 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 following.

- a. 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.
- b. 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.
- c. Identified strengths should be used as resources in meeting identified priorities.
- d. 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

- a. Family concerns and the activities outlined in the care coordination plan
- b. Number and complexity of the priorities and concerns
- c. Availability of services within the area
- d. 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

- a. review the care coordination plan with the family and make modifications as needed;
- b. discuss family satisfaction with service provider(s);
- c. determine whether there are new situations or concerns to be added to the plan;
- d. complete Program Status form, as appropriate; and
- e. 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

- a. update the risk indicators on the Identification and Referral form;
- b. review potential eligibility for the North Carolina Infant–Toddler or Preschool programs;
- c. observe, document, reinforce, support parent–child interaction; and
- d. 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:

- a. Transfer of the child to another Child Service Coordinator
- b. Referral of the child to the North Carolina Infant–Toddler program or the preschool program
- c. Termination of the child from the North Carolina Infant–Toddler program
- d. Termination of the child’s eligibility

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

- a. Updating the care coordination plan
- b. Contacting 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
- c. Notifying the appropriate care givers of the change in status
- d. Completing and submitting the Program Status form to the local health department
- e. Documenting the change in the care coordination file

5.15 Transitions to Other Programs

5.15.1 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 Early Intervention Services Web page at <http://www.ncei.org/ei/index.html> and the North Carolina Infant–Toddler program manual for additional information.

5.15.2 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:

- a. Family assumes Child Service Coordination responsibilities
- b. Family refuses enrollment
- c. Family discontinues participation
- d. Family is lost to follow-up
- e. Family moves out-of-state
- f. Family moves to another county in the state
- g. Child ages out of the program
- h. Child expires
- i. 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:

- a. Update and document the care coordination plan with current status and any future plan of action for each unresolved concern/priority.
- b. Document the reason for closure and care coordination status of the child and family.
- c. Contact the new Child Service Coordinator to review the family file and share significant information, if applicable.
- d. Notify appropriate caregivers of the change in status.
- e. Complete the Program Status form.
- f. Facilitate a new Letter of Agreement signed by the family and the new Child Service Coordinator.
- g. Inform families that Child Service Coordination can be reopened upon request, if requirements are met.
- h. Notify the Health Check outreach worker at the time of closure.

Instructions for reopening:

- a. Update original Identification and Referral form.
- b. 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

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

5.18 Waiting Lists

A family is placed on a waiting list if they have not been contacted by the Child Service Coordinator within 14 calendar days of the Child Service Coordinator receiving an Identification and Referral form or a phone referral on the family. Children who are potentially eligible for the North Carolina Infant–Toddler program may not be placed on the Child Service Coordination program waiting list, but they must be referred to the local Consortium within two days of determining that the child may be eligible.

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

- a. 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;
- b. annual education of hospital nursery staff and other primary referral sources about the eligibility criteria for the Child Service Coordination program; and
- c. use of existing family information for those who receive Maternity Care Coordination or Maternal Outreach Worker services.

6.0 Providers Eligible to Bill for the Service

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 the following:

- a. Target population(s) the agency will serve without regard to a child's Medicaid eligibility
- b. Plans for providing service coordination to families
- c. Sharing information between agencies

- d. Designated contact persons in each agency
- e. Projected number of enrolled children
- f. Meeting program requirements
- g. 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
1928 Mail Service Center
Raleigh NC 27599-1928

The maximum caseload size for a full-time Child Service Coordinator is 75 families. Child Service Coordinator working with more complex families, families with more than one child with special needs or other special circumstances, the number should decrease. Caseload size for a part-time Child Service Coordinator should be adjusted downward according to time spent in the program.

6.2 Staffing Qualifications

A qualified Child Service Coordinator should

- a. be experienced in working with families and children and with community resources and
- b. 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. 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
- b. 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
- c. 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:

- a. documentation of regular conferences with the new employee to review the records of clients with complex needs;
- b. timely access for consultation with the new employee;
- c. providing and/or accessing additional skills-building educational opportunities for the new employee to supplement on-the-job training; and
- d. 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:

- a. A signed Letter of Agreement with the current Child Service Coordinator
- b. Family identification and demographic information
- c. Family and Child Strengths and Needs Assessment form, including documentation of parent/child interaction and other relevant forms
- d. A care coordination plan
- e. A signed release of information form(s) (use standard agency or applicable interagency form), as needed
- f. Copies of all correspondence and program forms including Identification and Referral form (DHHS 3748), Program Status Reports (DHHS 3750), and other relevant materials
- g. Total service time component (for example, 35 minutes = 2 units)

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.

It is not necessary to complete a Child Service Coordination Program Status form once a child is determined eligible for the Child Service Coordination Program or North Carolina Infant Toddler Program until closure to that program occurs or when transferring to a different provider agency.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines.

Child Service Coordination services are reimbursed up to six units per month. One unit = 15 minutes. Child Service Coordination must be billed per date of service.

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

- a. Home visit for newborn care and assessment
- b. Home visit for postnatal assessment and follow-up care
- c. Maternal care skilled nurse home visit

- d. Maternal outreach worker services
- e. Maternity care coordination

8.1 Claim Type

CMS-1500 (HCFA-1500)

8.2 Diagnosis Codes That Support Medical Necessity

Code	Description
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, less than 500 grams
V21.32	Low birth weight status, 500-999 grams
V21.33	Low birth weight status, 1000-1499 grams
V21.34	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

Code	Description
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

8.3 Procedure Code(s)

HCPCS procedure code T1016—Case management, each 15 minutes

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	Text stating that providers must comply with Medicaid guidelines was added to Section 8.0.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
7/1/06	Section 5.4	This section was updated to direct providers to the Early Intervention Services Web page for eligibility requirements for the North Carolina Infant-Toddler program.
7/1/06	Section 5.15	The web address for the Early Intervention Services Web page was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.