41

41 Nurse-Family Partnership (NFP)

Nurse-Family Partnership (NFP) is a nationally recognized, evidence-based program that provides prenatal, postpartum and infant home visiting services for the family unit until the child reaches age two. NFP nurse visiting services are available to eligible pregnant Medicaid recipients for intensive targeted case management rendered by specially trained nurses.

NFP nurse visiting services include care coordination, assessments and screenings, case management, and preventative health education and counseling. These nursing services are tailored to each woman's needs and delivered in-person or via telehealth in the home setting, or in an alternative community setting as indicated by recipient's need. The goals/objectives of the NFP program include:

- improved health outcomes for mother and child,
- reduced maternal and infant mortality rates, and
- an increase in healthy spacing between births to 24 months.

Referral by an Alabama Coordinated Health Network (ACHN) provider of an eligible Medicaid recipient to an Alabama Medicaid enrolled NFP entity is required. This referral is needed before the NFP entity submits for reimbursement to the Agency for services rendered to Alabama Medicaid recipients. Recipient participation in NFP is voluntary. Additionally, recipients can choose the Alabama Medicaid enrolled NFP provider in their region.

41.1 Provider Enrollment

Medicaid's fiscal agent enrolls providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will receive a notification when it is time to re-validate. Failure to re-validate and provide appropriate documentation to complete the enrollment process will result in an end-date being placed on the provider file. A new enrollment application must be submitted once a provider enrollment file has been closed due to failure to timely re-validate.

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41.1.1 National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as an NFP provider is added to the Medicaid system with the National Provider Identifiers provided to the Agency at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for NFP-related claims.

NOTE:
The 10-digit NPI is required when filing a claim

Nurse-Family Partnership providers are assigned a provider type of 21 (Targeted Case Management), and specialty code 923 (NFP).

41.1.2 Enrollment Policy for NFP Providers

Nurse-Family Partnership (NFP) provider entities may enroll with the Agency beginning April 1, 2022. An NFP provider entity must be certified by the Changent prior to enrolling with Alabama Medicaid. NFP certification requires, at a minimum, that each entity's appropriate personnel have Changent approved training in the prenatal, postpartum, and new parent topics.

Certified NFP entities must submit their Changent model fidelity letter when enrolling with Alabama Medicaid. Additionally, NFP provider entities will be required to pay an application fee in compliance with CMS requirements.

For information regarding becoming a certified NFP entity, please reference the information on the Agency's website on the NFP page.

41.1.3 Provider Termination and/or Change of Ownership

1. A participating Nurse-Family Partnership (NFP) provider has the right to withdraw from the Medicaid program after submitting written notice to Medicaid of its intent at least thirty (30) days in advance.
2. Medicaid may terminate the NFP provider's participation in the Medicaid program if the provider loses their Changent certification for any reason, as well as in cases involving fraud or willful or grossly negligent non-compliance with all applicable program, State and federal guidelines.
3. Medicaid must be notified in writing within thirty (30) days of the date of an NFP entity's owner and/or name change. The existing contract will be terminated, and a new contract must be signed to continue participation in the Medicaid program.

41.2 Benefits and Limitations

41.2.1 Benefits

Nurse Family Partnership (NFP) services are available to Medicaid eligible persons who:

1. Are referred to a qualified, Agency enrolled, NFP entity/provider by the recipient's assigned ACHN.

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2. Recipients must meet the following NFP criteria for participation:

   - First time mother
   - High-risk as defined by the Changent, and
   - Enrolls and receives her first home visit no later than the end of the 28th week of pregnancy, unless otherwise specified by Changent.

   NFP services include, but are not limited to:

   - Prenatal Services
     - Monitoring for high blood pressure or complications
     - Diet/nutrition education
     - Infant care education
     - Family stress guidance
     - Stress management
     - STD prevention education
     - Tobacco/alcohol education
     - Intimate partner violence screening/education
     - Anxiety and depression screening/referrals
     - Needs assessing/screening
     - Making referrals for care
     - Monitoring and follow up
   - Postpartum Services
     - Assessment of mom's health
     - Diet and nutrition education
     - Stress management
     - STD prevention education
     - Tobacco/alcohol education
     - Emotional/physical changes
     - Infant care and parenting
     - Partner relationship support
     - Breastfeeding support
     - Education for well-woman visits for preventive services
     - Anxiety and depression screening/referrals
     - Needs assessing/screening
     - Making referrals for care
   - Infant-Related Care
     - Infant health assessment, development and referrals
     - Child developmental screening at major developmental milestones from birth to age two (2).

41.2.2 Limitations

Medicaid will not separately reimburse for any direct care services, such as wound care, rendered by an NFP nurse in the course of their NFP case management visit.

41.3 Documentation Requirements

Nurse-Family Partnership (NFP) is a Targeted Case Management (TCM) service, and as such NFP providers must adhere to all core elements of TCM.

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For more information regarding these core elements, refer to TCM Chapter, Chapter 106, Section 106.2.1 of this Provider Billing Manual.

The NFP provider must maintain complete and accurate medical, mental health, case management, and fiscal records that fully disclose the extent of the services provided. In addition, the NFP provider must make available to Medicaid, at no charge, all information describing services provided to eligible recipients. The provider must also permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies.

All documentation must be legible, signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. Additionally, the author of each entry must either, personally or electronically sign his or her entry. A stamped signature is not acceptable.

NFP records must include all mandated data elements and documentation required by Changent, along with documentation of the following:

(a) name of recipient,
(b) the recipient Medicaid ID,
(c) the Changent Client ID,
(d) Alabama Coordinated Health Network (ACHN) Referral Form,
(e) dates of services,
(f) name of NFP provider and person providing services,
(g) nature, start and end time, extent or units of services provided,
(h) place(s) of service,
(i) weeks of gestation or weeks postpartum at time of visit, and
(j) a written assessment of the client's progress.
(k) Nurse -Family Partnership Home Visit Form
(l) Consent for services
(m) Demographic Intake (Demographics update when applicable)
(n) Psychological assessment (GAD-7, PHQ-9 etc.)
(o) Referrals

The NFP provider's records must also contain the following information:

- A systematic, recipient-coordinated Plan of Care (POC).
- Family history
- Medical history
- Educational/vocational history
- Mental health treatment history, when applicable
- Legal history
- Substance abuse history

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41.3.1 Eligibility Verification

Providers are advised to always verify recipient's eligibility on the date(s) of service. It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are times when a recipient's eligibility status may change throughout the month. All providers must maintain a paper copy of the eligibility response in the recipient's file. For more information, refer to the Provider Manual, Chapter 3: Verifying Recipient Eligibility. The sources available for obtaining recipient information:

The Automated Voice Response System may be accessed by dialing 1 (800) 727-7848 using a touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.

The Web User Guide provides instructions for performing recipient eligibility verification via the web portal. Instructions for accessing and login are also included in the guide. The Web Portal verification system will provide contact information for the recipient's attributed PCP. Providers can access the Web User Guide at the following link: https://www.medicaid.alabamaservices.org/ALPortal.

41.3.2 Consent

Prior to providing services a dated and signed (handwritten) consent shall be on file.

41.3.3 Signatures

The Home Visiting Nurse must obtain a handwritten signature to be kept on file, (the home visit form) as verification that the recipient was present on the date of service for which the provider seeks payment for face-to face encounters.

When payment has been made on claims for which a signature is not available and of the Agency accepted expectation is not applicable, the funds paid to the provider covering the claim will be recouped.

Electronic or Digital Signatures: An electronic signature validates an electronic medical record in the same way a handwritten signature validates a written medical record. Forms that are electronically sign must be created and on file on the same date of service for which the provider seeks payment.

The recipient signature is not required when there is no personal contact between recipient and provider.

NOTE:
Effective January 1, 2024, at least one of the minimal two monthly visits must be in-person or face-to-face to be eligible for reimbursement by Medicaid.

41.3.4 Telehealth Encounters

Telehealth encounter should last a minimum of 10 to 15 minutes and cover the NFP visit structure.

Documentation at minimal should include but are not limited to the following: the home visit encounter form, an assessment based upon the recipient phase

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(prenatal, postpartum/newborn, infant/ toddler), progress note, plan of care and a home visit form.

41.3.5 Journal Notes

Journal notes are not sufficient documentation for telehealth encounters and /or eligibility verification.

Journal notes can be submitted to document brief interactions between the home visiting nurse and the recipient.

Examples include but are not limited to the following:

- Phone calls from the recipient to the nurse or vice versa
- Updates on a referral
- Missed appointment (No Shows)
- Late entry note

41.3.6 Mistaken Entry

A mistaken entry in the record shall be corrected by a method that does not obliterate, white-out, or destroy the entry. Corrections to a record shall have a single line through the erroneous information, keeping the original entry legible. In addition, to the name or initials of the individual making the correction and the date of the correction.

41.3.7 Amended Records

Documentation submitted for review may include amended records. Amended records are legitimate occurrences in the documentation of clinical services and include a late entry, addendum and/or a correction the medical record.

Amended records must:

- clearly and permanently identify any amendment, correction or delayed entry as such,
- clearly indicate the date and author of any amendment, correction or delayed entry,
- clearly identify all original content, without deletion, and
- be amended prior to claims submission and/or medical record request. Records that have been amended and do not meet the Agency standards will be subject to recoupment.

Records that have been incorrectly amended during an audit period will be subject to recoupment.

41.3.8 Progress Notes

Progress notes should not be prepopulated or predated each recipient must have individualized documentation that is specific to the interaction as it relates to their care. The progress notes should match the goals on the care plan and the care plan should match the needs of the recipient.

Documentation must provide enough detail and explanation to justify the reimbursement requested.

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Documentation should not be repetitive. Examples include, but are not limited to the following:

- Progress note that look the same for other recipients.
- Progress notes that state the same words with no evidence of progression, maintenance, or regression.
- Care plans that look the same for other recipients.
- Care plans with goal and actions that stay the same and have no progression.

41.3.9 Comprehensive Assessment

A written comprehensive assessment is documentation of the recipient's assets, deficits, and needs. The completed assessment must be maintained in the recipient's file. The needs identified in the assessment will be the basis for the recipient's individualize plan of care.

41.3.10 Plan of Care

The Plan of Care (POC) lists the recipient's needs, strengths, and goals. The POC also lists the actions required to meet the identified needs of the recipient. It is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system. The Plan shall identify the recipient's need and problems and possible services which will reduce the probability of the recipient having a preterm birth, low birth weight baby or other negative birth outcome. Circumstance may require the recipient to have more than one plan of care. The POC must be completed within the first 30 days of contact with the recipient. It must be reviewed and updated every 30 days and when there are changes in the recipient's condition or circumstances. Revisions to the POC must be documented with updated goals and interventions as needed. Once the POC goal is achieved, the care plan must be closed and the completion date documented.

The plan of care shall be current and contain six components: the assessment, diagnosis, outcomes, planning, implementation and evaluation. The care plan shall be evaluated and or updated monthly.

Plan of care written in the format of a progress note will not be eligible for payment.

Components of the Plan of care:

Assessment

The recipient's individualize needs are based on the recipient's assessment and through the collection of objective and subjective data during recipient encounters.

Diagnosis

Diagnosis shall be based on the recipient's comprehensive assessment.

The assessment determines if the diagnosis shall be problem-focused, risk for/potential or health-promotion diagnosis.

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Outcome(s)

Outcomes are recipient centered actions specifically chosen to resolve an identified need or achieve a want or desire. The recipient's goals should be SMART Goals:

- Specific,
- Measurable,
- Achievable,
- Relevant,
- and Time based.

Planning

Identifies the steps and resources needed to achieve the outcome.

Implementation

Implementations are actions taken by the nurses to assist the recipient in achieving their goal(s). The intervention process shall include, but not be limited to:

- Referrals to community or social service agencies, as needed (calling or submitting a written request on behalf of the recipient, provider, caregiver/family) and validate the recipient received the service.
- Linking recipient to needed resources or healthcare providers (Perform activities to assist the recipient connect to the resource or provider, and validate the recipient received the service).
- Conducting timely follow-up with the recipient, referral resources, and his/ her providers as appropriate.
- Establishing support systems.
- Providing relevant education

Evaluation

The evaluation process includes documenting follow-ups and monitoring of the recipient's progress toward the goals and determining if the interventions were appropriate. This process includes determining if the goal and or intervention will improve the recipient's quality of health and meet their needs. staff shall:

- Document the recipient's progress toward accomplishing each goal.
- Documentation shall include the status of each goal i.e., met, unmet, or in progress.
- Document the closing date when the POC goal(s) are met.

Revision

Care plan revision includes modifying the goals and interventions based on the evaluation of the recipient's progress and need to ensure the appropriateness of the services to suit the recipient's needs. Revisions are required when:

- There is a change in the recipient's health or needs
- There is a change in the recipient's diagnosis
- There is a request or need identified by the recipient
- There is a change in the recipient's goal
- The intervention chosen is not suitable to aid in achieving the goal

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41.4 Reimbursement

1. Nurse-Family Partnership (NFP) provider entities may submit a claim to Medicaid once each month for each family unit designated by the Changent Client ID. At least one qualifying visit must occur prior to the submission of the claim. However, it is expected that at least two visits per month with the recipient will occur and there must be documentation in the recipient's record for each visit performed. Additional visit dates must be listed on the claim as separate details. All visits beyond the first must be filed with an XE modifier appended to the corresponding NFP service (e.g., T2023 HD U1 XE). If at least two visits cannot be completed during the month, there must be documentation in the recipient's record to explain why. The dates of service must be listed on the claim. NOTE: Claims paid in error will be subject to recoupment.

NOTE:
Effective January 1, 2024, at least one of the minimal two monthly visits must be in-person or face-to-face to be eligible for reimbursement by Medicaid.

2. All NFP claims must have a referral from the recipient's assigned ACHN to receive payment from Medicaid. The Alabama Coordinated Health Network Nurse-Family Partnership (NFP) Referral Form must be completed in accordance to the instructions, ensuring the recipient's 13-digit Medicaid ID number is on the form. When filing an electronic claim using Medicaid's web portal, the ACHN NPI should be entered into the "referring physician" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the ACHN NPI.
3. All NFP claims must include the Changent Client ID to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the Changent Client ID should be entered in the "referral number" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the Changent ID as the referral number.
4. NFP claims for prenatal services must include the Date of Last Menstrual Period (LMP) to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the LMP should be entered in the "Last Menstrual Period" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the LMP (date qualifier code = 484).
5. NFP claims for post-partum services must include the Date of Delivery to receive payment from Medicaid. When filing an electronic claim using Medicaid's web portal, the Date of Delivery should be entered in the "Initial Treatment Date" field. If using a vendor/clearinghouse software, the provider will need to confirm with the vendor on where to enter the Date of Delivery/Initial Treatment Date (date qualifier code = 454).
6. The NFP provider agrees to accept payment in full as the amount paid for covered NFP services.

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41.4.1 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

NFP providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NFP providers must include the following information on the claim:

- The dates on which the NFP services were rendered,
- The recipient's ACHN NPI as referring provider,
- The Changent Client ID assigned to the family unit (referral number),
- The weeks of gestation or weeks postpartum at time of visit,
- The ACHN referral number, and
- The Z71.9 (counseling, unspecified) diagnosis code

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

41.4.2 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The following procedure code and applicable modifiers are required on each filed claim for NFP services:

Procedure Code	***First Modifier***	***Second Modifier***	***Date Required***
T2023 – Targeted Case Management (Monthly Billing)	HD – Pregnant and parenting women's program	U1 – Prenatal Case Management	LMP (date qualifier code = 484).
T2023 – Targeted Case Management (Monthly Billing)	HD – Pregnant and parenting women's program	U2 – Postpartum Period (delivery through 12 months postpartum)	Delivery Date (date qualifier code = 454).

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Procedure Code	*First Modifier*	*Second Modifier*	*Date Required*
T2023 – Targeted Case Management (Monthly Billing)	HD – Pregnant and parenting women's program	U3 – Postpartum Period (12 months through 2-years postpartum)	Delivery Date (date qualifier code = 454).

NOTE:

Postpartum services (U3) can be billed under the Mother or Child's Medicaid ID. Prenatal services (U1) and Postpartum (U2) MUST be billed under the mother's Medicaid ID.

NOTE:

Use of both a first and second modifier will be required for reimbursement.

41.4.3 Diagnosis Codes

Effective April 1, 2023, all Nurse-Family Partnership (NFP) claims submitted to Medicaid must include a diagnosis code of Z71.9 (counseling, unspecified) for reimbursement. Claims with dates of service prior to April 1, 2023 do not require the Z71.9 diagnosis code.

41.4.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by NFP providers.

41.4.5 Time Limit for Filing Claims

Medicaid requires claims for NFP service to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

41.5 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
Becoming a Medicaid Provider	Chapter 2
Verifying Recipient Eligibility	Chapter 3
CMS 1500 Claim Filing Instructions	Chapter 5
Targeted Case Management	Chapter 106
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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