2020 MATERNAL HEALTH SUMMARY

SERVICES, DOCUMENTATION AND CODES

The following provides a summary of maternal health services provided for women through an IDPH Title V funded Maternal Health Center. For guidelines for services, refer to the most current edition of the *Maternal and Child Health Administrative Manual* and the *Maternal Health Center Provider Manual* as found on the Iowa Medicaid Enterprise (IME) website.

Documentation

Documentation for each encounter with a client must adhere to requirements in IAC 441-79.3(2). In maternal health centers, data from encounters is entered into the electronic database known as **signify**community™; however, **signify**community™ is not a complete medical record. Specific information about the client who receives a direct care visit must be entered in the client's medical record maintained in the agency.

Information Required For Each Encounter Based on the Service Provided	
• Description of service or office notes or narratives • Complaint and symptoms; history; examination findings • Assessments • Clinical impression or diagnosis • Individualized plan of care (if client is high-risk) • Specific procedures, diagnostic tests or treatments performed • Laboratory tests	• Test orders • Results • Medication • Supplies • Client's progress, response to pregnancy, changes in treatment, and revision of diagnosis • Specific forms for completed assessments such as Form 470-2942, Prenatal Risk Assessment

Information Necessary to Support Each Item of Service Reported on the Medicaid Claim Form	
• Name of client • Name of provider agency • Place of service • Complete date of the service including beginning & ending date if more than one day • A record of the time to support the units billed specifying a.m. or p.m. • First and last name and professional credentials of the person providing the service	• Signature of person providing the service or the initials of the person if a signature log indicates the person's identity • Specific procedures or treatments including nature, content, or units of service • Name, dosage, and route of administration of medication dispensed or administered Any supplies dispensed as part of the service

When a service is reimbursed as units of time, where one unit equals 15 minutes, units are calculated as: 8-22 min = 1 unit
23-37 min = 2 units
38-52 min = 3 units
53-67 min = 4 units

Not all services are billed as time-based units. For some services a unit is equal to one encounter. Refer to the procedure code section of the *Maternal Health Center Provider Manual* for the value of a unit for a particular service.

Funding Services

Information in this document related to funding is based on Medicaid codes and requirements. Iowa Medicaid uses the HCFA Common Procedure Coding System (HCPCS). Services or charges cannot be fragmented for each procedure code billed. Claims submitted without a procedure code and a ICD-10 diagnosis code will be denied.

Maternal health centers must bill Medicaid (IME) or the Medicaid MCO's contracted with IME for all Medicaid eligible women and are reimbursed on a fee- for-service basis. **New requirement as of July 1, 2019:** Maternal health centers must submit claims to third party insurers before submitting them to Medicaid. For clients with a third party insurer, maternal health centers must include the denial from the third party insurer with any claims submitted to IME or the Medicaid MCO. Maternal health centers who are unable to bill third party insurers will need to use Title V grant funds to cover services for clients with third party insurance coverage. Refer to IME Informational Letter 2047 for more information.

The amount billed should reflect the actual cost of providing the service. Maternal health centers should also bill other third party insurers. Iowa Administrative Rules 641-76. Documentation, including personnel time studies, must be available in the agency to demonstrate how costs are determined. The Medicaid fee schedule amount is the maximum payment reimbursed by Medicaid for each code. The fee schedules are on the Iowa Medicaid Enterprise website at https://secureapp.dhs.state.ia.us/MedicaidFeeSched/X35.xml Title V funds are utilized to fund services as described by the specific agency contract with the Iowa Department of Public Health.

Maternal health centers may bill IDPH for presumptive eligibility determinations for pregnant women, Title XIX care coordination, and Title XIX home visits for care coordination. All documentation of these services must be in TAV connect so IDPH can do quality review of these service prior to billing.

MCAH agencies should use Title V grant fund to provide service to women who are not eligible for Medicaid and have no insurance or are under insured.

Summary of Services

The following information is based on Medicaid and maternal health program guidelines as of the date of this document.

signifycommunity **documentation**

See the **signify**community Maternal Health Manual in the **signify**community Health Library for guidance on documentation. For direct care services the full documentation of the service you provided should be in a paper or electronic medical record.

SERVICES FOR ALL WOMEN

Contents

Administration of medication; oral, intramuscular, or subcutaneous (for progesterone 17P administration)		
Documentation	**Special Considerations**	**Code/Other funding sources**
• Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) • Refer to client's chart for complete documentation. Report the total time of the service (duration).	This code is intended to provide administration of progesterone in the clinic setting. Visits can be provided by RN or LPN. This medication (17P) is covered by IME as a physician – administered medication benefit, and not a pharmacy benefit. Claims submitted by pharmacies will be denied by IME. The agency will need to coordinate with patient's provider to get the medication to administer to the patient. Typical administration is a shot once weekly between 16 weeks until 37 weeks.	Code **T1502** **Bill to IME/MCO**

Alcohol and/or substance abuse screening with brief intervention		
Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation. Documentation in client's medical chart should include the following: Time in and time out specifying a.m. or p.m.	This is alcohol and substance abuse screening with brief intervention which includes administration of the following: • CRAFFT for adolescents under age 18 years • SBIRT for clients age 18 to 21 years • Brief intervention Must be provided by an RN or social worker (BSW or licensed). Time in and time out are required. Brief intervention is a required component of the service. It incorporates principles of motivational interviewing. The CRAFFT includes • Administration of the tool • Brief intervention SBIRT = Screening, Brief Intervention, and Referral to Treatment. SBIRT includes: • Two question pre-screen • AUDIT - Alcohol Use Disorders Identification Test ***AND/OR*** DAST – Drug Abuse Screening Test • Brief intervention Caution: Although the SBIRT tool indicates that <3 drinks a day for women is low risk, **encourage women who think they might be pregnant or are pregnant not to drink any alcohol.** <u>There is no known safe amount of alcohol consumption for pregnant women.</u>	Code **99408** for (15-30 minutes) Code **99409** for (over 30 minutes) For a billable service the following must be provided and documented: • The CRAFFT with brief intervention OR • The AUDIT and/or DAST with brief intervention **Bill to IME/MCO**

Annual alcohol screening Alcohol and/or drug screening		
Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation. Documentation in client's medical chart should include the following: • For G0442: Time in and time out specifying a.m. or p.m. • For **H0049**: Report the total time of service (duration)	For Code G0442, time in and time out are required for a minimum of 15 minutes of service. Use the following tools: • CRAFFT (under age 18) • AUDIT - Alcohol Use Disorders Identification Test (≥ age 18) AND/OR • DAST – Drug Abuse Screening Test (≥ age 18) These codes do not include the brief intervention component. Codes G0442 and H0049 cannot both be billed for the same day for the same client. Codes G0442 and H0049 cannot be billed in conjunction with Code 99408. Caution: Although the AUDIT tool indicates that some drinks a day for women is low risk**, encourage women who think they might be pregnant or are pregnant not to drink any alcohol**. <u>There is no known safe amount of alcohol consumption for pregnant women.</u>	Code **G0442** for annual alcohol screening (15 minutes) Code **H0049** for alcohol and/or drug screening For a billable service, the following must be provided and documented: • The CRAFFT OR • The AUDIT and/or DAST **Bill to IME/MCO**

Care Coordination –

Linking a client to the health care system (medical, dental, mental health or other Medicaid programs or services). Activities involve collecting information on the health needs of the client and assisting families to connect to services based on those needs. Services must include linking the family to a Medicaid eligible service and may include linking the family to other non-Medicaid services as well.

Prior to a Medicaid eligible client being enrolled with a Medicaid Managed Care Organization(MCO), you can provide medical and dental care coordination and bill these services to IDPH.

Providing PE and care coordination on the same date prior to enrollment in Medicaid.
Care coordination related to a PE service will be paid by IDPH -- regardless of what other services may be provided to the client on the same day. Therefore, care coordination will be paid even if other medical or dental direct care services are provided on the same day as the PE and care coordination. Best practice is -- once a client has coverage (by receiving the NOA for the PE service), next steps are to care coordinate to get them into medical and dental care as needed.
Keep in mind the following:

- **The payer source for the care coordination service related to a presumptive eligibility will be Title XIX-PE-CC**. This is what identifies it as payable so it will flow through for IDPH FFS billing.
- The care coordination service must involve linking the client up with services -- e.g. not just checking to see if they have a medical home or dental home.

If you are providing care coordination related to the PE service (whether medical, dental, or mental health), you may document them under the same service entry in TAV. Enter the type of care coordination service in TAV as 'Care Coordination Presumptive Eligibility'.

Once a Medicaid member has been enrolled with a MCO, DHS has given the responsibility for medical care coordination to the MCO's, however you should be providing dental care coordination to every client enrolled in the Maternal Health Program to ask about dental home, to make referrals to a Dentist when appropriate and follow up monitoring to assure that needed services are received

If providing dental care coordination, you can also include medical care coordination service:

- Referral to physician or mid-level practitioner
- Referral to mental health provider
- Referral for substance abuse or tobacco cessation counseling

If providing dental care coordination, you can also include a non-Medicaid service:

- Referral to WIC
- Referral energy assistance
- Referral to housing assistance
- Referral to a food pantry
- Referral to legal, financial assistance
- Referral for GED
- Referral to Storks Nest.

Care coordination includes assisting clients in gaining access to services and follow up monitoring to assure that needed services are received and arranging support services such as medical transportation or interpreter services

Documentation	Special Considerations	Code/Other funding sources

Document the entire service in **signify**community™ according to the MH manual
• Must document time in and time out, specifying a.m. or p.m.
 	
Documentation in **signify**community™ should include:
• County of Service
• Location
• Concerns and issues
• Staff response
• If coordinating dental/medical care:
  ○ Dental apt. summary
  ○ Medical apt. summary
• Referrals, outcomes, plan for follow up.
• Feedback from client/family
• Service provider
• Oral Health Summary
 	
For transportation Care Coordination, the following must be documented in **signify**community™:
• County of Service
• Location
• Contacted person
• Type of Medicaid Service
• Trip date
	Provided by a registered nurse or a person with a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology; a person with a degree in dental hygiene; or a licensed practical nurse or a paraprofessional working under the direct supervision of a health professional.
	
	Must involve phone or face-to-face contacts with the family or provider(s) on behalf of client. Texting and emails are allowable if unable to reach the client in person. There must be a response, two-way communication, to be a billable service.
	
	Must include linkage to medical, dental, mental health or other Medicaid related programs/services.
	
	Do not bill care coordination for:
	• Written reminders for services, unsuccessful attempts to reach families, activities that are part of direct care
	• Referral/arranging appointment for treatment following direct care provided by the MH agency. (Note: follow-up that is provided on subsequent days from the direct service can be billed as care coordination).
	
	Care coordination to arrange transportation may occur on the same day as a direct care service.
	
	Interpretation for care coordination may be billed on the same day as the care coordination service.
	
	Texting for care coordination:
	• Providing care coordination by texting to help a client access the health care system is allowed
	• A two-way text exchange is required
	• Texts with no response are not billable
	• Medicaid related services must be the central topic of the care coordination exchange
	• Texts may not include protected health information
		No Code
		
		Bill IDPH per client for services
		
		Do not exceed one 15-minute unit when billing texting for care coordination
		
		A TAV Billing Report is sent each month to IDPH for payment of service

• Transportation type • Service provider	• Documentation should include who participated in the text exchange, what issues were addressed, time in and time out including a.m. and p.m. Emailing for care coordination: • Providing care coordination via email exchange is allowed • This communication tool is typically used only when phone or face-to-face interaction is not possible • A two-way email exchange is required • Emails with no response are not billable • Medicaid related services must be the central topic of the care coordination exchange • Emails may not include protected health information • Documentation should include who participated in the email exchange, what issues were addressed, time in and time out including a.m. and p.m. • Full disk encryption is required on the computers used for this service • Agencies must assure that electronic information is protected through regular system back-ups • A protocol for saving care coordination emails must be developed by the agency Typically care coordination provided on the same day as a direct care service cannot be billed separately to Medicaid for Medicaid enrolled clients. It is expected to be part of the direct care service however there are some exceptions to this rule: 1. Medical care coordination may be billed if a dental direct service is provided by other staff (RDH) on the same day (only if no medical direct care was provided). 2. Dental care coordination by RDH may be billed if a medical direct service is provided by other staff on the same day (only if no dental direct care was provided). 3. Care coordination to arrange transportation may occur on the same day as a direct care service. 4. Interpretation for care coordination may be billed on the same day as the care coordination service.	

Counseling for alcohol misuse		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation. Documentation in client's medical chart should include the following: Time in and time out specifying a.m. or p.m.	This is face-to-face behavioral counseling for alcohol misuse. Must be provided by an RN or social worker (BSW or licensed)	Code **G0443** (15 minutes) **Bill to IME/MCO**

Counseling for Obesity		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation.	This is face-to-face behavioral counseling for obesity. Must be provided by a licensed dietitian or an RN. Time in and time out are required to bill this service.	Code G0447 (15 minutes) **Bill to IME/MCO**

Depression Screening		
Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation. Documentation in client's medical chart should include the following: • Time in and time out specifying a.m. or p.m. • Narrative interpretation including screening score, interpretation of the score, and follow up activities or recommendations	The Edinburgh Postnatal Depression Scale (EPDS) is the recommended tool for depression screening during pregnancy and for up to one year following the birth of the child. Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies Narrative interpretation must be included even if the score is normal. Include any anticipatory guidance, e.g. instructions to contact the primary care provider if anything changes.	Code G0444 Use this code only if Health Education and/or psychosocial services are not provided on the same date of service (Otherwise screening should be done as part of those services) **Bill to IME/MCO**

Domestic Violence Screening		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation.	This is domestic violence screening using the Abuse Assessment Screen (AAS). Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies. Assure that referral resources are available as needed. Assure that staff providing the service have been	**96160** This an encounter code and is not billed based upon time. **Bill to IME/MCO**

	appropriately trained.	

Evaluation and Management –
Evaluation and management (E & M) for an office visit with a new or established client. E& M codes are based on documentation and medical complexity of diagnosis, problem-focused history, problem-focused examination, medical decision-making, counseling and coordination of care. Refer to the procedure codes and nomenclature in the *Maternal Health Center Provider Manual* for more details.

Documentation	Special Considerations	Code/Other funding sources
Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) Report the total time of the service (duration). In the client medical record include the following: • History (including chief complaint) • Exam • Nursing diagnosis • Plan of care Describe the scope of the service and include referral or follow up needed. Record first and last name of service provider and credentials.	E & M is a clinical encounter direct care service. This code cannot be used for providing care coordination services. There are additional E& M codes open in the *Maternal Health Center Provider Manual* for new and established patients; however, the required review of systems and complexity would require a nurse practitioner, CNM, or physician. There currently are no MH agencies with approved work plans to provide medical direct antepartum care so billing for E&M codes with higher complexity could not be supported. Service provided to an existing client as follow-up for an oral problem detected during a previous screening service.	**99201** self-limited or minor – approximately 10 min. **New** Office/outpatient visit for the evaluation and management **99211** self-limited or minor – approx. 5 minutes **Established Patient** Office/outpatient visit for the evaluation and management **Bill IME/MCO** Title V for uninsured/ underinsured Encounter code can only be used once per day per client.

Health Education Services Provided by a Registered Nurse –
Education services provided by a registered nurse to improve the clients mental and physical health, including the following:

- Importance of continued prenatal care
- Normal changes of pregnancy:
    - Maternal changes
    - Fetal changes
- Self-care during pregnancy
- Comfort measures during pregnancy
- Danger signs of pregnancy
- Labor and delivery:
    - Normal process of labor
    - Signs of labor
    - Coping skills
    - Danger signs
    - Management of normal labor
- Preparation for baby:
    - Feeding
    - Equipment
    - Clothing
- Education on the use of over-the-counter drugs
- Education about HIV prevention

Other topics based on clients health care needs assessment

Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) • Indicate in **signify**community™ if you provided education on the following so we can track data on these performance measures ○ Breastfeeding	Provided by a registered nurse. Brochures and pamphlets may be provided as reinforcement of face-to-face education. Any cost incurred is part of health education or other direct care service code and is included in the cost plan. Keep a list of teaching and reference materials you have supplied to the patient. Also document modification made to accommodate the patient's literacy skills and native language. Mailing brochures and pamphlets may not be billed as a separate service.	**H1003** *Prenatal care at risk enhanced service education* – Encounter code once per date of service. **Bill to IME/MCO** Or Title V funding may be used if you want to

○ Immunization ○ Physical activity ○ Safe Sleep ○ Shaken Baby Prevention ○ Text4baby ○ Tobacco cessation ○ Insurance coverage after delivery Report the total time of the service (duration).	To be billed to an individual client, health education must be provided on a one-to-one basis, targeting the client's needs and not as part of a class. You can bill for Psychosocial services provided by the same RN that provided health education on the same date of service- This is a change in policy by IME effective 03/1/2015	provide a group class.

Immunization administration with counseling		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) Documentation in client's medical chart should include the following • Total time of service (duration) • First and last name of service provider & title / credentials • Education provided to client • Vaccine given including dosage, administration route, site, date and time • Anticipatory guidance provided • Provision of VIS (and date of VIS) • Documentation must adhere to requirements in IAC 441- 79.3(2)	This code is only for clients up to age 19 Due to NCCI edits, the following service will not pay when billed on the same date as 90460: E & M (See IME Informational Letter #1219)	**90460** for each vaccine administered. Submit cost per cost analysis For vaccines with multiple components (combination vaccines) report **90461** for each additional component beyond the first component. Examples: • HPV: 90460 • Influenza: 90460 • MMR: 90460, 90461 - 2 units **Bill to IME/MCO** For VFC vaccine you may not bill for the vaccine since it is free.

Immunizations –
Initial or subsequent administration of immunization

Documentation	Special Considerations	Code/Other funding sources
Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) Documentation in client's medical chart should include the following • Time in and time out specifying a.m. or p.m. • First and last name of service provider & title / credentials • Education provided to client • Vaccine given including dosage, administration route, site, date and time. Documentation must adhere • to requirements in IAC 441-79.3(2)	Typically, VFC vaccine is used (at no cost). If vaccine is provided outside of the VFC cohort, bill for the vaccine. Do not use these immunization administration codes if using 'immunization administration with counseling' (Code 90460/90461).	• **90471** *initial administration of vaccine (single or combination), subcutaneous or intramuscular* • ***90472*** *subsequent administrations of vaccine (single or combination) on same day* as Code **90471** or Code **90473** • **90473** administration of one vaccine (single or combination) by intranasal or oral means • **90474** *subsequent administrations of vaccines (single or combination) by intranasal or oral means on same day as* Code **90473** • **90630** *influenza virus, quadrivalent (IIV4), split virus, preservation free, intramuscular use* • **90651** *HPV vaccine (types 6, 11, 16, 18, 31,* • *33, 45, 52, 58), 3 dose schedule, IM use* • Bill vaccine at cost. Refer to the procedure codes and nomenclature in the *Maternal Health Center Provider Manual* for a listing of all applicable vaccine codes **Bill to IME/MCO** For VFC vaccine you may not bill for the vaccine since it is free.

Interpreter Services –
Services that include:
- Sign language or oral interpretive services
- Telephonic oral interpretive services

Documentation	Special Considerations	Code/Other funding sources

Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) For telephonic oral interpretive services, make sure to mark 'phone' as the interaction type. In client's medical record include the following: • Date of service • Name of interpreter or company • Time in and time out including a.m. or p.m.	These services are provided by interpreters who provide only interpretive services. Interpreters are either employed or contracted by the Medicaid provider agency billing the services. Service providers on staff who are also bilingual are not reimbursed for the interpretation, but only for their medical or dental services. These services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service. This service does not include written translation of printed documents. It is the responsibility of the provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to IAC 645 Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org). IME must be billed for all clients for interpretation services used in conjunction with a dental service.	Code **T1013** for *sign language or oral interpretive services* (15-minute unit) For determining 15 minute units: • 8-22 minutes = 1 unit • 23-37 minutes = 2 units • 38-52 minutes = 3 units • 53-67 minutes = 4 units Reimbursable time may include the interpreter's travel and wait time. **Bill IME/MCO** Code **T1013 with UC modifier** *For telephonic oral interpretive services* (per minute unit) Use the diagnosis code that pertains to the service being interpreted. If the interpretation is for presumptive eligibility or care coordination, use Z76.89 for the diagnosis code.

Lactation Classes

Non-physician- provider: provide a breast feeding class using an evidence based curriculum provided by an RN, licensed dietitian, Certified Lactation Consultant (CLC) or International Board Certified Lactation Consultation

Documentation	Special Considerations	Code/Other funding sources
Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic)	Note this service is for Breastfeeding Education not for breastfeeding peer	**S9443** Lactation *Classes*– You can bill Medicaid per Medicaid eligible person for

Documentation should include: • What specific breastfeeding education topics were discussed during the class some topic might including but not limited to: o hunger cues, o feeding frequency and duration, o latch, o milk transfer, o positioning (clutch hold, cradle hold, cross cradle hold, laid back and side lying), o signs of adequate intake (count of wet and dirty diapers, sound of swallowing, weight gain), o reluctant nurser, o milk expression and breast pumps. • The credentials of the instructor. RN, licensed dietitian, Certified Lactation Consultant(CLC) or International Board Certified Lactation Consultant. • Date of service and place of service must be included. • Time in and Time out is not required, the code is billed per encounter. • Report the total time of the service (duration).	<u>support.</u> We hope peer support occurs before and after the educational classes between participants however for Medicaid billing it cannot be just a support group.	attending the class. This is a service is for women enrolled in the Maternal Health program. **Bill to IME/MCO**

Nursing Assessment and Evaluation –
Nursing contact for the purpose of providing assessment and evaluation of a known medical condition such as: preterm labor, pre-eclampsia, urinary tract infection

Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic). Report the total time of the service (duration). In the client's medical record, include the following: • First and last name of service provider & credentials • Medical history including chief complaint • Nursing data, physical assessment findings • Evaluation • Plan of care	Must be provided by a registered nurse. Must be provided in the office setting, not a home visit. If you do a nursing assessment in the home you should bill S9123.	Code **T1001**: *Nursing assessment/evaluation* **Bill IME or MCO-** Encounter code can only be used once per day per client.

Nursing Visit in the Home – Prenatal or post-partum home visit by a nurse		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Document details of the home visit in the client's medical record maintained in the agency. Report the total time of the service (duration). Documentation must adhere to requirements in IAC 441-79.3(2) as noted above.	Must be provided by a registered nurse. May be provided during pregnancy or post-partum period. For antepartum visits include the following: • Nursing assessment including physical status, mental and emotional status • Home environment in relation to safety and support services • Client's knowledge of health behaviors to ensure healthy pregnancy outcome • Other service needed as identified in risk assessment Since the primary purpose of the home visit is to provide direct care services, the home visit for care coordination service for the mother or infant cannot also be billed. The postpartum home visit is made within two weeks of the infant's discharge from the hospital. If you are unable to schedule in the first two weeks, it is best to complete no later than six weeks. If the client refuses a home visit, provide a postpartum clinic visit or phone care coordination. The post-partum Home Visit shall include: • Nursing assessment to include mother's health status, discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome • Family planning • A review of parenting skills including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant (if applicable) An assessment of the infant's health including a review of infant care including feeding and nutritional needs, oral health, breast-feeding	**S9123** –Nursing Visit in home - (per hour) For time spent, include only face- to-face time. Do not include travel time (if applicable) or time documenting the service. A limit of ten units (hours) per client over a period of 200 days is placed on this code. Payment for services beyond this limit will require documentation to support the medical need for more visits. **Bill to IME/MCO** **Some MCO's require a prior authorization before this service is provided.**

	support, recognition of illness, accident prevention, immunizations, and well-child care • Identification and referral to community resources as needed The place of service must be noted on the medical record A home visit made for the purpose of providing nursing services should include: medical history, nursing assessment and evaluation, a plan of care including any needed follow up and referrals. Oral health services may be provided and billed in conjunction with the nursing home visit. These services are limited to initial or periodic screening, fluoride varnish, nutritional counseling, tobacco counseling, or oral hygiene instruction. A minimum of 1 hour must be spent on maternal health nursing services in order for oral health services to be billed. **This code is also used for a nurse providing Listening Visits in the home.**	

Oral Health Direct Care Services –

Oral health services within the provider's scope of practice may include:

- Initial oral screen
- Periodic oral screen
- Risk assessment
- Child prophylaxis
- Adult prophylaxis
- Topical application of fluoride varnish
- Nutritional counseling for the control and prevention of oral disease
- Tobacco counseling for prevention of oral disease.
- Oral hygiene instruction
- Sealant (per tooth)
- Bitewing x-rays

Documentation	Special Considerations	Code/Other funding sources

Document the entire service in **signify**community™ according to the MH manual Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed for D1310, D1320 and D1330. Documentation must include the counseling/instruction issues that were addressed with client. For services where billing is NOT based upon timed units, report the total time of each service (duration). For sealant applications document the tooth number, surface, and product used. For bitewing films document the number taken, type, and tooth number/quadrant. For fluoride varnish application, document brand of fluoride and concentration Assure that one of the diagnosis "Z" codes is provided for each procedure code. If diagnosis codes Z01.21 is used, dental screen with abnormal findings, at least one of the K diagnosis codes must be included. Use as many K codes as needed. Assure the appropriate ICD 10 code	Client must have a signed treatment consent Dental screenings, fluoride varnish applications, nutritional counseling, tobacco counseling, and oral hygiene instruction may be provided by an agency registered nurse, nurse practitioner or physician assistant who has participated in IDPH-approved oral health training. Include TD modifier in documentation. Prophylaxis, sealant, and bitewings must be provided by a dental hygienist only. All health professionals must assure that they are working within their respective scopes of practice. A dental referral must be provided at the time of each oral screen. The client's risk level must be assessed, documented and entered into TAV each time an oral screening is provided. When providing direct care oral health services, any care coordination provided on the same day as the direct care is considered part of the direct care service. Do not bill care coordination separately. For example: after completing an oral health screen, making arrangements on that day for a referral to a dentist for follow-up and treatment cannot be billed as care coordination. Follow-up to the referral that is done on subsequent days (from the direct service) can be billed as care coordination. Sealant applications are limited to ages 6-18 or	**Diagnosis codes**: **Refer to ICD 10 code handout provided by IDPH** **Procedure codes:** **D0190 w/CC modifier:** Initial oral screen by non-dentist (Add TD modifier when provided by RN) **D0190:** Periodic oral screen by non-dentist (Add TD modifier when provided by RN) **D0150:** Initial oral exam by dentist **D0120:** Periodic oral exam by dentist Risk Assessment for every screen provided: **D0601**: Low Risk **D0602**: Moderate Risk **D0603**: High Risk (Add TD modifier when provided by RN) **D1120**: Prophy (age 12 yr. and younger) **D1110**: Prophy (age 13yr. and over) **D1206***:* Topical fluoride varnish (Add TD modifier when provided by RN) **D1310**: Nutritional counseling for control and prevention of oral disease (15-minute unit) (Add TD modifier when provided by RN) **D1320** Tobacco counseling for prevention of oral disease (15-minute unit) (Add TD modifier when provided by RN) **D1330**: Oral hygiene instruction (15-minute unit) (Add TD modifier when provided by RN) **D1351** Sealant per tooth (6-18 yrs, first and second permanent molars, permanent bicuspid and deciduous molars) **D0270**: Bitewing – single film **D0272**: Bitewing – two films **D0274**: Bitewing – four films

is used to designate first or subsequent pregnancy and trimester. Documentation must adhere to requirements in IAC 441- 79.3(2) as noted above.	those with a physical or mental disability. For Codes D1310, D1320 and D1330, a minimum of 8 minutes must be provided to bill the service.	**Bill all direct oral health services to IME** **Bill Dental Care Coordination to IDPH**

Prenatal Risk Assessment –
To determine risk for pregnant Medicaid members upon initial entry into care using DHS form# 470-2942, Medicaid Prenatal Risk Assessment. Repeat at 28 weeks when a low-risk pregnancy is identified on the first assessment or when an increase in risk status is noted through subsequent client interactions.

Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) Report the total time of the service (duration). Enter results of the prenatal risk assessment on the DHS form #470-2942 both columns and keep the paper copy in the clients file. It is best practice to send a copy of the risk assessment to the client's primary medical/obstetrical care provider.	May only be billed by one provider unless additional assessment is required at a later date. If sharing responsibility for completing the form, establish a written agreement specifying payment agreement for services between collaborating parties. Have the client sign a release of information form prior to sharing the information. Additional assessments may be billed at a later date if client need is demonstrated. Note the reason for an additional assessment in medical record. To score the Medicaid Prenatal Risk Assessment, add the total score value on the left side and either the B1 column (initial visit score value) or the B2 column (re-screen visit between 24-28 weeks' gestation score value) to obtain the total score. A total score of 10 or higher meets the criteria for high risk on this assessment When a high-risk pregnancy is identified, inform the woman and provide appropriate enhanced services as described in the individualized plan of care. (See Enhanced Services.) Complete the Medicaid Risk Assessment for all prenatal clients, even those who are not eligible for Medicaid. If you document the risk assessment in WHIS and the client is not eligible for Medicaid put zero's in the spot for the Medicaid number.	**96160** *Completion of Medicaid Prenatal Risk Assessment, form 470-2942* **Bill to IME/MCO**
Presumptive Eligibility Determination for Pregnant Women – The process of presumptive eligibility determination for pregnant women by a qualified provider		
Documentation	**Special Considerations**	**Code/Other funding sources**

Document the entire service in **signify**community™ according to the MH manual. The documentation must include: • County of Service • Location • NOA number/result of NOA • Documents kept on file and given to family • If pregnant woman is choosing to apply for full Medicaid or not • Client/family feedback • Coverage explained • Agency service provider is identified. DHS requires documentation in the Health Services Application Form and Case File or documentation via MPEP the Iowa Medicaid Portal. *Note: To provide PE services, all agency staff must be certified as Qualified Entities (QE) under the supervision and authority of a Presumptive Provider Organization (agency). To*	The agency must have a memorandum of understanding (MOU) with DHS prior to providing this service and then maintain a qualified provider status with DHS. Eligible clients must be pregnant and have an Iowa address. Eligibility is based only on a woman's statements regarding her family income; a qualified provider can "presume" that the pregnant woman will be eligible for Medicaid. For Pregnant Women US citizenship verification is not required as part of the presumptive eligibility determination for pregnant women. *The Guide for Qualified Providers* from DHS outlines the steps required to make a presumptive eligibility determination. Eligibility for ambulatory care coverage continues up to the last day of the month following the month of the presumptive eligibility determination. If the woman formally applies for Medicaid during this period, coverage will continue until DHS makes a decision on the application. Ambulatory care means all Medicaid covered services except charges associated with inpatient care in a hospital. You may bill care coordination to link women to needed ambulatory medical, dental or mental health care on the same date of service. The *Guide for Qualified Providers* describes a pregnant woman's options for applying for ongoing Medicaid and what should be explained to her about the impact of a decision to apply for ongoing Medicaid. *Should we have the applicant apply for PE or should they just apply for regular/ongoing Medicaid?* • It is up to the applicant to decide the benefits, if any, for which they want to apply. • It is the responsibility of the Presumptive Provider to ensure the applicant understands their options so that the applicant can make	***No Code*** **Bill IDPH** per pregnant woman or per family if her children are included in the PE determination. A TAV Billing Report is sent each month to IDPH for payment of service

become a QE, staff must complete web-based training provided by DHS to do PE for Pregnant Women. The training is not that same as the child health training.	an informed decision. • A woman who is not a U.S. citizen and is undocumented will not qualify for full, ongoing Medicaid so should not apply for it. • If the applicant chooses to apply for both PE and ongoing Medicaid, providers should not routinely send in paper copies of the application to Provider Services, the MPEP Support Desk, or to local DHS offices. However, providers are required to save signed copies of the applications and make these available upon request. For more information on Presumptive Eligibility or becoming a Qualified Entity, call 855-889-7985 or email IMEMPEPSupport@dhs.state.ia.us.	

Preventive medicine counseling		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation.	Use of this code is intended for: Counseling, risk factor reduction, and behavioral change intervention services related to testing for chlamydia and/or gonorrhea Chlamydia/gonorrhea screening is routine care for OB primary care providers. Do not duplicate service provided by the medical home. It is a good idea to provide this service in conjunction with a urine pregnancy test	Code 99401 (15-minute unit) Code 99402 (30-minute unit) **Bill to IME** Codes 99401 and 99402 will not pay if another counseling-type code is billed for the client on the same day Code 99000 may be used for handling and conveyance of the chlamydia and/or gonorrhea specimens to a lab for analysis.
Pt education, non-physician provider, individual, per session (LISTENING VISITS IN CLINIC SETTING)		

Documentation	Special Considerations	Code/Other funding sources
Document the service in **signify**community™ according to the MH manual Refer to client's chart for complete documentation. Use IDPH recommended forms for documentation. Report the total time of the service (duration).	This code is intended to provide Listening Visits in the clinic setting. Visits can be provided by RN or SW who have completed training.	Code **S9445** **Bill to IME/MCO**

Transportation –
To arrange transportation for prenatal and postpartum services that is not otherwise payable under the Medicaid program. Includes non-emergency medical, dental, mental health local transportation by:

- Vehicle provided by volunteer (individual or organization)
- Taxi
- Bus, intra or interstate carrier
- Wheelchair van
- Transportation by caseworker or social worker
- Parking fees, tolls, other related costs

Documentation	Special Considerations	Code/Other funding sources

Document the entire service in **signify**community™ according to the MH manual • Complete in **signify**community™ "mileage field" if transportation is provided by mile. • First and last name of service provider and credentials • The invoice of cost for the transportation service must be accessible. This may be reported in the "comments" field or maintained on a transportation log. • Invoice of cost • Mileage if transportation is paid per mile If a service log containing the above information is maintained, the service note must include reference to client record.	Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received. This does not include out- of-town transportation. Access2 care arranges and pays for transportation (both in-town and out-of- town) to Medicaid covered medical, dental, and/or mental health appointments for Medicaid enrolled client contact Access2Care at 1-866-572-7662. Each MCO has their own transportation broker. Amerigroup: Logisticare at 844-544-1389. UnitedHealthcare: MTM at 1-888-513-1613. A transportation cost plan must be on file in the agency.	**Use diagnosis code V68.9 with the following codes:** **A0080** *Non-emergency transportation; vehicle provided by volunteer* (individual or organization), with no vested interest. Per round trip **A0100** *Non-emergency transportation; taxi.* Per round trip **A0110** *Non-emergency transportation; bus, intra or interstate carrier.* Per round trip **A0120** *Medical transportation (minibus, other nonprofit)*. Per round trip **A0130** *Non-emergency transportation; wheelchair van.* Per round trip **A0160** *Non-emergency transportation, by caseworker or social worker.* Per round trip **A0170** *Transportation; parking fees, tolls, other* Bill actual cost of transportation for the date the transportation was provided to the health related appointment to **IME/MCO**. For non-Medicaid eligible clients utilize local funding sources, community resource.

Urine Pregnancy Test - Urine test for determination of pregnancy by visual color comparison		
Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual and in the medical record (paper or electronic) Report the total time of the service (duration). The documentation must include: • test performed • test results • counseling provided • follow – up care or referrals	Staff must demonstrate competency on the procedure per agency protocols and be able to distinguish color variations correctly (not color blind). Pregnancy testing is not a core MH service and you are not required to do it. If test is positive provide options counseling according to Iowa law or refer to medical provider for options counseling. If the pregnancy test is negative you should refer the client to her health care provider or a family planning clinic for reproductive life planning, contraception method counseling, and STI evaluation. You will not be able to bill Medicaid as she would not be eligible to enroll in the MH program.	**81025** *Urine Pregnancy Test* by visual comparison. **Bill to IME/or MCO's**

Enhanced Services for High-Risk Women

In addition to the services listed above, these services may be provided to women with high-risk pregnancies as defined by a score of 10 or higher on the Medicaid Prenatal Risk assessment:

More Intense Health Education
Nutrition Services
Diabetes Management by a Dietician
Psychosocial Services
Social Work Visit in the Home

Care Plans		
In **signify**community™ document as barriers to care and solutions	Following the Prenatal Risk Assessment, all high-risk clients of the maternal health center individualized plan of care. The plan should be revised as necessary based on needs assessments at each contact.	Not a billable service.

More Intense Health Education –
Services of greater intensity that are not provided as part of care coordination or other service. The following topics should be covered based on documented risk assessment as specified in the individualized plan of care:

- High-risk medical conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, gestational diabetes, gum disease, chronic urinary conditions, genetic disorders, and anemia.
- Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension.
- Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases.
- Alcohol, Tobacco, other drugs. For smoking cessation refer to Quitline Iowa at 800-784-8669 or https://iowa.quitlogix.org/en-US/
- Education on environmental and occupational hazards.
- High-risk sexual behavior.
- Oral Health

Documentation	**Special Considerations**	**Code/Other funding sources**
See Health Education		**H1003; Bill to IME/MCO**

Nutrition Services –

Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss client's attitude about breastfeeding. At least one follow-up nutritional assessment is allowed, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data. Includes development of an individualized nutritional care plan and referral to food assistance programs, if indicated.

Nutritional interventions may include but are not limited to the following:

- Nutritional requirements of pregnancy as linked to fetal growth and development
- Recommended dietary allowances for pregnancy
- Appropriate weight gain
- Vitamin and iron supplements
- Information to make an informed infant feeding decision
- Education to prepare for the proposed feeding method and the support services available for the mother
- Infant nutritional needs and feeding practices

Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Need must be identified and documented for nutrition needs and service provision if the client is enrolled in WIC. Report the total time of the service (duration).	Provided by a licensed dietitian Services must be above and beyond WIC services. Services must be provided one-to-one based on a needs assessment and not provided as part of a class.	**S9470** *Nutrition counseling dietitian visit* - per encounter (one unit per date of service) **Bill to IME/MCO**

Diabetes Management by a Dietitian –
Must be provided by a licensed dietitian

Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual Document details of diabetic nutrition service provided in client's medical record maintained in the agency. Report the total time of the service (duration). Documentation must adhere to requirements in IAC 441-79.3(2) as noted above	Services must be provided by a licensed dietitian	**S9465** *Diabetic management program, dietitian visit*- per encounter (one unit per date of service) **Bill to IME/MCO**

Psychosocial Services –

A psychosocial needs assessment including:

- Demographic factors
- Mental and physical health history and concerns
- Adjustment to pregnancy and future parenting
- Environmental needs
- Family composition, patterns of functioning, and support systems
- An assessment-based plan of care
- Risk tracking
- Counseling and anticipatory guidance as appropriate
- Referral and follow-up services

Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Document detail of the social work visit in client's medical record maintained in the agency. Report the total time of the service (duration). Documentation must adhere to requirements in IAC 441-79.3(2) as noted above.	Psychosocial services must be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family counseling, health or human development, health education or individual and family studies or a registered nurse. A social worker does not require a license to provide this service Services must be provided in	**H0046** *Mental health services, not otherwise specified* **–** per encounter **Bill to IME/MCO**

	an office setting. You can bill for Psychosocial services provided by the same RN that provided health education on the same date of service- This is a change in policy by IME effective 03/1/2015.	

Social Work Visit in the Home – The purpose of the visit is based on documented risk assessment and as specified in the individualized plan of care.		
Documentation	**Special Considerations**	**Code/Other funding sources**
Document the service in **signify**community™ according to the MH manual Report the total time of the service (duration). Home visits made for the purpose of providing social work service include the following: • social history • psychosocial assessment • counseling services and plan of care	Must be provided by a BSW or licensed social worker. May be provided antepartum or postpartum Since the primary purpose of the home visit is to provide direct care, care coordination for maternal health cannot also be billed. Can be used for Listening Visits provided by a BSW.	**S9127** *Social work visit in the home* – per encounter (one unit per date of service) One unit of time equals one encounter. Maximum of four encounters per pregnancy. For time spent, include only face-to-face time. **Bill to IME/MCO**

Care Coordination Visit in the Home – To provide care coordination visit in the home based on documented need		
Documentation	**Special Considerations**	**Code/Other funding sources**

Document the service in **signify**community™ according to the MH manual Must include interaction type as home visit. Include time in and time out, specifying a.m. or p.m. per encounter to support the units billed	In some situations, it will be helpful to work one-on-one with a family in their home. The necessity of the home visit may be due to a medical condition or when working with non-English speaking families or families without phones. Care Coordination may involve: • Providing information about available health care services • Assisting clients in making health care appointments • Making referrals • Coordinating access to health care and following up to make sure that the needed services were received • Coordinating access to needed medical support services (transportation or interpreter services)	**No Code** *Care Coordination Visit in the Home* **Bill <u>IDPH</u>** for Medicaid eligible women A TAV Billing Report is sent each month to IDPH for payment of service