Maternal Health Services Summary

IDPH
IOWA Department of PUBLIC HEALTH

Building Health Equity for Healthy Communities

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Table of Contents

Introduction

This document provides a summary of maternal health services provided to pregnant and postpartum clients through IDPH Title V funded Maternal Health Centers (MHCs). For detailed 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 in the appendices of this document and on the Iowa Medicaid Enterprise (IME) website.

Documentation

Documenting in Your Agency Health Record

For direct care services provided, a client-based chart must also be maintained for the complete clinical record. Documentation must comply with generally accepted principles for maintaining health records and with requirements established by DHS in Iowa Administrative Code 441 Chapter 79.3 as outlined below. All health client records (hard copy and/or electronic) are property of IDPH.

Record Retention

Agencies shall retain all medical (including dental) records for a minimum of six (6) years from the day the Contractor submits its final expenditure report; or, in the case of a minor client, for a period of one (1) year after the client reaches the age of majority, whichever is later.

Iowa Code:

Documentation for each encounter with a client must adhere to requirements in IAC 441-79.3(2). The tables below outline the required elements of the client record as well as what is required for each encounter with the client. Refer to the following link for detailed information: https://idph.iowa.gov/Portals/1/userfiles/88/DHSRulesforDocumentationofServicesFeb2016.pdf

Information required for each medical record (from Iowa Code 441-79.3(2))
Identification: 1) Client Name: each page or separate electronic document shall contain the clients first and last name. This includes when printing from an EHR.   2) Client birthdate and medicaid ID: must be identified and associated with the client's name in the record.
Reason for Service (as applicable to the service being provided):   1) The member's complaint, symptoms, and diagnosis.   2) The member's medical or social history. Iowa Administrative Code 441-79.3 and 79.4.   3) Examination findings.   4) Diagnostic test reports, laboratory test results, or X–ray reports.   5) Goals or needs identified in the member's plan of care.   6) Physician orders and any prior authorizations required for Medicaid payment.   7) Medication records, pharmacy records for prescriptions, or providers' orders.   8) Related professional consultation reports.   9) Progress or status notes for the services or activities provided.

10) All forms required by the department as a condition of payment for the services provided.
11) Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
    a) For MHC - A care plan is required for all client's who are considered "high-risk" as identified by a IME Prenatal Risk Assessment Score of 10 or greater.
12) The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13) Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

Elements Required to Document Services Provided:
1) The specific procedures or treatments performed.
2) The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3) The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4) The location where the service was provided if otherwise required on the billing form.
5) The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6) Any supplies dispensed as part of the service.
7) The first and last name and professional credentials, if any, of the person providing the service.
8) The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

Outcome of Service:
1) The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

Clarification on Units of Time for Time-Based Services

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. Encounter-based services must have the service duration (time in/time out or total number of minutes) documented in the client's record (not just in signifycommunity).

4

Signed Consents and Release of Information

All maternal health clients must have a signed consent and release of information. Release of information must be signed by the client if any part of the medical record will be released to another individual or agency. The release must include specific authorization for release of information protected by state or federal law including substance abuse, mental health, and/ or HIV/AIDS related information. Note – signatures should be included for specific authorization for release of information for substance abuse, mental health, and/or HIV/AIDS related information if the Medicaid Prenatal Risk Assessment or any other specific information will be shared with the client's OB provider. Refer to the agency's policy and legal counsel for any specific policies related to completing the release of information form. For clients receiving only oral health services, these items do not need to be signed if this information is not collected or shared.

signifycommunity Documentation

In MHCs, data from encounters is entered into the electronic database known as signifycommunity™ for the purposes of collecting data for Title V programming and for billing in some circumstances. Signifycommunity™ 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. Maternal health centers may use a paper chart or an electronic health record. All services billed for using the Maternal Health Center provider type must be entered into signifycommunity following the guidelines for each service included in this document, and within the signifycommunity Maternal Health manual.

General signifycommunity Documentation Guidance

All clients must be entered into signifycommunity. Prior to adding a new contact, use the search bar to ensure the client is not already entered into the system. If the client already has a record, ensure the agency has ownership of the record so all activities and surveys can be viewed. Complete all demographic information for each new client in the client overview section, or verify demographic information if the client already has a record. A new episode must be created for *each pregnancy*, and all activities and surveys must be added to the episode associated with the current pregnancy.

Documenting Medical Home in signifycommunity:

Medical home is captured at the episode level for Maternal Health and should reflect whether or not the client has a *regular source of ob/gyn care* for the current pregnancy. Medical home status should be verified and updated if needed at each client visit. Select the "Provider Update" dropdown to indicate medical home (yes or no).

Documenting enabling services in signifycommunity:

Documentation for Presumptive Eligibility Services 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

Documentation for Care Coordination must 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

Documentation for transportation Care Coordination must include:
- County of Service
- Location
- Contacted Person
- Type of Medicaid Service
- Trip Date
- Transportation Type
- Service Provider

Documentation for interpretation of PE or Care Coordination (including Dental Care Coordination)

Medicaid Administrative Funds can be used to pay for interpretation for PE and Care Coordination services. To document in signifycommunity, add a Health Service activity with the appropriate Type of Service (T1013 or T1013 UC) and all necessary fields completed, with a Primary Payer of "Title XIX – MAF". Document in the comment field of the enabling service activity (PE or Care Coordination) that interpretation was provided for the service.

Program Enrollment in signifycommunity:

MH clients may be enrolled into one of five programs for maternal health: Maternal Health, Presumptive Eligibility Only, Oral Health Only, Postpartum Only, or Lactation Class Only. This is selected at the episode level.

Adding Activity Bundles

Once the record and episode have been created, use the Universal Add button to add an Activity Bundle. Using bundles is a best practice for data entry into signifycommunity, as the bundles include all required activities and some optional activities, and includes a feature that

cascades common data elements into each activity so the same data points do not need to be entered multiple times. The table below outlines each Activity Bundle option and the activities that are included in each bundle. Refer to the signifycommunity Manual for Oral Health Bundle information.

A Health Services activity must be added for each service billed (even if the agency does not use Softactics for billing). Additionally, maternal health program data is collected via three surveys: an Intake Survey, an All Visits survey, and a Discharge survey. Each client enrolled in the full maternal health program must have all three surveys completed. Refer to the Maternal Health Portal for templates of the surveys.

Common Fields: Common Fields allow users to enter the data elements once, and they will cascade into all activities in the bundle. Common Fields for all maternal health bundles except Presumptive Eligibility and Oral Health Only include:

- Primary Diagnosis
- ICD-10
- Interaction Type
- County of Service
- Location
- Place of Service
- Primary Payor
- Primary Payor No.
- Secondary Payor
- Secondary Payor No.
- Service Provider
- Prior Auth No.
- Documentation Source

Bundle	Included Activities and prepopulated fields

First Visit	**Obtain Documentation**
	    Type of document: Maternal Health Consent; Maternal Health Release
	Complete Survey
	     Topics: Complete the Pregnancy Intake Survey
	                 Complete the All Visits Survey
	                 Complete the Oral Health Survey
	Presumptive Eligibility
	Health Services
	    Topic: Medicaid Prenatal Risk Assessment (Initial Screen)
	Health Services
	    Topic: Health Education
	Health Services
	    Topic: Psycho/Social
	Health Services
	    Topic: Abuse Assessment Screening
	Health Services
	    Topic: SBIRT
	Dental Referral
	Follow-Up Appointment

Subsequent Visit	**Health Services** Topic: Medicaid Prenatal Risk Assessment (Rescreen) **Health Services**

	Topic: Health Education
	Health Services
	   Topic: Psycho/Social
	Health Services
	   Topic: Abuse Assessment Screening
	Health Services
	   Topic: SBIRT
	Complete Survey
	   Topic: Complete All Visit Survey
	Dental Referral
	Follow-Up Appointment

Postpartum Visit	**Health Services**
	   Topic: Health Education
	Health Services
	   Topic: Psychosocial
	Health Services
	   Topic: blank
	Dental Referral
	Follow-Up Appointment
	Complete Survey
	   Topics: Complete the All Visits Survey
	         Complete the Discharge Survey
	         Complete the Oral Health Survey

Postpartum Only	**Obtain Documentation**
	   Type of document: Maternal Health Consent; Maternal Health Release
	Complete Survey
	   Topics: Complete the Intake Survey
	         Complete the All Visits Survey
	         Complete the Discharge Survey
	         Complete the Oral Health Survey
	Health Services
	   Topic: Health Education
	Health Services
	   Topic: Psychosocial
	Health Services
	   Topic: blank
	Dental Referral
	Follow-Up Appointment

Initial Home Visit	**Obtain Documentation**
	   Type of document: Maternal Health Consent; Maternal Health Release
	Complete Survey
	   Topics: Complete the Intake Survey
	         Complete the All Visits Survey
	         Complete the Oral Health Survey
	Presumptive Eligibility

	Health Services Topic: Home Visit **Dental Referral** **Follow-Up Appointment** **Health Services**

Subsequent Home Visit	**Complete Survey**
	    Topics: Complete the All Visits Survey
	Health Services
	    Topic: Home Visit
	Dental Referral
	Follow-Up Appointment
	Health Services

Final Home Visit	**Complete Survey**
	    Topics: Complete the All Visits Survey
	            Complete the Discharge Survey
	            Complete the Oral Health Survey
	Health Services
	    Topic: Home Visit
	Dental Referral
	Health Services

Listening Visit (in the home or in clinic)	**Complete Survey**
	    Topic: Complete All Visit Survey
	            Complete the Discharge Survey
	            Complete the Oral Health Survey
	Health Services
	    Topic: Listening Visit
	Dental Referral
	Follow-Up Appointment

Lactation Class Only	**Obtain Documentation**
	    Type of document: Maternal Health Consent; Maternal Health Release
	Complete Survey
	    Topics: Complete the Intake Survey
	            Complete the Discharge Survey
	            Complete the Oral Health Survey
	Health Services
	    Topic: Lactation Class
	Dental Referral
	Follow-Up Appointment

PE Only	**Presumptive Eligibility** **Care Coordination** **Follow-Up Appointment** **Complete Survey** Topic: Complete the Oral Health Survey

Oral Health Bundles

Oral Health Only	**Obtain Documentation**
	   Type of document: Maternal Health Consent; Maternal Health Release
	Referral
	Dental
	   Topic: Dental Screening
	Dental
	   Topic: Risk Assessment
	Dental
	   Topic: Fluoride Varnish
	Dental
	   Topic: Oral Hygiene Instruction
	Dental
	   Topic: Dental Nutrition Counseling
	Care Coordination
	   Primary Payer: Other
	Complete Survey
	   Topic: Complete the Oral Health Survey

Dental Screening	**Dental Referral**
	Dental
	   Topic: Dental Screening
	Dental
	   Topic: Risk Assessment
	Dental
	   Topic: Fluoride Varnish
	Dental
	   Topic: Oral Hygiene Instruction
	Dental
	   Topic: Dental Nutrition Counseling
	Dental
	   Topic: Tobacco Counseling
	Follow-Up Call
	Complete Survey
	Topic: Complete the Oral Health Survey

Dental High Risk	**Send/Give Educational Materials** **Care Coordination** **Follow-Up Call** **Activity Date: 1 Month from Bundle Date**
Dental Moderate Risk	**Send/Give Educational Materials** **Care Coordination** **Follow-Up Call** **Activity Date: 6 Months from Bundle Date**

Health Screening Surveys

signifycommunity includes several surveys to capture health screenings, including the Edinburgh Postnatal Depression Screen, and SBIRT (includes AUDIT, DAST, and CRAFFT). If

a screening is conducted with a client, the screening tool must be included in the client's chart. With the exception of listening visits, using the surveys in signifycommunity is **not required** as long as the screening tool is kept in the client chart per agency policy.

Billing for Maternal Health 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. MHCs must bill Medicaid (IME) or the Medicaid MCOs contracted with IME for all Medicaid eligible pregnant clients and are reimbursed on a fee-for-service basis.

MHCs must bill for dental services to the members assigned dental plan (PAHPs) or if not assigned then FFS to IME. ICD-10 codes are not required for dental claims billed to the dental plans.

Medicaid Reimbursement Rates

The amount billed should reflect the actual cost of providing the service. MHCs 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 grant funds are utilized to fund services as described by the specific agency contract with the Iowa Department of Public Health, however MHCs may use Title V grant funds to provide services to clients who are not eligible for Medicaid and have no insurance or are underinsured.

Prior Authorization

Each Medicaid MCO has specific requirements around obtaining prior authorization for services. This document includes general information about MCOs, however MHCs should always check the current MCO websites prior to billing any service to ensure prior authorization requirements have not changed.
- Iowa Total Care Prior Authorization Website:
  https://www.iowatotalcare.com/providers/preauth-check/medicaid-pre-auth.html
- Amerigroup Prior Authorization Website:
  https://providers.amerigroup.com/Pages/PLUTO.aspx

Preventive dental services do not require prior authorization.

Third Party Liability

When a third party liability (other insurance) for medical expenses exist, this resource shall be used before the IME or the MCO makes any payments, unless IME or the MCO pays the total amount allowed under their fee schedule and then seeks reimbursement from the liable third-

party in the form of pay and chase[1]. For clients with other insurance, MHCs must include the Explanation of Benefits (EOB) from the insurance plan with any claims submitted to IME or the Medicaid MCO. In lieu of the EOB, if a denial is not available due to provider credentialing issues, the MHC must submit a current letter from the client's insurance plan stating that MHCs are not an approved provider type.

List on the claim form any payments made by the other insurance, whether made to the provider or to the member. If the other source denies payment, indicate this on the Medicaid claim form.
- After insurance makes a payment, submit a claim to IME or the MCO for consideration, unless payment in full is received.
- On the claim, show the amount that was paid by the other insurance. Providers are not required to show the contractual write-off as payment from a third-party payer. Indicate only the actual payment you received from the third-party payer.
- IME or the MCO will make payment only according to their fee schedule. The third-party payment plus any IME or the MCO payment cannot exceed the allowed.
- If the third-party payment equals or exceeds the IME or the MCO allowed amount, Medicaid will pay the claim at $0.00. Medicaid now considers the claim paid, and the provider cannot bill the Medicaid member.

Since denial is not available due to credentialing issues with commercial dental plans, the MHC must submit a letter from the third party payor stating MHCs are not an approved provider type in place of the EOB for dental claims where a client has private dental insurance.

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[1] "Pay and chase" means the provider bills IME or the MCO, even though the client has health insurance and IME or the MCO bills the insurance company. Medicaid allows "pay and chase" for certain situations, including when services are provided to:
- Children whose medical is provided from an absent parent.
- Children under the age of 21 for preventative pediatric services, which include all drugs; home health services with procedure codes S9122, S9123, S9124; and the following V codes:

V01.0-V01.9	V20.0-V20.2	V77.0
V02.0-V02.9	V70.0	V77.7
V03.0-V06.9	V72.0-V72.3	V78.2-V78.3
V07.0-V07.9	V73.0-V75.9	V79.2-V79.3

Enabling Services

Presumptive Eligibility Determination for Pregnant Women

The process of presumptive eligibility determination for pregnant women by a qualified provider.

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.

Billing Code(s) and Considerations
Charge MAF for all costs associated with providing this service.

Required Credentials
None

Required Training
To provide PE services, staff must be certified as Qualified Entities (QE) under the supervision and authority of a Presumptive Provider Organization (agency). To 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.

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.

DHS requires documentation in the Health Services Application Form and Case File or documentation via MPEP the Iowa Medicaid Portal.

Screening Tools, Forms, Etc.
The Guide for Qualified Providers from DHS outlines the steps required to make a presumptive eligibility determination. 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. 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 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.

Care Coordination

Care coordination is 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. 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.

Billing Code(s) and Considerations

- Charge MAF for all costs related to providing the service.
  - 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 the time and supplies for providing 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), the next steps are to utilize care coordination to get them into medical and dental care as needed.
  - Keep in mind:
    - The payer source for the care coordination service related to a PE will be Title XIX-MAF.
    - The care coordination service must involve linking the client up with services, not just checking to see if they have a medical home or dental home.
- 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.

Required Credentials

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.

Required Training

IDPH EPSDT Training

MCO Billing Considerations*

Once a Medicaid member has been enrolled with a MCO, DHS has given the responsibility for medical care coordination to the MCOs. However, each maternal health program client should receive dental care coordination; including asking about dental home, making referrals to a dentist when appropriate and follow up monitoring to assure needed services are received. Dental Care Coordination remains the responsibility of the MHCs even after the client's assignment to their dental plan.

Minimum Charting Requirements

General Considerations:

- Must involve phone or face-to-face contacts with the family or provider(s) on behalf of client.
- 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 signifycommunity. Enter the type of care coordination service in signifycommunity as 'Care Coordination Presumptive Eligibility'.

Texting and Email for Care Coordination:

- Texting and emails are allowable if unable to reach the client in person.
  - 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 to be documented as care coordination.
    - Texts with no response are not considered care coordination, but rather follow up calls
    - Medicaid-related services must be the central topic of the care coordination exchange.
    - Texts may not include protected health information.
    - 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 to be considered care coordination
    - Emails with no response are not considered care coordination, but rather follow up calls.
    - 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.

16

- ○ 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.

Providing Dental Care Coordination:
- 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 to energy assistance.
  - Referral to housing assistance.
  - Referral to a food pantry.
  - Referral to legal, financial assistance.
  - Referral for GED.
  - Referral to Storks Nest.

Special Circumstances

Time spent providing care coordination on the same day as a direct care for Medicaid enrolled clients is considered part of the direct care service. When providing dental care coordination on the same day as a direct dental service, the dental care coordination can be entered it into signifycommunity as a dental care coordination service, but the payment source would be "other" since the direct service reimbursement is actually paying for the dental care coordination time. This allows the provider to get "credit" for all of the dental care coordination provided. Other exceptions include:

1. Time spent to provide 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. Time spent to provide 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. Time spent to provide care coordination to arrange transportation may occur on the same day as a direct care service.
4. Time spent to provide interpretation for care coordination may be billed on the same day as the care coordination service.

17

Care Coordination Visit in the Home*

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).

Billing Code(s)

For a care coordination visit in the home, charge associated costs to Medicaid Administrative Funds. Time can only be charged for medical care coordination for clients with FFS Medicaid. All time for dental care coordination can be billed to the Medicaid Administrative Funds.

This service can only be provided to clients with a high-risk score (>10) on the Medicaid Prenatal Risk Assessment.

Required Credentials

None

Minimum Charting Requirements

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.

Core Maternal Health Services

(Required for Tier 2 Agencies)

Depression Screening

Billing Code(s) and Considerations
G0444
Record Time in and Time out, specify a.m. or p.m.

96160 Administration & Interpretation of health risk - Depression Screen
96160-XU Administration & Interpretation of health risk - Depression Screen - Distinct Non-Overlapping Services
This is an encounter code and is not billed based upon time.

Use these codes only if Health Education, psychosocial services, or a home visit are not provided on the same date of service (Otherwise screening should be done as part of those services).

The XU modifier should be used if another 96160 screening is completed (Medicaid Prenatal Risk Assessment or Domestic Violence Screen). Only 2 96160 codes can be billed on the same date of service.

Required Credentials
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.

Required Training
IDPH Direct Service Orientation

Minimum Charting Requirements
Charting guidance for Medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. 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.

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.

Screening Tools, Forms, Etc.
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.

Health Education Services Provided by a Registered Nurse*

Education services provided by a registered nurse to improve the client's mental and physical health. This service can be provided in a clinic setting. For clients with a Prenatal Risk Assessment score greater than 10, additional health education topics must be addressed, as outlined in the Health Education for High Risk Clients section below.

Billing Code(s) and Considerations
H1003: Prenatal care at risk enhanced service education – Encounter code once per date of service.

Other Considerations
- 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.
- Mailing brochures and pamphlets may not be billed as a separate service.
- 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.
- Health Education and Psychosocial services provided by the same RN on the same date of service **can both be billed together** - This is a change in policy by IME effective 03/1/2015.

Required Credentials
Provided by a registered nurse.

Required Training
IDPH Direct Service Orientation

Minimum Charting Requirements and Educational Topics
Charting guidance for Medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. The following specific elements must be followed for this service:
- Report the total time of the service (duration).
- Keep a list of teaching and reference materials supplied to the patient. Also document modification made to accommodate the patient's literacy skills and native language.
- Care plan created with client if high-risk per Prenatal Risk Assessment tool.

Provision of Services
The following health topics are to be included in health education <u>over the course of the client's care:</u>
- How to access their healthcare provider and emergency services if needed.
- Importance of continued prenatal care.
- Normal changes of pregnancy:
  - Maternal changes
  - Fetal changes
- Self-care and comfort measures including beneficial (seat belt use) detrimental lifestyle practices (teratogen avoidance).

- If high-risk per Prenatal Risk Assessment, the following topics must be addressed:
    - Education on any high-risk medical conditions.
    - Smoking cessation and Quitline referral if indicated.
    - Alcohol avoidance.
    - Illicit drug avoidance.
    - Environmental and occupational hazards.
    - Avoiding high-risk sexual behaviors.
- Danger signs of pregnancy:
    - Warning signs of pregnancy complications should include criteria and mechanism for notification of health care providers and emergency services.
    - May include, but not limited to, the following:
        - headache, visual changes, seizures
        - chest pain or breathing difficulty
        - thoughts of self harm or harming someone else
        - reddened, painful area in lower extremities (DVT)
        - decreased fetal movement
        - contractions four or more in an hour
        - increased vaginal discharge
        - vaginal bleeding or bloody show
        - water breaks or leaks
        - low back pain or pelvic pressure
        - nausea, vomiting or diarrhea
        - abdominal tenderness
        - temperature of 100.4◦ F or higher
        - signs of bladder infection increased urination frequency, urgency or pain
- Labor and delivery:
    - Normal process of labor
    - Signs of labor
    - Coping skills
    - Danger signs
    - Management of normal labor
- Preparation for baby:
    - Feeding
    - Equipment (including sleep environment topics)
    - Clothing
- Education on the use of over-the-counter drugs.
- Education about HIV prevention.
- Other topics based on clients health care needs assessment.
- Required topics based on Title V National and State Performance Measures FY 2021-2025:
    - Tobacco cessation
    - Breastfeeding
    - Safe Sleep
    - Maternal Mortality Review Committee Recommendations

Health Education for High Risk Clients
Additional educational requirements for clients with Prenatal Risk Assessment scores of 10 or more.

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.

Nursing Visit in the Home

Prenatal or postpartum home visit by a nurse in the home.

Provision of Services

Antepartum Visits Shall Include:

- 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 (Health Education).
- Health education topics including pregnancy and postpartum danger signs:
  - Warning signs of pregnancy complications should include criteria and mechanism for notification of health care provider.
  - May include but not limited to the following:
    - headache, visual changes, seizures
    - chest pain or breathing difficulty
    - thoughts of self harm or harming someone else
    - reddened, painful area in lower extremities (DVT)
    - decreased fetal movement
    - contractions four or more in an hour
    - increased vaginal discharge
    - vaginal bleeding or bloody show
    - water breaks or leaks
    - low back pain or pelvic pressure
    - nausea, vomiting or diarrhea
    - abdominal tenderness
    - temperature of 100.4∘ F or higher
    - signs of bladder infection increased urination frequency, urgency or pain
- In addition to developing a care plan, the following topics must be covered if the client is deemed high-risk by the prenatal risk assessment:
  - Education on any high-risk medical conditions.
  - Smoking cessation and Quitline referral if indicated.
  - Alcohol avoidance.
  - Illicit drug avoidance.
  - Environmental and occupational hazards.
  - Avoiding high-risk sexual behaviors.
- Other service needed as identified in risk assessment.

The Postpartum Home Visit Shall Include:

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.

- 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 support, recognition of illness, accident prevention, immunizations, and well-child care.
- Identification and referral to community resources as needed.

Billing Code(s) and Considerations
S9123

Other Considerations
- For time spent, include only face- to-face time. Do not include travel time (if applicable) or time documenting the service.
- A limit of 10 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.
- Since the primary purpose of the home visit is to provide direct care services, time spent providing care coordination is considered part of the direct service, and MAF cannot be used to cover any costs associated with the home visit for care coordination service for the mother or infant cannot also be billed.
- 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 one 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. See the "Listening Visits" service summary for specific requirements for that service.

Required Credentials
Must be provided by a registered nurse.

Required Training
IDPH Direct Service Orientation

Minimum Charting Requirements
Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this 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.

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 Direct Care Services

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

Billing Code(s) and Considerations

Procedure codes:
D0190 oral screen by non-dentist
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
D1120: Prophy (age 12 yr. and younger)
D1110: Prophy (age 13yr. and over)
D1206: Topical fluoride varnish
D1310: Nutritional counseling for control and prevention of oral disease
D1320 Tobacco counseling for prevention of oral disease
D1330: Oral hygiene instruction
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
D9990: Interpretation provided face to face by paid interpreters during a direct service; one time per member per day (not based on time in/time out)

Other Considerations
- Bill the members assigned dental plan for all oral health services unless the member has not been assigned (PE) then bill IME.
- Bill all time spent providing care coordination and associated costs to the Medicaid Administrative Funds; including interpretation provided during the care coordination.

26

- 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 for time to provide 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 can be documented as care coordination, but is reimbursed as part of the direct service. This care coordination can be documented as a care coordination activity but the payment source must be "other". Follow-up to the referral that is done on subsequent days (from the direct service) can be documented as care coordination and the time spent billed as care coordination.
- Sealant applications are limited to ages 6-18 or those with a physical or mental disability.

Required Credentials

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. 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.

Required Training

All staff providing oral health services must take the Maternal Health Training from the I-Smile Coordinator.

Minimum Charting Requirements

Documentation must adhere to requirements in IAC 441- 79.3(2) as noted above.

Documentation must include the counseling/instruction issues that were addressed with the client including client specific concerns. All services must 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.
- The client's risk level must be assessed, documented and entered into Signify each time an oral screening is provided.

Screening Tools, Forms, Etc.

Client must have a signed treatment consent.

A dental referral must be provided at the time of each oral screen based on the risk assessment.

Prenatal Risk Assessment

Completion of Medicaid Prenatal Risk Assessment, form 470-2942.

Billing Code(s) and Considerations

96160 Administration & Interpretation of health risk - Medicaid Prenatal Risk Assessment
96160-XU Administration & Interpretation of health risk - Medicaid Prenatal Risk Assessment - Distinct Non-Overlapping Services

This is an encounter code and is not billed based upon time.

The XU modifier should be used if another 96160 screening is completed (Depression or Domestic Violence Screen). Only 2 96160 codes can be billed on the same date of service.

This form will need to be submitted with prior authorization requests from the MCOs and IME when requesting services for clients deemed "high-risk" by this tool.

Other Considerations

- May be billed in addition to Health Education and/or Psychosocial. If done as part of the home visit cannot be billed separately.
- 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 or release of information on the Prenatal Risk Assessment form prior to sharing the information.
- If the Prenatal Risk Assessment is completed by the OB provider and sent to the MH Agency, the agency should **not** complete or bill for a new assessment, and use the completed assessment from the OB provider. The agency may rescreen the client at 28 weeks and bill for the service if they are low risk on the initial screen.
- Additional assessments may be billed at a later date if client need is demonstrated. Note the reason for an additional assessment in medical record.

Required Credentials

Must be provided by a registered nurse or social worker. A social worker may provide this service if an RN is available for any health or medical diagnosis related questions (Approved by IME 10/2020).

Required Training

IDPH Direct Service Orientation

Minimum Charting Requirements

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 client's file.

It is best practice to send a copy of the risk assessment to the client's primary medical/obstetrical care provider.

Screening Tools, Forms, Etc.

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.

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. Clients with any of the additional factors on the back of the form are automatically considered high-risk. If any of these factors are present, indicate in the assessment tool and in the Maternal Health Data System.

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. Enhanced services provided based on the Prenatal Risk Assessment are indicated in this document with an asterisk (*).   (See Enhanced Services.)

Complete the Medicaid Risk Assessment for all prenatal clients, even those who are not eligible for Medicaid.

Care Plan Minimum Criteria

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.

The care plan may be a part of the client's chart and its own form, or the goals section in signifycommunity.

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.

Billing Code(s) and Considerations
H0046 (Mental health services, not otherwise specified – per encounter.)

Other Considerations
- They agency may 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.
- Psychosocial services can only be billed for clients with a high-risk score (>10) on the Medicaid Prenatal Risk Assessment.
- The 2-question screen for alcohol and drug use is considered part of this service. Full screening, brief intervention, and referral to treatment can be billed separately (see Alcohol and/or Substance Abuse Screening with Brief Intervention).
- A depression screen should be completed as part of this service and cannot be billed separately.
- Domestic violence screening with the AAS or another approved screening tool can be billed in addition to the psychosocial assessment (see Domestic Violence Screening).

Required Credentials
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 an office setting.

Required Training
IDPH Direct Service Orientation

Minimum Charting Requirements
Document detail of the social work 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.

Additional Maternal Health Direct Services

Administration of Medication; Oral, Intramuscular, or Subcutaneous

This code is intended to provide administration of progesterone (17p) in the clinic setting. Use of this service requires a physician order.

Billing Code(s) and Considerations

T1502

*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 the patient's OB provider to get the medication to administer to the patient.

Required Credentials

Must be provided by a registered nurse or LPN.

Minimum Charting Requirements

This service should be recorded per agency policy in the client's chart.

Total time (duration) will need to be recorded for billing.

Screening Tools, Forms, Etc.

Typical administration is a shot once weekly between 16 weeks until 37 weeks.

Alcohol and/or Substance Abuse Screening with Brief Intervention

Alcohol and substance abuse screening with brief intervention - includes administration of the following:

- A 2-question pre-screen.
- If positive on the pre-screen:
    - CRAFFT for adolescents under age 18 years.
    - AUDIT and/or DAST for clients age 18 to 21 years.
    - Brief intervention.
    - Referral to treatment.

Billing Code(s) and Considerations

Brief intervention MUST be done in order to bill these codes
99408 for (15-30 minutes)
99409 for (over 30 minutes)
Record Time in and Time out, specify a.m. or p.m.

Required Credentials

Provided by a registered nurse or social worker (BSW or Licensed).

Required Training

SBIRT Training - contact the IDPH MH program for training opportunities.

Minimum Charting Requirements

Charting guidance for Medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. The following specific elements must be followed for this service:

- The tool must be retained in the client's chart as well as a narrative of the brief intervention.
- Motivational interviewing techniques should be utilized.
- Referral should also be documented in the client chart.

Screening Tools, Forms, Etc.

The CRAFFT includes:

- Administration of the tool.
- Brief intervention.

SBIRT = Screening, Brief Intervention, and Referral to Treatment. SBIRT includes:

- 2-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. There is no known safe amount of alcohol consumption for pregnant women.

Other tools:

- UNCOPE: often used in juvenile corrections.

- NIDA's TAPS (Tobacco, Alcohol, Prescription medications, and other Substance) Tool.
- WHO's: ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) v3.0.
- 5 Ps: for pregnant and postpartum.

Annual Alcohol Screening, Alcohol and/or Drug Screening

Billing Code(s) and Considerations
G0442 Annual alcohol screening
H0049 for alcohol and/or drug screening

Required Credentials
Must be provided by a registered nurse or social worker (BSW or Licensed).

Required Training
Included in SBIRT training.

Minimum Charting Requirements
Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. The following specific elements must be followed for this service:
- The tool must be retained in the client's chart as well as a narrative of the brief intervention.
- Motivational interviewing techniques should be utilized.
- Referral should also be documented in the client chart.

Screening Tools, Forms, Etc.
- CRAFFT for adolescents under age 18 years.
- AUDIT and/or DAST for clients age 18 to 21 years.

Counseling for Alcohol Misuse

This is face-to-face behavioral counseling for alcohol misuse.

Billing Code(s) and Considerations

G0443 (15 minutes)

Record Time in and Time out, specify a.m. or p.m.

Required Credentials

Must be provided by an RN or social worker (BSW or licensed).

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. Refer to client's chart for complete documentation per agency's policy

Documentation in client's medical chart should include time in and time out specifying a.m. or p.m.

Counseling for Obesity

This is face-to-face behavioral counseling for obesity.

Billing Code(s) and Considerations

G0447 (15 minutes)
Record Time in and Time out, specify a.m. or p.m.

Required Credentials

Must be provided by a licensed dietitian or registered nurse.

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. Full details of the counseling should be recorded per agency policy in the client's chart.

Time in and time out are required to bill this service.

Diabetes Management by a Dietitian*

Billing Code(s) and Considerations
S9465

Diabetic management program, dietitian visit- per encounter (one unit per date of service).

This service can only be billed for clients with a high-risk score (>10) on the Medicaid Prenatal Risk Assessment.

Required Credentials
Services must be provided by a licensed dietitian.

Minimum Charting Requirements
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.

Domestic Violence Screening

Billing Code(s) and Considerations

96160 Administration & Interpretation of health risk - Domestic Violence Screen
96160-XU Administration & Interpretation of health risk - Domestic Violence Screen - Distinct Non-Overlapping Services

This is an encounter code and is not billed based upon time.

The XU modifier should be used if another 96160 screening is completed (Medicaid Prenatal Risk Assessment or Depression Screen). Only two 96160 codes can be billed on the same date of service.

Required Credentials

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.

Required Training

Training on intimate partner violence and the Abuse Assessment Screen - contact the IDPH MH program for training opportunities.

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. The following specific elements must be followed for this service:
- The tool must be retained in the client's chart.
- Referral should also be documented in the client chart.

Screening Tools, Forms, Etc.

This domestic violence screening using the Abuse Assessment Screen (AAS).

Assure that referral resources are available as needed.

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.

E & M is a clinical encounter direct care service.

Billing Code(s) and Considerations

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.

This is an encounter code and is not billed based upon time.

Other Considerations

- Encounter code can only be used once per day per client.
- 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.

Required Credentials

Must be provided by a registered nurse.

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. Report the total time of the service (duration).

Include the following in the client medical record:
- 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.

Immunization Administration with Counseling

Billing Code(s) and Considerations

90460 for each vaccine administered. Submit cost per cost analysis. This service cannot be provided without a physician order.

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

Other Considerations
- VFC vaccines may not be billed for as the vaccine is free.
- 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)

Required Credentials

Per agency policy.

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. 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).

Immunizations

Initial or subsequent administration of immunization. This service cannot be provided without a physician order.

Billing Code(s) and Considerations

- 90471 for initial administration of vaccine (single or combination), subcutaneous or intramuscular.
- 90472 for subsequent administrations of vaccine (single or combination) on same day as Code 90471 or Code 90473.
- 90473 for administration of one vaccine (single or combination) by intranasal or oral means.
- 90474 for subsequent administrations of vaccines (single or combination) by intranasal or oral means on same day as Code 90473.
- 90630 for influenza virus, quadrivalent (IIV4), split virus, preservation free, intramuscular use.
- 90651 for HPV vaccine (types 6, 11, 16, 18, 31, 33, 45, 52, 58), 3 dose schedule, IM use.

Other Considerations

- 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.
- VFC vaccines may not be billed for as the vaccine is free.
- 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).

Required Credentials

Per agency policy.

Minimum Charting Requirements

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).

Interpreter Services

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

Billing Code(s) and Considerations

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.

D9990 face to face interpretation during direct dental services; billed to the clients Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid; one time per client per day

Other Considerations
- 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.
- 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.
- 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.

Required Credentials

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).

Minimum Charting Requirements

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.

Lactation Classes

Non-physician provider: provide a breastfeeding class using an evidence based curriculum.
*Note this service is for Breastfeeding Education not for breastfeeding peer support.

Billing Code(s) and Considerations
S9443 Lactation Classes

Other Considerations
- You may bill Medicaid for each Medicaid eligible person attending the class. This is a service for women enrolled in the Maternal Health program.
- Peer support should occur before and after the educational classes between participants; however for Medicaid billing it cannot be only a support group.

Required Credentials
RN, licensed dietitian, Certified Lactation Counselor (CLC), Certified Lactation Specialist (CLS) or International Board Certified Lactation Consultation (IBCLC).

Required Training
IDPH Direct Service Orientation

Minimum Charting Requirements
Documentation should include:
- What specific breastfeeding education topics were discussed during the class some topic might including but not limited to:
    - Hunger Cues
    - Feeding Frequency and Duration
    - Latch
    - Milk Transfer
    - Positioning (clutch hold, cradle hold, cross cradle hold, laid back and side lying)
    - Signs of Adequate Intake (count of wet and dirty diapers, sound of swallowing, weight gain)
    - Reluctant Nurser
    - Milk Expression and Breast Pump
- 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).

Listening Visits (Patient Education, Non-Physician Provider, Individual, Per Session)

Active reflective listening with clients to facilitate and support problem solving. With an emphasis on working collaboratively to find solutions. This service has a required training prior to providing the service.

Billing Code(s) and Considerations

Bill IME S9123 for **home visit** by a nurse:
- "Per hour" for time spent, includes only face to face time do not include travel time visit must be 31 minutes long to be billed for one unit.
- Limit of 10 units in 200 days.
- Must be provided by an RN.

Bill IME S9127 for **home visit** by a social worker:
- "Encounter code" not based on timed unit.
- Limited to four Listening Visits.
- Must be provided by a BSW or licensed social worker.

Bill IME S9445 for Listening Visits in a **clinic/office** setting by RN or Social Worker:
- Patient education not otherwise classified, non-physician provider.

Notes:
- Must bill IME your cost for the home visit.
- Must offer same service to women with no insurance (use Title V grant funds).

Other Considerations:

MHC Agency must have an approved Listening Visit protocol on file prior to beginning listening visits.

Required Credentials:

S9127 - Social Work Visit in the Home: Bachelor's in Social Work or Licensed Social Worker (LMSW or LISW)
S9445 - Patient Education, Non-Physician Provider, Individual, Per Session: Bachelor in social work, counseling, sociology, psychology, family counseling, health or human development, health education or individual and family studies.

Required Training

Listening Visit training - contact the IDPH MH program for training opportunities. This training is offered every other year for providers who have worked in the Title V MH program for a minimum of six months.

Minimum Charting Requirements:

Utilize specific forms for Listening Visits (available on the MH Portal).

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, or postpartum follow up.

Billing Code(s) and Considerations

T1001

Other Considerations

- Encounter code can only be used once per day per client.
- Must be provided in the office setting, not a home visit. If the nursing assessment is in the home S9123 should be billed.
- This code is useful when doing a full postpartum nursing assessment on a patient in a clinic setting. The postpartum assessment should include a comprehensive assessment of client's health and psychosocial status.

Required Credentials

Must be provided by a registered nurse.

Required Training

IDPH Direct Service Orientation

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual.

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.

Report the total time of the service (duration).

Nutrition Services*

Billing Code(s) and Considerations
S9470

Nutrition counseling dietitian visit - per encounter (one unit per date of service).

This service can only be billed for clients with a high-risk score (>10) on the Medicaid Prenatal Risk Assessment. 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.

Required Credentials
Provided by a licensed dietitian.

Minimum Charting Requirements
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).

Screening Tools, Forms, Etc.
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.

Preventive Medicine Counseling

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 practice to provide this service in conjunction with a urine pregnancy test.

Billing Code(s) and Considerations

99401 (15-minute unit)

99402 (30-minute unit)

Other considerations

- 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.

Required Credentials

Must be provided by a registered nurse.

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. Refer to client's chart for complete documentation.

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. May be provided antepartum or postpartum.

Billing Code(s)
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.

This service can only be billed for clients with a high-risk score (>10) on the Medicaid Prenatal Risk Assessment.

Required Credentials
Must be provided by a BSW or licensed social worker.

Can be used for Listening Visits provided by a BSW.

Required Training
IDPH Direct Service Orientation

Minimum Charting Requirements
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

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.

Billing Code(s) and Considerations

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.

Other Considerations

- 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 resources.
- 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.
- Access2Care 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 clients. Contact Access2Care at 1-866-572-7662.
- Each MCO has their own transportation broker:
  - Amerigroup: Logisticare at 844-544-1389.
  - Iowa Total Care: Access2Care at 1-833-404-1061 (TTY 711), press 2 for Iowa Total Care Member Services, then press 1 for Transportation.
- A transportation cost plan must be on file in the agency.

Required Credentials

None

Minimum Charting Requirements

Document the entire service in signifycommunity™ according to the MH manual:

- Complete in signifycommunity™ "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.

Urine Pregnancy Test

Urine test for determination of pregnancy by visual color comparison.

Billing Code(s) and Considerations

81025

Urine Pregnancy Test by visual comparison.

Required Credentials

Staff must demonstrate competency on the procedure per agency protocols and be able to distinguish color variations correctly (not colorblind).

Minimum Charting Requirements

Charting guidance for medicaid requirements for the client visit must be followed as outlined on pages 2-3 of this manual. Report the total time of the service (duration).

The documentation must include:
- Test Performed
- Test Results
- Counseling Provided
- Follow-up Care or Referrals

Screening Tools, Forms, Etc.

Pregnancy testing is not a core MH service and you are not required to do it.

If the test is positive, provide options counseling according to Iowa law or refer to a medical provider for options counseling.

If the pregnancy test is negative, refer the client to their 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.