Birth Centers

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. BIRTH CENTERS ELIGIBLE TO PARTICIPATE

Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payers.

B. COVERAGE OF SERVICES

Payment will be made for prenatal care, delivery, and postpartum care provided by a certified nurse-midwife in a birth center.

Prenatal Risk Assessment

The Iowa Departments of Human Services and Public Health have jointly developed the *Medicaid Prenatal Risk Assessment* to help the clinician determine which pregnant members are in need of supplementary services to complement and support routine medical prenatal care.

To determine risk for pregnant Medicaid members upon entry into care use the *Medicaid Prenatal Risk Assessment*, form 470-2942. To access this form online, click here.

The form categorizes prenatal risk factors and assigns a score value related to the seriousness of the risk. In individual cases, the clinician may determine that the value the form assigns is not appropriate and, based on professional judgment, may choose a lesser value.

To determine a woman's risk status during the current pregnancy, add the total score value on the left side and either column B1 (initial visit score value) or column B2 (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

When a high-risk pregnancy is reflected, inform the woman and refer her to an Iowa Department of Public Health maternal health agency or provide enhanced services. (See Enhanced Services.) If you are referring the client to a maternal health agency, with the client's permission, provide a copy of the *Medicaid Prenatal Risk Assessment* to the agency providing enhanced services and keep a copy in the member's medical records.

To access the map showing locations of maternal health agencies, click here.

When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care or when an increase in the pregnant woman's risk status is indicated.

1. Risk Factors Related to History

The left side of the *Medicaid Prenatal Risk Assessment* includes medical, dental, historical, environmental, or situational risk factors. A description of many of the risk factors is located on the back of the form. Included are abortions (AB) first trimester, AB second trimester, uterine anomaly, history of pyelonephritis, illicit drug use, and poor social situation.

Assign cigarette use and smoking a point value if the person smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."

Indicate the risk factor "Last pregnancy within 1 year," when the member has been pregnant within 12 months of the beginning of the present pregnancy.

2. Risk Factors Related to Current Pregnancy

The right side of the form includes risk factors related to the current pregnancy. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the mid to last trimester. For this reason these risk factors are assessed twice during the pregnancy on the form.

A description of the following risk factors is located on the back of the form:

- Bacteriuria
- Pyelonephritis
- Bleeding after the twelfth week
- Dilation
- Uterine irritability
- Surgery
- Hypertension

Depression is the most common complication of pregnancy. It is under recognized and has an impact on pregnancy since it may lead to poor self-care including not following through with health care recommendations. Untreated depression has been associated with unfavorable health behaviors in pregnancy and subsequent fetal growth restrictions, preterm delivery, placental abruption, or newborn irritability.

Using the following two questions to screen for depression may be as effective as more lengthy tools.

- Over the past two weeks, have you ever felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

A positive response to either question suggests the need for further assessment. A positive response to either of these questions is sufficient to make a referral for enhanced services.

Use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These are common examples only and are not meant to be a comprehensive list.

Source: *Psychosocial Risk Factors: Prenatal Screening and Interventions*, ACOG Committee Opinion No. 343, American College of Obstetricians and Gynecologists, Obstet Gynocal 2006, 108.469-77.

3. Enhanced Services

Additional services are available to women determined to have high-risk pregnancies. The services included in the Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, *Caring for the Future: The Content of Prenatal Care*.

National studies have shown that low-income women who receive these services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting improved birth outcomes for Medicaid-eligible pregnant women in Iowa.

Maternal health centers that provide enhanced services work with physicians to provide services to high risk pregnant women. This process allows members determined to be at high risk to access additional services that Medicaid does not provide under other circumstances. It is expected that the primary medical care provider will continue to provide the medical care.

The enhanced services include:

- Health education
- Nutrition services
- Psychosocial services

a. Health Education

A registered nurse shall provide health education services. In addition to the education services listed earlier, education on the following topics should be provided as appropriate:

- High-risk medical conditions related to pregnancy, such as pre-eclampsia, preterm labor, vaginal bleeding, gestational diabetes, 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
- Smoking cessation. Refer to Quitline Iowa at 800-784-8669, or on the web at https://www.quitnow.net/iowa/
- Alcohol use
- Drug use
- Education on environmental and occupational hazards
- High-risk sexual behavior

You may make referrals to:

- Tobacco cessation counseling or treatment for alcohol or illegal drugs
- Psychosocial services for:
  - Parenting issues or unstable home situations,
  - Stress management,
  - Relationship issues,

- Financial stress,
- Domestic violence,
- Communication skills and resources,
- Depression, or
- Self-esteem

b. Nutrition Services

Need must be identified and documented for nutrition needs and service provision if the member is enrolled in the Women, Infants, and Children Nutrition Program (WIC). Services provided if enrolled in WIC must be above and beyond what WIC provides. Service must be provided one-on-one based on needs assessment and not provided as part of a group class.

A licensed dietitian shall provide nutrition services. Nutrition assessment and counseling shall include:

- Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss the member's attitude about breastfeeding.
- At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- Development of an individualized nutritional care plan.
- Referral to food assistance programs, if indicated.
- Nutritional interventions include:
  - 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.

c. Psychosocial Services

Psychosocial assessment and counseling shall involve a psychosocial needs assessment of the mother outlining a profile that includes:

- Demographic factors
- Mental and physical health history and concerns
- Adjustment to pregnancy and future parenting
- Environmental needs
- A profile of the mother's 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

Psychosocial services shall be provided by a registered nurse 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.

4. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

C. BASIS OF PAYMENT

Payment for services rendered by birth centers is based on a fee schedule. The fee schedule amount is the maximum payment allowed.

Click here to access the fee schedule for Birth Centers.

D. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Providers who do not have Internet access can obtain a copy upon request from the Iowa Medicaid Enterprise (IME).

It is your responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

NOTE: Birth center services should be billed as a package if all services are provided. If billed separately, each procedure should be billed only once (i.e., do not bill prenatal care each time a visit occurs). Claims submitted without a procedure code and appropriate diagnosis code will be denied.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Birth Center providers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.