



Iowa Department of Human Services

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For Human Services use only:

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Employees' Manual, Title 8
Medicaid Appendix

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MATERNAL HEALTH CENTER MANUAL TRANSMITTAL NO. 15-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***MATERNAL HEALTH CENTER MANUAL***, Chapter III, *Provider-Specific Policies*, pages 1, 2, 6, 11, 12, 16, 17, and 18, revised.

Summary

The ***Maternal Health Center Manual*** is revised to:

- ◆ Align with current policies, procedures, and terminology, including ICD-10 updates.
- ◆ Update links due to the Department's new website.

Effective Date

October 1, 2015

Material Superseded

This material replaces the following pages from the ***MATERNAL HEALTH CENTER MANUAL***:

<u>Page</u>	<u>Date</u>
Chapter III 1, 2, 6, 11, 12, 16-18	April 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/Maternalhc.pdf>.

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. MATERNAL HEALTH CENTERS ELIGIBLE TO PARTICIPATE

A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services. Team members must be employed by or under contract or Memorandum of Understanding (MoU) with the center. The team must have at least:

- ◆ A physician
- ◆ A registered nurse
- ◆ A licensed dietitian
- ◆ A person with at least a bachelor's degree in social work, counseling, sociology, or psychology

The prenatal and postpartum care shall be in accordance with the latest edition of the Standards for Obstetric-Gynecologic Services published by the American College of Obstetricians and Gynecologists.

Medical services shall be provided under the supervision of:

- ◆ A physician, or
- ◆ A physician assistant, or
- ◆ A nurse practitioner

These people may be employed by or under contract to the center. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of their profession, as defined by the Code of Iowa. Provide written summary of care to the referring physician.

B. COVERAGE OF SERVICES

Services shall be provided as medically necessary. For all members (including low risk clients) payment will be made for:

- ◆ Prenatal risk assessment (determines if client is low or high risk status)
- ◆ Prenatal and postpartum medical care
- ◆ Health education services
- ◆ Oral health services



- ◆ Postpartum follow-up service based on the member's needs. This could include a:
 - Postpartum home visit by a nurse,
 - Home visit by a social worker,
 - Clinic visit for health education, or
 - Follow up phone call.

Enhanced prenatal services for members determined high risk may include:

- ◆ Additional health education
- ◆ Nutrition counseling
- ◆ Social services
- ◆ Additional care coordination

1. 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.



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

(2) 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. If a client chooses to not participate in WIC, all services may be provided. 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.



E. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognized 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.

Click [here](#) to access the fee schedule for Maternal Health Centers. 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.

1. Maternity Care

<u>Code</u>	<u>Description</u>
G0444	Annual depression screening, 15-minute unit
H0046	Mental health services, not otherwise specified, per encounter
H1003	Prenatal care, at risk enhanced service education, 15-minute unit
S9123	Nursing visit in the home, per hour
S9127	Social work visit in the home, per encounter
S9465	Diabetic management program, dietitian visit
S9470	Nutrition counseling dietitian visit
T1001	Nursing assessment or evaluation, per encounter
59025	Fetal non-stress test
59425	Antepartum care only; 4 to 6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
81025	Urine pregnancy test, by visual color comparison
90460	Immunization administration with counseling – first component
90461	Immunization administration with counseling – each additional component
90471	Immunization administration
90472	Immunization administration, each vaccine
90473	Immunization administration – initial intranasal or oral
90474	Immunization administration – subsequent intranasal or oral
99401	Preventive medicine counseling/risk factor reduction – 15-minute unit
99402	Preventive medicine counseling/risk reduction – 30-minute unit



<u>Code</u>	<u>Description</u>
99408	Alcohol substance abuse screen and intervention
99420	Administration and interpretation of health risk assessment (includes completion of Medicaid Prenatal Risk Assessment, form 470-2942 , and screening for domestic violence)

a. New Patient

<u>Code</u>	<u>Description</u>
99201	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none">◆ A problem-focused history;◆ A problem focused examination; and◆ Straightforward medical decision-making. <p>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the member's and family's needs. Usually, the presenting problems are self limited or minor. Physician, ARNP, CNM, or PA typically spends 10 minutes face-to-face with the member or family.</p>
99202	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none">◆ An expanded problem-focused history;◆ An expanded problem-focused examination; and◆ Straightforward medical decision-making. <p>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the member's and family's needs. Usually, the presenting problems are of low to moderate severity. Physician, ARNP, CNM, or PA typically spends 20 minutes face-to-face with the member or family.</p>
99204	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none">◆ A comprehensive history;◆ A comprehensive examination; and◆ Medical decision making of moderate complexity.



When a member receives a vaccine outside of VFC coverage, Medicaid will provide reimbursement for the vaccine. Codes for other injections:

<u>Code</u>	<u>Description</u>
90782	Injection of medication
J2788	RHO D immune globulin 50 mcg
J2790	Rhogam, RHO D immune globulin 300 mcg
J1055	Injection, Medroxyprogesterone acetate for contraceptive use

NOTE: When billing for J code drugs the National Drug Code (NDC) is required on the claim form. Refer to the claim form instructions for guidance.

3. Interpretation Services

<u>Code</u>	<u>Description</u>	<u>Unit</u>
T1013	Sign language or oral interpretive services	15 minute unit
T1013	Telephonic oral interpretive services (Bill T1013 with modifier "UC")	1 minute unit

4. Local Transportation

In the diagnosis code area of the claim form, use diagnosis code V76.89.

<u>Code</u>	<u>Description</u>	<u>Unit</u>
A0080	Non-emergency transportation; vehicle provided by volunteer (individual or organization), with no vested interest	Per round trip
A0090	Non-emergency transportation; vehicle provided by individual with 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	Non-emergency van	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	



5. Oral Health Services

In the diagnosis area of the claim form, use the appropriate diagnosis code. Use a "DA" modifier with oral health codes identified below:

<u>Code</u>	<u>Mod</u>	<u>Procedure</u>	<u>Comment</u>
D0120	TD	Screening evaluation	Once every six months
D0150		Initial screening evaluation	One time per member (Also allowed when provider has not seen member within three years)
D0190	CC TD	Initial screening	Provided by a non- dentist for a new patient NOTE: No modifier should be used for an established patient.
D0270		Bitewing radiograph, single film*	Once every 12 months
D0272		Bitewing radiograph, two films*	Once every 12 months
D0274		Bitewing radiograph, four films*	Once every 12 months
D1110		Adult prophylaxis (age 13 and older)	Once every six months
D1206		Topical fluoride varnish	Three times per year, at least 90 days apart
D1310		Nutritional counseling for the control and prevention of oral disease	15-minute unit once every six months
D1320		Tobacco counseling for the control and prevention of oral disease	15-minute unit once every six months
D1330		Oral hygiene instructions	15-minute unit once every six months

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<u>Code</u>	<u>Mod</u>	<u>Procedure</u>	<u>Comment</u>
D1351		Sealant, per tooth	One time per tooth ages 6 – 18 (Replacement sealants may be covered when record documents medical necessity)

* Before radiographs are taken, standing orders must be in place with a specific dentist who will read the radiographs, provide an examination, and establish a treatment plan.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Maternal Health Centers 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://dhs.iowa.gov/sites/default/files/All-IV.pdf>