

Maternal Health Center

Provider Manual



Iowa Department
of Human Services



Iowa
Department
of Human
Services

Provider and Chapter

Maternal Health Centers

Page

1

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TABLE OF CONTENTS

[Chapter I. General Program Policies](#)

[Chapter II. Member Eligibility](#)

[Chapter III. Provider-Specific Policies](#)

[Chapter IV. Billing Iowa Medicaid](#)

[Appendix](#)

III. Provider-Specific Policies





TABLE OF CONTENTS

	<u>Page</u>
CHAPTER III. PROVIDER-SPECIFIC POLICIES	1
A. MATERNAL HEALTH CENTERS ELIGIBLE TO PARTICIPATE	1
B. COVERAGE OF SERVICES	1
1. Prenatal Risk Assessment.....	2
a. Risk Factors Related to History	3
b. Risk Factors Related to Current Pregnancy	3
c. Enhanced Services.....	4
2. Interpreter Services	8
a. Documentation of the Service.....	8
b. Qualifications	8
C. BASIS OF PAYMENT.....	9
D. RECORDS	9
E. PROCEDURE CODES AND NOMENCLATURE	11
1. Maternity Care	11
a. New Patient	12
b. Established Patient	13
2. Injections	15
3. Interpretation Services	16
4. Local Transportation.....	16
5. Oral Health Services.....	17
F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS	18



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. Payment will be made for:

- ◆ Prenatal risk assessment
- ◆ Prenatal and postpartum medical care
- ◆ Health education services
- ◆ Oral health services



- ◆ Enhanced (more intense) prenatal services for members determined high-risk
- ◆ 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 services 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.



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.

a. 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.

b. 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 may be assessed twice during the pregnancy on the form.

A definition 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 Gynecol 2006, 108:469-77.

c. **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](#)

(1) 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

(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. 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

(3) 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.



2. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for your 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 (IAC) Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org/).



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

Maternal health centers are reimbursed on a fee-for-service basis. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. For some codes, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

D. RECORDS

The documentation for each “patient encounter” shall include the following (when appropriate):

- ◆ Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer
- ◆ Specific procedures or treatments performed
- ◆ Medications or other supplies
- ◆ Member’s progress, response to and changes in treatment, and revision of diagnosis



Information necessary to support each item of service reported on the Medicaid claim form:

- ◆ Date of service
- ◆ Place of service
- ◆ Name of member
- ◆ Name of provider agency and person providing the service
- ◆ Nature, content, or units of service
- ◆ A record of the time to support the units billed (time include AM/PM)

The requirements for documenting medical transportation services include the following:

- ◆ Date of service
- ◆ Member's name
- ◆ Address of where member was picked up
- ◆ Destination (medical provider's name and address)
- ◆ Invoice of cost
- ◆ Mileage if the transportation is paid per mile

The requirements for documenting interpretation services include the following:

- ◆ Date and time of the service
- ◆ Member's name
- ◆ Interpreter's name and company
- ◆ Service duration
- ◆ Cost of providing the service

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to members' medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.



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>
59425	Antepartum care only; 4 to 6 visits
59426	Antepartum care only; 7 or more visits
99420	Completion of Medicaid Prenatal Risk Assessment, form 470-2942
S9465	Diabetic management program, dietitian visit
90471	Immunization administration
90472	Immunization administration, each additional vaccine
H0046	Mental health services, not otherwise specified, per encounter
S9123	Nursing visit in the home, per hour
S9470	Nutrition counseling dietitian visit
59025	Fetal non-stress test
59430	Postpartum care only (separate procedure)
H1003	Prenatal care, at risk enhanced service education, 15-minute unit
S9127	Social work visit in the home (encounter code)
81025	Urine pregnancy test, by visual color comparison
T1001	Nursing assessment or evaluation, per 15 minutes



a. New Patient

Code Description

99201 Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components:

- ◆ A problem-focused history;
- ◆ A problem focused examination; and
- ◆ Straightforward medical decision-making.

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.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- ◆ An expanded problem-focused history;
- ◆ An expanded problem-focused examination; and
- ◆ Straightforward medical decision-making.

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.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- ◆ A comprehensive history;
- ◆ A comprehensive examination; and
- ◆ Medical decision making of moderate complexity.



Code **Description**

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 moderate to high severity. Physician, ARNP, CNM, or PA typically spends 45 minutes face-to-face with the member or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- ◆ A comprehensive history;
- ◆ A comprehensive examination; and
- ◆ Medical decision making of high complexity.

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 moderate to high severity. Physicians typically spend 60 minutes face-to-face with the member or family.

b. Established Patient

Code **Description**

99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- ◆ A problem-focused history;
- ◆ A problem-focused examination;
- ◆ Straight-forward medical decision-making.



Code **Description**

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.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- ◆ An expanded problem-focused history;
- ◆ An expanded problem-focused examination;
- ◆ A medical decision making of low complexity.

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 15 minutes face-to-face with the member or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- ◆ A detailed history;
- ◆ A detailed examination;
- ◆ A medical decision making of moderate complexity.

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 moderate to high severity. Physician, ARNP, CNM, or PA typically spends 25 minutes face-to-face with the member or family.



Code **Description**

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- ◆ A comprehensive history;
- ◆ A comprehensive examination;
- ◆ A medical decision making of high complexity.

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 moderate to high severity. Physicians typically spend 40 minutes face-to-face with the member or family.

Do not submit a copy of the *Medicaid Prenatal Risk Assessment*, form 470-2942. Maintain the form in the medical file.

2. Injections

Immunizations are usually given in conjunction with a medical service. Bill the vaccine administration codes in addition to the CPT code.

You **must** provide Medicaid immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are found at <http://www.idph.state.ia.us/ImmTB/Immunization.aspx?prog=Imm&pg=Vfc> or at (800) 831-6293.

For VFC vaccine, bill code 90471, 90472, or 90473 for vaccine administration in addition to the CPT code. Charge your usual and customary charge for the administration 90471, 90472, and 90473. The charges in box 24F should be "0" for the vaccine.

NOTE: 90473 (immunization administration by oral or nasal route) cannot be used with 90471.



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 V68.9.

<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 diagnosis code 528.9. 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

 Iowa Department of Human Services	Provider and Chapter Maternal Health Centers Chapter III. Provider-Specific Policies	Page 18
		Date April 1, 2014

<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://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.