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and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Prenatal Care Coordination Providers
HMOs and Other Managed Care Programs

Revised Pregnancy Questionnaire

Wisconsin Medicaid has completely revised the Prenatal Care Coordination Program Pregnancy Questionnaire, HCF 1105 (Rev. 02/06). This form replaces the questionnaire previously published in the Prenatal Care Coordination Services Handbook that was issued in May 2001.

Effective for dates of service on and after April 1, 2006, providers are required to use the revised Prenatal Care Coordination Program Pregnancy Questionnaire and instructions. The revised questionnaire is a basic screening tool that continues to serve the following purposes:

- Determining eligibility for the Medicaid prenatal care coordination (PNCC) benefit by identifying those risk factors that place a woman at high risk for a poor birth outcome.
- Making an initial assessment of the strength and needs of the pregnant woman.

Providers are encouraged to review the instructions for completing the pregnancy questionnaire, including the eligibility criteria and the definition of the coded risk factors indicated on the questionnaire, prior to using the new assessment tool. Refer to Attachment 1 of this *Wisconsin Medicare and BadgerCare Update* for Prenatal Care Coordination Program Pregnancy Questionnaire Completion Instructions, HCF 1105A (Rev. 02/06).

The form and instructions completely replace the Guidance Manual for the Pregnancy Questionnaire, POH 1043. They also replace Appendices 8, 9, and 10 of the Prenatal Care Coordination Services Handbook. Refer to PNCC services publications for additional information. Providers should use this information in conjunction with the Prenatal Care Coordination Services Handbook.

Obtaining Copies of the Form

The Prenatal Care Coordination Program Pregnancy Questionnaire is located in Attachment 2 for photocopying and may also be downloaded and printed from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

Providers may obtain paper copies of the questionnaire by sending a request to the following address:

Forms/Publications Manager
Division of Health Care Financing
PO Box 309
Madison WI 53701-0309

Providers may choose to submit an electronic request by completing an electronic order form (DMT 25A). The DMT 25A and instructions for electronically ordering forms and publications are included on the Department of Health and Family Services Web site at *dhfs.wisconsin.gov/forms/printformsonline.htm*.

Reimbursement

Reimbursement for the revised pregnancy questionnaire is $40.00. Refer to Attachment 3 for a revised maximum allowable fee schedule.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Prenatal Care Coordination Program
Pregnancy Questionnaire Completion Instructions

(A copy of the Prenatal Care Coordination Program Pregnancy Questionnaire Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID
PRENATAL CARE COORDINATION PROGRAM PREGNANCY QUESTIONNAIRE COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

This form is mandatory. Providers are required to use this form. Wisconsin Medicaid will not accept versions (i.e., retyped or otherwise reformatted) of this form.

The purpose of the Prenatal Care Coordination Program Pregnancy Questionnaire, HCF 1105, is to do the following:
- Determine eligibility for the Medicaid prenatal care coordination (PNCC) benefit by identifying those risk factors that place a woman at high risk for a poor birth outcome.
- Make an initial assessment of the strengths and needs of the pregnant woman.

USING THE PREGNANCY QUESTIONNAIRE TO DETERMINE ELIGIBILITY FOR PRENATAL CARE COORDINATION
Providers are required to use the pregnancy questionnaire to determine eligibility for the PNCC benefit.

To determine eligibility, providers need to do the following:

- Administer the pregnancy questionnaire in its entirety. The questionnaire must be reviewed and finalized in a face-to-face contact with the pregnant woman.
- Circle the coded risk factors that apply. The codes are listed along the right border of the form. Refer to the table below for the definition of the codes.
- Count the number of circled risk factors. A pregnant recipient is eligible to receive services if one of the following is true:
  - ✓ She is identified as having four or more risk factors.
  - ✓ She is less than 18 years old (regardless of the number of risk factors identified).
- Indicate eligibility for PNCC services by checking “Yes” or “No” in Section V of the pregnancy questionnaire. Write down the number of risk factors or the woman’s age as appropriate.
- Sign and date the form in Section V.

Note: A qualified professional is required to review, sign, and date all pregnancy questionnaires completed by paraprofessional staff.

Definition of Codes
Providers should use the following table to interpret the coded risk factors listed along the right border of the pregnancy questionnaire.

Code	Definition
SECTION I — GENERAL INFORMATION	
Lim Eng	Limited English proficiency (determined during assessment process)
A <20, A >39	Age: Younger than 20 or older than 39
E- H	Ethnicity: Hispanic
R- AI, A, B, HPI, O	Race: American Indian, Asian, Black, Hawaiian/Pacific Islander, Other
Edu <12	Education: Primary/secondary less than 12th grade
MS- S	Marital Status: Single
SECTION II — CURRENT PREGNANCY	
Tim- L, NAA	Desired timing of pregnancy: Later or Not at all
PNC- 2, 3, N	Medical Prenatal Care started: Second or third trimester or no appointment yet (use date of appointment and due date to determine trimester care began)
BMI <19.8, BMI ≥26.1	Body Mass Index (BMI): Less than 19.8 or greater than or equal to 26.1 *(BMI = weight in pounds ÷ height in inches ÷ height in inches x 703)*
WIC- Y	Receiving Special Supplemental Nutrition Program for Women, Infants, and Children services: Yes

Code	Definition
SECTION III — PREGNANCY HISTORY	
PreT	History of preterm births: one or more
Loss 20+	Miscarriage or pregnancy loss at 20+ weeks: one or more
LBW	History of low birth weight (less than 5½ pounds) births: one or more
Int <12m	Interval between pregnancies: Less than 12 months (compare date last pregnancy ended and timing of current pregnancy)
SECTION IV — CONCERNS	
1. Y	Illness/infection: Yes
2. Y	Dental pain or bleeding gums: Yes
4. Y	Tobacco use during pregnancy: Yes
7. Y	Alcohol use during pregnancy: Yes
8. Y	Street drug use: Yes
9. Y	Physical violence problems: Yes
10. Y	Unsafe residence: Yes
11. Y	Hunger problems: Yes
12. Y	Housing problems: Yes
13. Y	Appointment barriers: Yes
14. Y	History of mental health concerns: Yes
15. Y	Symptoms of depression: Yes
16. H	Stress level: High
17. 0	Social supports: 0

GUIDELINES FOR USING THE PREGNANCY QUESTIONNAIRE AS AN INITIAL ASSESSMENT TOOL

Basic Screening Tool

The pregnancy questionnaire is a basic screening tool. All of the questions are integral to the initial assessment process. Strengths and needs identified during the initial assessment must be addressed during the initial care plan development.

Strength-Based Approach

The administration of the pregnancy questionnaire in many cases is the initial interaction between the care coordinator and the pregnant woman and her family. This initial interaction increases the likelihood that the woman will enter into an ongoing relationship with the care coordinator to receive PNCC services. Forming the relationship with the pregnant woman and her family is a key first step. The care coordinator must be willing to enter the lives of families and base the interaction on the concerns, priorities, and goals identified by the recipient.

Ideally, the administration of the pregnancy questionnaire should occur within the context of a conversational-style interaction. A conversational style uses the woman's and/or her family's stories, personal observations as well as survival, support, exception, possibility, and esteem questions to discover strengths. The completion of the questionnaire needs to occur within the context and relevancy of what the woman and her family are seeking or needing for services that day as well as in the months to come.

Follow-up Assessment

Completing the pregnancy questionnaire should be viewed as the initial phase of an ongoing assessment process. In most cases, more information will be needed to develop a comprehensive care plan. Follow-up assessment questions can be woven into multiple interactions over time, whereby information is derived from conversations and observations. This activity is an important component of ongoing care coordination and monitoring services. While the questionnaire is the beginning point of identifying the woman's needs, strengths, and goals, the ongoing assessment process is what ultimately drives the nature of services to be provided.

A sample of follow-up assessment questions is included in the table of this attachment. Other commercial or self-designed assessment tools may also be used to complement the pregnancy questionnaire. Some comprehensive assessment tools are appropriate for all women receiving PNCC services, regardless of their response on the initial assessment tool. For example, mental health experts recommend that all pregnant and postpartum women be screened for perinatal depression. The care coordinator may need to establish a relationship with the recipient before asking more in-depth, personal questions. However, if a safety or other critical concern is identified, the care coordinator should conduct the follow-up assessment immediately. It may be necessary to update the care plan based on the follow-up assessments.

GUIDELINES FOR COMPLETING THE PREGNANCY QUESTIONNAIRE

Refer to the following table for step-by-step guidelines for completing the pregnancy questionnaire. Complete every section of the questionnaire unless the woman objects to a question(s). Background information is provided for select questions. The questions marked with an asterisk (*) identify possible risk factors. The rationale for identifying the situation as a risk factor is provided and referenced. Suggestions for additional assessment questions are provided when appropriate.

Element	Description
SECTION I — GENERAL INFORMATION	
***Limited English Proficiency**	Assess proficiency with the English language throughout the initial assessment process. (This item is not associated with a question on the pregnancy questionnaire.) Identify Limited English Proficiency as a risk factor if the recipient has language barriers or requires interpreter services. **Background for Risk Factor:** Language barriers may contribute to difficulty accessing services and understanding educational materials.
Element 1 — Name — Recipient	Record the recipient's last and first name and middle initial.
Element 2 — Date of Birth — Recipient	Record the recipient's date of birth.
Element 3 — *Age — Recipient	Record the recipient's age; verify consistency with her birth date. Adolescents less than 18 years old are eligible for PNCC services, regardless of the number of identified risk factors. For teens 18 and 19 years old and women over the age of 39, age is identified as one risk factor; at least four risk factors are needed for PNCC eligibility. **Background for Risk Factor:** Teens and women over the age of 39 at the time of conception have an increased risk for adverse pregnancy outcomes.[1] Risk factors associated with teen pregnancy include inadequate weight gain, poor nutrition, sexually transmitted infections, complications during pregnancy, and late or no prenatal care. Compared with the overall proportion of premature infants in Wisconsin in 2004 (11.0 percent), higher percentages of premature infants were born to teenagers less than 18 years old (16.0 percent).[2] Women over the age of 39 face additional risk for genetic defects and the effects of chronic disease.
Element 4 — *Ethnicity	Check the appropriate box to specify the recipient's ethnicity. **Background for Risk Factor:** In Wisconsin in 2004, the Hispanic infant mortality rate of 5.1 deaths per 1,000 births to Hispanic women was higher than the white infant mortality rate (4.5 deaths per 1,000 births to white women).[2] Over the period from 1984-2004, the Hispanic infant mortality rate fluctuated but remained essentially unchanged, whereas total mortality and white infant mortality declined gradually.
Element 5 — *Race	Check the appropriate box to specify the recipient's race. **Background for Risk Factor:** In Wisconsin in 2004, the black infant mortality rate for 2004 was 19.2 deaths per 1,000 births to black mothers and the white infant mortality rate was 4.5 deaths per 1,000 births to white women. The black infant mortality rate has remained much higher than the rate for other populations in Wisconsin for two decades. The American Indian infant mortality rate was 9.0 deaths per 1,000 live births (three-year average, 2002-2004). Compared with the overall proportion of premature infants in 2004 (11.0 percent), higher percentages of premature infants were born to black women (17.1 percent) and Laotian/Hmong women (11.5 percent) in Wisconsin.[2]
Element 6 — *Education (Indicate highest grade completed.)	Check the appropriate box to specify primary/secondary or college education and record the highest grade completed. **Follow-Up Assessment:** (a) Have you received your General Education Development (GED)? (b) Are you in school now? (c) Have you in the past or are you currently receiving special education services or exceptional education services? **Background for Risk Factor:** Less than a high school education is associated with increased risk for adverse pregnancy outcomes.[1] In 2004, Wisconsin women with less than a high school education had higher percentages of low birth weight infants (9.0 percent) and premature infants (12.6 percent) when compared to the overall proportion of low birth weight (7.0 percent) and premature infants (11.0 percent).[2]
Element 7 — *Marital Status	Check the box to indicate the recipient's marital status. **Background for Risk Factor:** In a Florida study, mothers who were unmarried represented the most prevalent risk factor on prenatal screens for all races.[1] In 2004, Wisconsin women who were unmarried had higher percentages of low birth weight infants (9.6 percent) and premature infants (13.4 percent) when compared to the overall proportion of low birth weight (7.0 percent) and premature infants (11.0 percent).[2]

Element	Description
SECTION I — GENERAL INFORMATION (Continued)	
Element 8 — Address — Recipient	Record street, city, state, and zip code where the recipient resides.
Element 9 — County	Record the county in which the recipient resides.
Element 10 — Telephone Number — Recipient	Record the recipient's home telephone number.
Element 11 — Other Telephone Number — Recipient	Record another telephone number, such as work or cell phone, where the recipient can be reached.
Element 12 — What is the best way to contact you? When is the best time to contact you?	Record information from the recipient such as "Call my work number during the day" or "Call my home number in the evening."
Element 13 — Name and Telephone Number — Emergency Contact Person	Record the telephone number and indicate the contact person's name and relationship to the recipient (e.g., friend, family member, neighbor).
Element 14 — Name — Medical Provider or Clinic	Record the name of the recipient's medical provider and clinic; check the box if the recipient does not have a medical provider.
Element 15 — Recipient Medicaid Identification Number	Record the recipient's Medicaid identification number.
Element 16 — How many times have you been to a dentist or dental clinic in the last two years?	Record the number of dental visits the recipient has had in the last two years.
SECTION II — CURRENT PREGNANCY	
Element 1 — When is your baby due?	Record the recipient's due date.
Element 2 — What was the date of your last menstrual period?	Record the date of the recipient's last menstrual period; verify its consistency with the due date.
Element 3 — *If you could change the timing of this pregnancy, when would you want it?	Check the appropriate box. **Background for Risk Factor:** This question is assessing pregnancy intention. Unintended pregnancy (identified by a response of later or not at all) is associated with increased risk of adverse pregnancy outcomes.[1]
Element 4 — *When was your first medical appointment for prenatal care?	Record the month and year of the first prenatal visit; check the appropriate box if no appointment has been made or if the recipient has scheduled an appointment. Record the date of the scheduled appointment, if applicable. To determine risk status, use the information on the recipient's due date (Element 1 of Section II) to determine in which trimester the recipient's prenatal care began. **Follow-Up Assessment:** If the recipient has attended a prenatal care appointment, ask "Have you seen your provider at least monthly for this pregnancy?" **Background for Risk Factor:** Late prenatal care beginning in the second or third trimester or no prenatal care is associated with increased risk of adverse pregnancy outcomes.[1] Compared with the overall incidence of low birth weight in 2004 (7.0 percent), higher percentages of low birth weight infants were born to Wisconsin mothers who received no prenatal care (23.1 percent).[2]

Element	Description
SECTION II — CURRENT PREGNANCY (Continued)	
Element 5 — *Your Weight Before Pregnancy, Current Weight, and Height	Record the recipient's weight before pregnancy and her current weight and height. To determine risk status, calculate the Basal Metabolic Index (BMI = pre-pregnancy weight in pounds ÷ height in inches ÷ height in inches x 703). **Background for Risk Factor:** A low or high pre-pregnancy weight, identified by BMI less than 19.8 or greater than or equal to 26.1, is associated with increased medical risks for the pregnancy.[1,3]
Element 6 — Are you pregnant with more than one baby?	Check the box to indicate yes or no. **Background:** Medical complications associated with multiple gestation include low birth weight, premature birth, maternal anemia, pregnancy-induced hypertension, placental or umbilical cord problems, and baby's abnormal position in the uterus.
Element 7 — Are you thinking about breastfeeding your baby?	Check the box to indicate yes, no, or undecided. **Background:** Breastfeeding is promoted and supported due to the health benefits to mother and baby. Breastfeeding promotes bonding and protects infants from some infections and allergies.
Element 8 — Have you had a Human Immunodeficiency Virus (HIV) test during this pregnancy?	Check the box to indicate yes or no. **Background:** The Centers for Disease Control and Prevention, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and the Institute of Medicine recommend universal HIV testing of pregnant women with patient notification. Human Immunodeficiency Virus testing is typically done as part of a routine battery of tests during pregnancy.
Element 9 — Have you had any bleeding or cramping?	Check the box to indicate yes or no. **Background:** Recognizing the early warning signs of preterm labor is a key strategy to reduce preterm births.
Element 10 — *Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children?	Check the box to indicate yes or no. **Background for Risk Factor:** Eligibility for WIC includes identification of risk factors associated with nutrition and health. Women who are not currently receiving WIC should be referred for services. The pregnancy questionnaire can be updated to reflect a change in status if she is later determined to be eligible for WIC services.
SECTION III — PREGNANCY HISTORY	
Element 1 — How many times have you been pregnant before?	Record the number of the recipient's previous pregnancies. **Background:** Women with multiple previous pregnancies may have increased risks for a poor birth outcome.
Element 2 — Number of Full-Term Babies	Record the number of full-term babies the recipient has had. **Background:** Assessment of previous full-term deliveries provides information about the woman's experience and educational needs related to pregnancy.
Element 3 — *Number of Babies Born More Than Three Weeks Early	Record the number of babies the recipient has had who were born more than three weeks early. **Background for Risk Factor:** Is a major risk factor for preterm birth and other adverse pregnancy outcomes. A history of preterm delivery.[1,4]
Element 4 — *Number of Miscarriages or Other Pregnancy Losses at 20 or More Weeks	Record the number of previous miscarriages or other pregnancy losses at 20 or more weeks. **Background for Risk Factor:** A risk factor that may contribute to adverse pregnancy outcomes is a previous fetal loss or "stillbirth."[1]
Element 5 — Number of Miscarriages or Other Pregnancy Losses Before 20 Weeks	Record the number of miscarriages or other pregnancy losses before 20 weeks; include spontaneous and elective abortions. **Background:** A history of multiple spontaneous abortions may indicate a need for specialized medical care. Multiple elective abortions increase the risk of incompetent cervix, which may result in miscarriage or preterm delivery.

Element	Description
SECTION III — PREGNANCY HISTORY (Continued)	
Element 6 — Number of Living Children	Record the number of living children. **Background:** Infant/child deaths are identified by comparing the number of living children with the total number of full-term and preterm babies.
Element 7 — *Number of Babies Weighing Less Than 5½ Pounds at Birth	Record the number of babies the recipient has had who weighed less than 5½ pounds at birth. **Background for Risk Factor:** A risk factor that may contribute to adverse pregnancy outcomes is a previous low birth-weight baby.
Element 8 — Number of Babies Weighing More Than Nine Pounds at Birth	Record the number of babies the recipient has had who weighed more than nine pounds at birth. **Background:** Babies with birth weights greater than nine pounds are associated with maternal diabetes and birth injuries.
Element 9 — *Date Last Pregnancy Ended	Record the date the recipient's last pregnancy ended. Compare this date with the timing of the current pregnancy to determine the interval (in months) between the pregnancies. **Background for Risk Factor:** A short interconception interval places demands on a woman's body and is associated with an increased risk of a low birth-weight baby.[4]
Element 10 — Outcome of Last Pregnancy	Check the appropriate box. **Background:** A woman who has experienced perinatal loss may have increased fears and concerns for the current pregnancy.
SECTION IV — CONCERNS	
Element 1 — *Do you have, or have you ever had, any of the following conditions?	Check a box to indicate yes or no and any applicable conditions. **Follow-Up Assessment:** (a) How long have you had the condition? (b) How do you manage or treat the condition? (c) Has the condition or treatment changed since you have been pregnant? (d) Do your health care providers know of the pregnancy and condition? **Background for Risk Factor:** An illness or condition requiring ongoing medical care is a risk factor for adverse pregnancy outcomes.[1]
Element 2 — *Do you have dental pain or bleeding gums when you eat or brush your teeth?	Check the box to indicate yes or no. **Follow-Up Assessment:** (a) Do you currently have any broken teeth, loose teeth, or a gum boil? (b) Did you know that your oral health can affect the health of your baby? **Background for Risk Factor:** Dental pain and bleeding gums are symptoms of peridontal disease. Research studies have identified a link between peridontal disease and preterm delivery.[5]
Element 3 — Before pregnancy, did you smoke cigarettes?	Check the box to indicate yes or no. If yes, record the average number of cigarettes smoked per day. **Background:** Previous smokers may require support services to prevent relapse.

Element	Description
SECTION IV — CONCERNS (Continued)	
Element 4 — *Since you have been pregnant, have you smoked cigarettes?	Check the box to indicate yes or no. If yes, record the average number of cigarettes smoked per day. **Follow-Up Assessment:** (a) During the three months before you were pregnant, how many cigarettes did you smoke on an average day? (b) Do you use any other form of tobacco? (c) Have you ever tried to quit? If yes, how many times? (d) What do you think has kept you from quitting in the past? (e) Do you have family members or friends who can help you quit? (f) Would you like help to quit smoking? **Background for Risk Factor:** Smoking during pregnancy is a leading modifiable risk factor for adverse pregnancy outcomes. Women who smoke have a 1.3 times greater risk for spontaneous abortion, as high as a 1.8 times greater risk for preterm delivery, a 2.7 times greater risk for a small gestational age baby, and a two times greater risk of placenta previa than women who do not smoke. Prenatal maternal smoking increases the risk of stillbirth by 40 percent to 60 percent and fetal mortality rates are 35 percent higher in smokers compared to non-smokers.[1,6] In 2004, Wisconsin women who smoked during pregnancy had higher percentages of low birth-weight infants (11.2 percent) and premature infants (13.0 percent) when compared with the overall proportion of low birth-weight (7.0 percent) and premature infants (11.0 percent).[2]
Element 5 — Does anyone in your household smoke?	Check the box to indicate yes or no. **Follow-Up Assessment:** (a) Do household members smoke in your house or car? (b) Are household members interested in resources to help them stop smoking? **Background:** Partner smoking is an important predictor of a woman's successful cessation attempt. Social support is an important component of smoking cessation efforts and a strategy to prevent relapse. Environmental tobacco smoke is a risk factor for Sudden Infant Death Syndrome and respiratory disease in infants.
Element 6 — In the three months before your current pregnancy, did you use any form of alcohol?	Check the box to indicate yes or no. If yes, record the average number of drinks consumed per week. **Follow-Up Assessment:** (a) In the three months before your current pregnancy, about how many days a week did you have one or more standard drinks (a standard drink is one 12-ounce bottle or can of beer or wine cooler, a 1.5-ounce shot of hard liquor, or one five-ounce glass of wine)? (b) How many drinks does it take to make you feel high? (c) Have any family members, friends, or health care providers been concerned about how much you drank in the last year? (d) Since you became pregnant, on average, about how many days a week do you have two or more standard drinks? (e) Have you ever felt the need to cut down or control your drinking? (f) Have you ever lost a job because of your drinking? (g) Has your drinking affected your family, especially your children? (h) Have you ever been stopped by the police when you were drinking? (i) Have you ever been injured while you were drinking? (j) Do you become very nervous or shaky if you stop drinking for more than a day? (k) Do you need to have a drink in the morning to start your day? (l) Do you have any medical problems that could be related to alcohol use, such as depression, suicidal ideation, anxiety, panic attacks, sleeping problems, headaches, and chronic fatigue? More serious medical problems may include liver dysfunction, repeated trauma, blood pressure elevation, and pancreatitis. **Background:** Assessment of previous alcohol use may provide information related to current use and the level of support and services needed to avoid alcohol use during pregnancy. Ongoing assessment is critical to identifying risk drinking. Follow-up assessment questions address frequency, binge use, tolerance, and family concern.

Element	Description
SECTION IV — CONCERNS (Continued)	
Element 7 — *Since you have been pregnant, have you used alcohol?	Check the box to indicate yes or no. If yes, record the average number of drinks per week. **Follow-Up Assessment:** Refer to the follow-up assessment question in Element 6 of this section. **Background for Risk Factor:** Alcohol use during pregnancy is a risk factor for adverse pregnancy outcomes.[1] Adverse outcomes may include low birth weight, premature birth, fetal and infant death, and birth defects including fetal alcohol effects and fetal alcohol syndrome.
Element 8 — *In the past year, have you used street drugs?	Check the box to indicate yes or no. **Follow-Up Assessment:** (a) What street drugs do you use? (b) In the last year, have you used drugs more than you intended? (c) In the last year, have you felt a need to cut down on your drug use? **Background for Risk Factor:** Use of street drugs during pregnancy is a risk factor for adverse pregnancy outcomes.[1] Adverse outcomes may include fetal and infant death, low birth weight, premature birth, and behavior changes in newborns such as more crying than normal and trouble eating and sleeping.
Element 9 — *Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you?	Check the box to indicate yes or no. **Follow-Up Assessment (To Be Conducted in Private):** (a) In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? (b) Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? (c) Within the last year, has anyone made you do something sexual that you did not want to do? (d) Are you afraid of your partner or anyone else? (e) Does your partner ever humiliate you? Shame you? Put you down in public? Keep you from seeing friends or from doing things you want to do? **Background for Risk Factor:** Domestic violence is a risk factor for adverse pregnancy outcomes.[1] Pregnant women are at an increased risk for intimate partner violence.
Element 10 — *Do you feel unsafe where you live?	Check the box to indicate yes or no. **Background for Risk Factor:** An unsafe home environment is a risk factor for adverse pregnancy outcomes.[1]
Element 11 — *During the past month, did you miss any meals, not eat when you were hungry, or use a food pantry because there was not enough food or money to buy food?	Check the box to indicate yes or no. **Follow-Up Assessment:** (a) Are you having nausea, vomiting, heartburn, or constipation? (b) Do you eat corn starch out of the box, laundry starch, paint chips, lots of ice, clay, dirt, or other things that are not food? (c) Are you on a special diet now? (d) Have you ever vomited to control your weight or vomited to feel better after eating too much? (e) Do you have a working stove and refrigerator? **Background for Risk Factor:** Food insecurity and inadequate nutrition are risk factors for low birth weight and preterm delivery.[1]
Element 12 — *Have you had any housing problems in the past three months?	Check the box to indicate yes or no. **Follow-Up Assessment:** (a) What is your current living situation? (b) Have you ever been homeless? **Background for Risk Factor:** Housing problems are risk factors for adverse pregnancy outcomes.[1] Homelessness reflects a severe lack of resources.

Element	Description
SECTION IV — CONCERNS (Continued)	
Element 13 — *Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments?	Check the box to indicate yes or no. **Follow-Up Assessment:** (a) What are the specific problems that cause you to miss appointments? (b) Do you have friends or family members that can help you? (c) Are you aware of community resources that can help? **Background for Risk Factor:** Problems with keeping appointments for medical prenatal care and social services are risk factors for adverse pregnancy outcomes.[1]
Element 14 — *Have you had problems with depression or received counseling or medications for mental health concerns?	Check the box to indicate yes or no. **Follow-Up Assessment:** Proceed with questions from a depression screening tool, such as the following: (a) Center for Epidemiologic Studies Depression Scale. (b) Edinburgh Postnatal Depression Scale. (Tools are available at *www.perinatalweb.org*/; select the link for "Wisconsin Association for Perinatal Care Web site" and select "Publications" from the menu.) **Background for Risk Factor:** A prior history of depression, anxiety, or other mental health concerns is a risk factor for perinatal depression. Depression may interfere with a woman's ability to seek and continue prenatal care, to make positive behavior changes (such as smoking cessation), and to provide a safe environment for herself and her children.[7]
Element 15 — *During the past month, have you had little interest in doing things, or have you been bothered by feeling down, depressed, or hopeless?	Check the box to indicate yes or no. **Follow-Up Assessment:** Proceed with questions from a depression screening tool, such as the following: (a) Center for Epidemiologic Studies Depression Scale. (b) Edinburgh Postnatal Depression Scale. (Tools are available at *www.perinatalweb.org*/; select the link for "Wisconsin Association for Perinatal Care Web site" and select "Publications" from the menu.) **Background for Risk Factor:** Women who report symptoms of little interest in doing things or feeling down, depressed, or hopeless are at increased risk for perinatal depression.[7]
Element 16 — *How do you rate your current stress level?	Check the appropriate box to indicate the recipient's current stress level. **Background for Risk Factor:** Maternal psychological stress is associated with increased risk for low birth weight and preterm delivery. Stress can adversely impact birth outcomes through direct physiologic pathways involving neuro-endocrine mechanisms, immune-inflammatory response, and vascular effects. Stress can also lead to adverse behaviors (e.g., smoking or substance abuse) with negative impacts on birth outcomes.[8]
Element 17 — *How many people can you count on when you need help?	Check the appropriate box. **Background for Risk Factor:** The effects of stress can be modified by social support.
Element 18 — Which of these things worry you a lot?	Check all that apply. **Background:** An assessment of stressors in the woman's life is needed to plan appropriate care coordination and education services.
Element 19 — What worries you the most?	Identify the recipient's primary concern. **Background:** An assessment of the primary concern will allow for prioritization of needs and services.
Element 20 — What do you do to deal with your problems?	Detail what the recipient does to deal with problems. **Background:** An assessment of coping strategies may identify both strengths and needs.

Element	Description
SECTION IV — CONCERNS	
Element 21 — Who can you count on for help with everyday activities, such as child care, meals, laundry, or transportation?	Identify the individuals that the recipient counts on for assistance. **Background:** The effects of stress can be modified by social support.
Element 22 — What topics would you like to learn more about?	Check all that apply. Write in other learning needs. **Background:** Learning needs must be assessed and included in the care plan before providing health education and nutrition counseling.

References

[1] Florida Department of Health. *Healthy Start Annual Report, 2004.*
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ATTACHMENT 2
Prenatal Care Coordination Program
Pregnancy Questionnaire

(A copy of the Prenatal Care Coordination Program Pregnancy Questionnaire is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1105 (Rev. 02/06)

WISCONSIN MEDICAID
PRENATAL CARE COORDINATION PROGRAM
PREGNANCY QUESTIONNAIRE

Instructions: Type or print clearly. Before completing this form, read the Prenatal Care Coordination Program Pregnancy Questionnaire Completion Instructions, HCF 1105A.

SECTION I — GENERAL INFORMATION

To be completed by Health Professional

1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Age — Recipient

4. Ethnicity ❑ Hispanic ❑ Non-Hispanic
5. Race ❑ American Indian ❑ Asian ❑ Black ❑ Hawaiian / Pacific Islander ❑ White ❑ Other

Lim Eng
A- <20
A- >39
E- H
R- AI,A, B,HPI,O

6. Education (Indicate highest grade completed.)
❑ Primary / secondary (1-12) _____ ❑ College (1-4 or 5+) _____
7. Marital Status
❑ Single ❑ Married

8. Address — Recipient (Street, City, State, Zip Code)
9. County

Edu<12
MS- S

10. Telephone Number — Recipient
11. Other Telephone Number — Recipient
12. What is the best way to contact you? When is the best time to contact you?
13. Name and Telephone Number — Emergency Contact Person
14. Name — Medical Provider or Clinic (Doctor, Nurse Practitioner, Midwife)
❑ I do not have a medical provider.
15. Recipient Medicaid Identification Number
16. How many times have you been to a dentist or dental clinic in the last two years?

SECTION II — CURRENT PREGNANCY

1. When is your baby due?
2. What was the date of your last menstrual period?

Tim- L,NAA
PNC- 2,3,N

3. If you could change the timing of this pregnancy, when would you want it?
❑ Earlier ❑ No change
❑ Later ❑ Not at all
4. When was your first medical appointment for prenatal care?
_____ (month / year)
❑ I have not seen anyone yet.
❑ I have an appointment set for _____. (MM/DD/YY)

5. Your Weight Before Pregnancy _____
Your Current Weight _____
Your Height _____
6. Are you pregnant with more than one baby (Twins, Triplets)?
❑ Yes ❑ No

BMI- <19.8
BMI- ≥26.1

7. Are you thinking about breastfeeding your baby?
❑ Yes ❑ No ❑ Undecided
8. Have you had a Human Immunodeficiency Virus (HIV) test during this pregnancy?
❑ Yes ❑ No

9. Have you had any bleeding or cramping?
❑ Yes ❑ No
10. Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?
❑ Yes ❑ No

WIC- Y

Continued

SECTION III — PREGNANCY HISTORY (If this is a first pregnancy, skip to Section IV.)

1. How many times have you been pregnant before?	2. Number of Full-Term Babies	3. Number of Babies Born More Than Three Weeks Early	PreT Loss 20+ LBW Int<12m
4. Number of Miscarriages or Other Pregnancy Losses at 20 or More Weeks	5. Number of Miscarriages or Other Pregnancy Losses Before 20 Weeks	6. Number of Living Children	
7. Number of Babies Weighing Less Than 5½ Pounds at Birth	8. Number of Babies Weighing More Than Nine Pounds at Birth	9. Date Last Pregnancy Ended	

10. Outcome of Last Pregnancy ❑ Live Birth ❑ Miscarriage / Other Loss

SECTION IV — CONCERNS

1. Do you have, or have you ever had, any of the following conditions? ❑ Yes ❑ No — 1- Y
Check all that apply.
❑ Asthma. ❑ High blood pressure. — 2- Y
❑ Chlamydia, gonorrhea, syphilis, or genital herpes. ❑ Seizures / epilepsy. — 4- Y
❑ Urinary tract infection. — 7- Y
❑ Diabetes. ❑ Other illness, infection, or condition requiring medical care. — 8- Y
2. Do you have dental pain or bleeding gums when you eat or brush your teeth? ❑ Yes ❑ No — 9- Y
3. Before pregnancy, did you smoke cigarettes? ❑ Yes ❑ No — 10- Y
If Yes, indicate the average number of cigarettes smoked per day. _____ — 11- Y
4. Since you have been pregnant, have you smoked cigarettes? ❑ Yes ❑ No — 12- Y
If Yes, indicate the average number of cigarettes smoked per day. _____ — 13- Y
5. Does anyone in your household smoke? ❑ Yes ❑ No — 14- Y
6. In the three months before your current pregnancy, did you use any form of alcohol? ❑ Yes ❑ No — 15- Y
If Yes, indicate the average number of drinks consumed per week. _____ — 16- H
7. Since you have been pregnant, have you used alcohol? ❑ Yes ❑ No — 17- 0
If Yes, indicate the average number of drinks consumed per week. _____
8. In the past year, have you used street drugs? ❑ Yes ❑ No
9. Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you? ❑ Yes ❑ No
10. Do you feel unsafe where you live? ❑ Yes ❑ No
11. During the past month, did you miss any meals, not eat when you were hungry, or use a food pantry because there was not enough food or money to buy food? ❑ Yes ❑ No
12. Have you had any housing problems in the past three months? ❑ Yes ❑ No
13. Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments? ❑ Yes ❑ No
14. Have you had problems with depression or received counseling or medications for mental health concerns? ❑ Yes ❑ No
15. During the past month, have you had little interest in doing things, or have you been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑ No
16. How do you rate your current stress level? ❑ High ❑ Medium ❑ Low
17. How many people can you count on when you need help? ❑ 0 ❑ 1-2 ❑ 3+

Continued

SECTION IV — CONCERNS (Continued)

18. Which of these things worry you a lot? Check all that apply.
    - ❑ Money problems.
    - ❑ My job.
    - ❑ My partner's job or unemployment.
    - ❑ My partner's drinking or drug use.
    - ❑ My own drinking or drug use.
    - ❑ My partner is in jail.
    - ❑ My relationship with my partner.
    - ❑ My partner did not want this pregnancy.
    - ❑ Labor and delivery.
    - ❑ Caring for this baby.
    - ❑ Caring for my other children.
    - ❑ Other _____ _____.

19. What worries you the most?

20. What do you do to deal with your problems?

21. Who can you count on for help with everyday activities, such as child care, meals, laundry, or transportation?

22. What topics would you like to learn more about? Check all that apply.
    - ❑ Baby's growth and development.
    - ❑ Breastfeeding.
    - ❑ Caring for your newborn.
    - ❑ Family planning / birth control.
    - ❑ Getting health care for you and your baby.
    - ❑ How to stop smoking.
    - ❑ Effects of alcohol on mother and baby's health.
    - ❑ Labor and delivery.
    - ❑ Managing the discomforts of pregnancy.
    - ❑ Nutrition during pregnancy.
    - ❑ Managing stress.
    - ❑ Other _____ _____.

23. Additional Information

SECTION V — TO BE COMPLETED BY HEALTH PROFESSIONAL

Is the recipient eligible for Prenatal Care Coordination (PNCC) services?

❑ Yes, based on a number of factors _____ or age _____.

❑ No.

SIGNATURE — Staff Completing Assessment	Date Signed
SIGNATURE — Qualified Health Professional (If Different from Above)	Date Signed

ATTACHMENT 3
Procedure Codes, Modifiers, and Maximum Allowable Fees for Prenatal Care Coordination Services
For Dates of Service on and After April 1, 2006

The following chart shows the Healthcare Common Procedure Coding System (HCPCS) procedure codes, modifiers, and maximum allowable fees for prenatal care coordination services performed on and after April 1, 2006.

HCPCS Procedure Code	HCPCS Procedure Code Description	Required Modifier and Description	Maximum Allowable Fee
H1000	Prenatal care, at-risk assessment		$40.00
H1002	Prenatal care, at-risk enhanced service; care coordination	**U2** Initial care plan development	$48.31
H1002	Prenatal care, at-risk enhanced service; care coordination		$8.20; each 15 minutes
H1003	Prenatal care, at-risk enhanced service; education		$12.50; each 15 minutes
H1003	Prenatal care, at-risk enhanced service; education	**TT** Individualized service provided to more than one patient in same setting	$2.50; each 15 minutes
H1004	Prenatal care, at-risk enhanced service; follow-up home visit		$10.70; each 15 minutes

Note: Prenatal care coordination services are limited to $887.46 per recipient, per pregnancy.