Prenatal Care Coordination Services

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wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

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Preface

The Wisconsin Medicaid and BadgerCare Prenatal Care Coordination Services Handbook is issued to prenatal care coordination providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% (as of January 2001) of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

Handbook Organization

The Prenatal Care Coordination Services Handbook consists of the following chapters:

- General Information.
- Covered Services and Related Limitations.
- Billing Information.

In addition to the Prenatal Care Coordination Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430 - 456 -- Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43 - 49.497 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101 -108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid
www.dhfs.state.wi.us/badgercare

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS, to provide health claims processing, communications, and other related services.

General Information

Wisconsin Medicaid prenatal care coordination services are available to Medicaid-eligible pregnant women, with a high risk for adverse pregnancy outcomes, during pregnancy through the first 60 days following delivery.

Prenatal care coordination (PNCC) was added as a Wisconsin Medicaid benefit as authorized by Act 39, the 1991-93 state budget, as amended by Act 269 Laws of 1991.

Definition of the Prenatal Care Coordination Benefit

Prenatal care coordination services help a recipient and, when appropriate, the recipient's family gain access to medical, social, educational, and other services related to the recipient's pregnancy. Wisconsin Medicaid PNCC services are available to Medicaid-eligible pregnant women with a high risk for adverse pregnancy outcomes during pregnancy through the first 60 days following delivery.

Prenatal care coordination services include all of the following:

- Outreach.
- Initial assessment.
- Care plan development.
- Ongoing care coordination and monitoring.
- Health education and nutrition counseling services (for recipients with an identified need).

Prenatal Care Coordination Goal

The goal of the PNCC benefit is to improve birth outcomes among women who are deemed at high risk for poor birth outcomes. The main objectives for obtaining this goal include ensuring that women at high risk:

- Are identified as early as possible in their pregnancy.
- Receive individual psychosocial support and services.
- Receive early and continuous prenatal care services.
- Receive necessary health and nutrition education.
- Are referred to available community services, as appropriate.
- Receive assistance in accessing and obtaining needed health and social services.

Prenatal care coordination services do not end with the completion of the initial assessment, unless the assessment determines the recipient does not need further assistance. To obtain the program's goal, it is critical that providers have the ability to offer all five components of the PNCC benefit, and not just the assessment, to eligible recipients.

- ***Care Coordination Provider*** **-** the entity that meets the requirements as a certified care coordination provider (refer to Provider Information in this chapter), is assigned the Medicaid billing provider number, and has legal liability for the provision of care coordination services.

- ***Care Coordinator*** **-** the individual who is providing care coordination services to recipients.

Scope of Service

The policies in this handbook govern services provided within the scope of professional practice as defined in ss. 49.46(2)(b)12, Wis. Stats., and HFS 105.52 and 107.34, Wis. Admin. Code. Please refer to the Covered Services and Related Limitations chapter of this handbook for more information on covered services and related limitations.

Provider Information

Provider Eligibility and Certification

Chapter HFS 105.52(1), Wis. Admin. Code, defines the following types of providers and agencies as eligible for Medicaid certification as PNCC providers:

- A community-based health organization.
- A community-based social services agency or organization.
- A county, city, or combined city and county public health agency.
- A county department of human services under s. 46.23, Wis. Stats., or social services under s. 46.215 or 46.22, Wis. Stats.
- A family planning agency certified under HFS 105.36, Wis. Admin. Code.
- A federally qualified health center (FQHC) as defined in 42 CFR 405.2401 (b).
- An HMO.
- An independent physician association (IPA).
- A hospital.
- A physician's office or clinic.
- A private case management agency.
- A certified nurse or nurse practitioner.
- A rural health clinic certified under HFS 105.35, Wis. Admin. Code.
- A tribal agency health center.
- A Women, Infants, and Children (WIC) program under 42 USC 1786.

For Medicaid certification as a PNCC service provider, qualified agencies must submit a comprehensive agency outreach and care management plan to Wisconsin Medicaid for approval. Refer to Appendix 18 of this handbook for information on plan submission requirements.

Subcontracting for Prenatal Care Coordination Services

Medicaid-certified PNCC providers may subcontract with agencies not certified by Medicaid for PNCC services. However, the Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

It is the certified provider's responsibility to ensure that the subcontractor provides services and maintains records in accordance with the Medicaid requirements for the provision of PNCC services. According to HFS 105.02(6)(a), Wis. Admin. Code, the following records must be maintained:

> Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by MA (Medicaid).

The Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

For more information on recordkeeping as it relates to PNCC services, refer to Recordkeeping in the Covered Services and Related Limitations chapter of this handbook. Please refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for additional information on required recordkeeping.

The Medicaid-certified provider is responsible for ensuring that its subcontractors:

- Meet all program requirements.
- Receive copies of Medicaid handbooks and other appropriate materials.

Wisconsin Medicaid sends provider materials to Medicaid-certified providers only, unless materials are specifically requested by individuals or agencies who are not certified by Medicaid. Published issues of *Wisconsin Medicaid and BadgerCare Updates*, the All-Provider Handbook, this handbook, and other provider publications may be reviewed and downloaded online at *www.dhfs.state.wi.us/medicaid/*.

Although the subcontracted agency may bill Wisconsin Medicaid using the certified provider's Medicaid number, Wisconsin Medicaid only reimburses the certified provider.

Recipient Information

Recipient Eligibility

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility. Refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility.

Presumptive Eligibility

Presumptive Eligibility is a Medicaid eligibility category that can allow an uninsured pregnant woman to receive pregnancy-related outpatient services while her application for Wisconsin Medicaid is being processed.

Under Presumptive Eligibility, pregnant women are eligible to receive all covered pregnancy-related outpatient services (including PNCC services). All Medicaid-certified outpatient providers can provide these services to women covered under Presumptive Eligibility. Inpatient services are not covered under Presumptive Eligibility. (Generally, Wisconsin Medicaid eligibility is determined by the time of delivery.)

Qualified providers may become certified to make Presumptive Eligibility determinations. Refer to the Provider Certification section of the All-Provider Handbook for more information on becoming certified to determine Presumptive Eligibility. For general information on Presumptive Eligibility, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Medicaid Managed Care Coverage

Prenatal care coordination is not covered by state-contracted Medicaid HMOs or special managed care programs (such as programs for people with disabilities). Therefore, submit claims for PNCC services directly to Wisconsin Medicaid for recipients enrolled in these programs.

Medicaid-certified PNCC providers located in counties with state-contracted HMOs must have on file a signed copy of a Memorandum of Understanding (MOU) with each HMO in their service area. The MOU encourages coordination between the provider and the HMO and reduces duplication of services. Refer to Appendix 15 of this handbook for a model MOU form.

Copayment

Prenatal care coordination services are not subject to recipient copayment.

Freedom of Choice

For recipients, participation in the PNCC program is voluntary. The recipient voluntarily participates in the program by maintaining contact with and receiving services from the care coordination provider. The care coordination provider may not "lock-in" recipients or deny the recipient's freedom to choose providers. Recipients may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers.

Covered Services & Related Limitations

Refer to the Medicaid Guidelines and Performance Measurements for Prenatal Care Coordination (Appendix 7 of this handbook) for detailed information about the benefit's operational standards and performance measurements.

This chapter outlines Medicaid-covered services, conditions, and limitations for prenatal care coordination (PNCC) services. Prenatal care coordination services include all of the following:

- Outreach.
- Initial Assessment.
- Care plan development.
- Ongoing care coordination and monitoring.
- Health education and nutrition counseling services (for recipients with an identified need).

Note: Providers should be prepared to offer all five components of the PNCC benefit - not just the initial assessment - to eligible recipients.

Refer to the Medicaid Guidelines and Performance Measurements for Prenatal Care Coordination (Appendix 7 of this handbook) for detailed information about the benefit's operational standards and performance measurements. Providers are encouraged to use the guidelines to help ensure that quality services are provided and activities are directed toward the program's objectives and goal as stated in the General Information chapter of this handbook.

Wisconsin Medicaid also uses the guidelines to monitor the administration of the benefit.

Outreach

Outreach involves identifying eligible, low-income pregnant women, who may be unaware of or not have access to PNCC services, and informing them about the benefit. Providers may use a variety of strategies to market and promote PNCC services in the community, such as informational brochures or community presentations.

Providers are not reimbursed separately for outreach activities. Wisconsin Medicaid includes the reimbursement for outreach activities in the reimbursement for the initial assessment.

Initial Assessment

Providers are required to administer an initial, comprehensive risk assessment to all recipients. The purpose of this assessment is to determine the needs and strengths of the recipients. The Department of Health and Family Services' (DHFS)-approved tool for the initial assessment is the Pregnancy Questionnaire (Appendix 8 of this handbook).

Complete *every* section on the Pregnancy Questionnaire unless the recipient objects to a particular section. Refer to Appendix 9 of this handbook for instructions on completing the Pregnancy Questionnaire. Providers may also consult the Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire for additional information on administering the questionnaire. Refer to Appendix 16 of this handbook for information on obtaining the Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire.

The Pregnancy Questionnaire must be:

- Reviewed and finalized in a face-to-face contact with the recipient.
- Signed and dated by the agency staff member who completed the questionnaire.

The person administering the Pregnancy Questionnaire must be an employee of the Medicaid-certified PNCC agency or an employee of an agency under contract to the PNCC agency.

Refer to Appendix 18 of this handbook for a list of types of qualified professionals who can administer or review the Pregnancy Questionnaire. Qualified professionals are required to review and initial all Pregnancy Questionnaires completed by paraprofessional staff.

Wisconsin Medicaid reimburses for the administration of the Pregnancy Questionnaire regardless of the recipient's score. Recipients may be reassessed at any time, but providers need only readminister the entire Pregnancy Questionnaire if the recipient's situation changes significantly.

Wisconsin Medicaid will reimburse only one comprehensive assessment per recipient, per pregnancy, per provider.

Providers may obtain copies of the Pregnancy Questionnaire at no cost by writing to:

Division of Health Care Financing
Bureau of Fee-for-Service Health Care Benefits
Attn: Forms Manager
P. O. Box 309
Madison, WI 53701-0309

When requesting the Pregnancy Questionnaire, note the form number HCF 1105 on the request.

Care Plan Development

Wisconsin Medicaid will reimburse care planning as a PNCC service when provided by qualified staff. Care planning includes developing *and* implementing the care plan. Wisconsin Medicaid will reimburse the development of a care plan for recipients who score 40 or more points on the Pregnancy Questionnaire. A completed questionnaire must predate the care plan.

Wisconsin Medicaid reimburses for the development of one care plan for each recipient, per pregnancy. (Wisconsin Medicaid reimburses for updates to the care plan under the ongoing care coordination and monitoring procedure code.)

The care coordinator is required to develop an individualized care plan for each eligible recipient. Medicaid does not require a specific care plan format, but the care plan must be:

- Developed (or reviewed) and signed or initialed by a qualified professional.
- In writing.
- Based on the results of the Pregnancy Questionnaire.

Note: Providers should note in the care plan if the recipient does not want to address issues identified in the Pregnancy Questionnaire.

The care coordinator is required to develop an individualized care plan for each eligible recipient.

Refer to Appendix 13 of this handbook for a blank model of a care plan. Providers are not required to use the sample.

To ensure the recipient's needs are met, the care plan must:

- Identify needs, problems, necessary services, necessary referrals, and frequency of monitoring.
- Include an array of services regardless of funding sources.

Refer to Appendix 10 of this handbook for a model of a Pregnancy Questionnaire Summary. Providers may use the Pregnancy Questionnaire Summary as an aid in identifying the recipient's unmet needs.

To the maximum extent possible, include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The recipient and care coordinator who developed the care plan are required to sign and date the plan.

Ongoing Care Coordination and Monitoring

A collateral is anyone who has direct supportive contact with the recipient, such as a family member, friend, service provider, guardian, housemate, or school official.

Ongoing care coordination and monitoring activities must be based on the recipient's written care plan. Wisconsin Medicaid will not cover ongoing care coordination and monitoring services that are not based on the recipient's care plan.

Ongoing care coordination and monitoring is a covered PNCC service for recipients who score 40 or more points on the Pregnancy Questionnaire. Except in urgent care situations, providers are required to complete the Pregnancy Questionnaire and a care plan for each recipient prior to providing ongoing care coordination and monitoring services. Providers may offer ongoing care coordination services on the same date they completed the Pregnancy Questionnaire and care plan.

Activities for Ongoing Care Coordination and Monitoring

Covered activities include the following:

- Recipient contacts.
- Collateral contacts.
- Information and referral.
- Assessment and care plan updates.
- Recordkeeping.

Recipient Contacts

Recipient contacts may be face-to-face, by telephone, or in writing, as appropriate. Except for health education and nutrition counseling, Wisconsin Medicaid does not cover recipient contacts for the direct provision of services. Wisconsin Medicaid reimburses for the provision of many medical services under other Medicaid benefits.

Wisconsin Medicaid does not limit the number of contacts providers may have with a recipient. However, reimbursement for the benefit is limited to a maximum amount per pregnancy, per recipient, per provider. Refer to Appendix 19 of this handbook for more information on reimbursement limitations.

Collateral Contacts

A collateral is anyone who has direct supportive contact with the recipient, such as a family member, friend, service provider, guardian, housemate, or school official. Since the purpose of contacts with a collateral is to mobilize services and support on behalf of the recipient, the provider is required to identify the role of the collateral in the recipient's care plan.

Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals or supervisors. Do not include time spent discussing or meeting on non-client-specific issues or time spent on general program issues.

Wisconsin Medicaid will not reimburse collateral contacts if there is no recipient contact during the month for which the provider is billing.

Information and Referral

Information and referral means providing recipients with current information about available resources and programs to help recipients gain access to needed services. Providers are required to ensure follow up on all referrals within two weeks, unless otherwise stated. Wisconsin Medicaid reimburses information and referral under ongoing care coordination and monitoring.

Wisconsin Medicaid does not cover care coordination services on behalf of family members who are not Medicaid eligible. However, providers may assist non-Medicaid-eligible family members in accessing services needed to best meet the eligible recipient's needs.

Refer to Appendix 11 of this handbook for a model of a Referral Form.

Appendix 16 of this handbook includes a list of resources that providers and recipients may consult.

Transportation Resources for Recipients
Although Wisconsin Medicaid does not cover transportation services as part of the PNCC benefit, providers often assist recipients in making transportation arrangements. Appendix 17 of this handbook provides information for assisting recipients with transportation arrangements.

Assessment and Care Plan Updates

Providers may update the Pregnancy Questionnaire and care plan, and administer other assessment tools, when necessary. Wisconsin Medicaid reimburses these activities as ongoing care coordination and monitoring services.

Assessment Updates
Providers may update the Pregnancy Questionnaire as frequently as needed. Providers may also administer other assessment instruments periodically, if appropriate, to determine the recipient's progress toward meeting established goals.

Use the ongoing care coordination and monitoring procedure code (W7092) when billing for updates to the Pregnancy Questionnaire and/or administration of other assessments.

Care Plan Updates
Providers are required to review and update the care plan at least every 60 days, or earlier if the recipient's needs change. The provider and the recipient are required to sign and date all updates to the care plan. The provider may initial updates to the care plan if a signature page is included in the recipient's file. Providers are required to keep signed copies of the updates in the recipient's file.

Use the ongoing care coordination and monitoring procedure code (W7092) when billing for updates to the care plan.

Recordkeeping

Wisconsin Medicaid considers recordkeeping a reimbursable ongoing care coordination and monitoring activity. Reimbursable recordkeeping activities include time spent on the following:

- Documenting the pregnancy (e.g., obtaining a signed statement from a physician, physician's assistant, certified nurse midwife, nurse practitioner, family planning clinic, or a Presumptive Eligibility provider).
- Updating care plans.
- Documenting recipient and collateral contacts.
- Preparing and responding to correspondence to and for the recipient.
- Documenting the recipient's activities in relation to the care plan.
- Determining and documenting the pregnancy outcome, including the infant's birth weight and health status.

Wisconsin Medicaid reimburses for recordkeeping only if a recipient contact occurred during the month for which the provider is billing.

If a recipient or collateral contact occurs on the last day of the month, the provider may bill Medicaid for the documentation of the contact in the following month (e.g., if the contact occurred on June 30, the provider may bill for the contact with the July contacts). Wisconsin Medicaid will only allow this exception if the provider documents the contact no later than the next business day.

Providers are required to review and update the care plan at least every 60 days, or earlier if the recipient's needs change.

Provision of Services in Urgent Situations

When ongoing care coordination services are provided in an urgent situation (e.g., the woman is pregnant and homeless, or pregnant and without food), the provider is required to:

- Document the nature of the urgent situation.

- Complete the Pregnancy Questionnaire and care plan as soon as possible but no later than 30 days following the actions taken to alleviate the urgent situation.

Note: Providers may offer ongoing care coordination services to recipients in urgent situations, but Wisconsin Medicaid will not reimburse for these services when they are provided to recipients who score fewer than 40 points on the Pregnancy Questionnaire.

As part of the care planning process, the provider is required to discuss and document the planned frequency of ongoing contacts and monitoring with the recipient (and the recipient's collaterals, if appropriate).

Frequency of Ongoing Monitoring

As part of the care planning process, the provider is required to discuss and document the planned frequency of ongoing contacts and monitoring with the recipient (and the recipient's collaterals, if appropriate). At a minimum, contacts should occur every thirty days. If possible, schedule more frequent visits during the early months of the pregnancy.

Postpartum Services

Wisconsin Medicaid covers PNCC services up to 60 days following delivery. Wisconsin Medicaid covers postpartum PNCC services only if the recipient received care coordination services prior to delivery. During the postpartum period, providers are required to:

- Make at least one face-to-face visit with the recipient.
- Encourage the recipient to choose a primary health care provider for the baby.
- Inform the recipient of the importance of immunizations and regular well-child checkups (HealthChecks) for the baby.

Refer to Appendix 7 of this handbook for additional information on services provided during the postpartum period.

Health Education and Nutrition Counseling

Wisconsin Medicaid covers health education and nutrition counseling under the PNCC benefit if all of the following occur:

- The medical need for health and/or nutrition education is identified in the Pregnancy Questionnaire. Providers should follow up with a more comprehensive assessment of the recipient's health education and nutrition needs and strengths. Providers may use any appropriate assessment tool to conduct the follow-up assessment.
- The recipient's written, individual care plan includes strategies and goals aimed at ameliorating the identified risk factors.
- A qualified professional (as defined in Appendix 18 of this handbook) provides the health education and nutrition counseling. The qualified professional is required to have the expertise, through education or at least one year of work experience, to provide health education and nutrition counseling.
- Services are provided face-to-face. Services may be provided in an individual or group setting. However, providers are required to establish clear strategies and goals for each recipient and include them in the recipient's individualized care plan.

Health education may include, but is not limited to, the following topics:

- Education and assistance to stop smoking.
- Education and assistance to stop alcohol consumption.
- Education and assistance to stop the use of illicit or street drugs.
- Education and assistance to stop potentially dangerous sexual practices.
- Education on environmental and occupational hazards related to pregnancy.
- Lifestyle management consultation.
- Reproductive health education.
- Preparation for childbirth.
- Preparation for the baby.

Nutrition counseling may include, but is not limited to, the following topics:

- Weight and weight gain.
- Medical conditions (for example, anemia, gestational diabetes).
- Previous and current nutrition-related obstetrical complications.
- Psychological factors affecting nutritional status (for example, depression, anorexia).
- Dietary factors affecting nutritional status (for example, the use of supplements, the lack of food resources).
- Reproductive history affecting nutritional status (for example, short inter-pregnancy interval, high parity).
- Breastfeeding education, infant nutritional needs.

Refer to Appendix 7 of this handbook for additional information on the provision of health education and nutrition counseling services.

Recipient Records

According to HFS 106.02(9), Wis. Admin. Code, all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. Providers may keep records in written or electronic formats. If providers keep electronic records, they are required to have hard copies available for review and audit.

As defined in HFS 105.52(5), Wis. Admin. Code, the recipient's file must include the following information, as appropriate:

- Verification of the recipient's pregnancy.
- The recipient's completed Pregnancy Questionnaire. The questionnaire must be scored, signed, and dated.
- The recipient's care plan, signed and dated as required. The provider may initial the care plan if a signature page is included in the recipient's record.
- Completed consent document(s) for release of information.
- A written record of all recipient-specific care coordination and monitoring activities. The record must include documentation of the following information:
  1. The recipient's name.
  2. The date of the contact.
  3. The full name and title of the person who made the contact.
  4. A clear description of the reason for and nature of the contact.
  5. The results of the contact.
  6. The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
  7. Where or how the contact was made.
- Referrals and follow up.
- All pertinent correspondence relating to coordination of the recipient's prenatal care.

The following are general guidelines for documentation of activities:

- Maintain accurate and legible documentation.
- Correct errors with caution. Do not erase or obliterate errors in established records. Instead, draw a line through the error so the words remain legible. Sign or initial and date the correction.
- Arrange the file in logical order if possible, so that documents can easily be reviewed and audited.
- Ensure that all entries are signed and dated and are in chronological order. Initials are acceptable if the recipient's file includes a page bearing the provider's full name and signature.
- Keep documentation concise, but descriptive and pertinent. The notation for each entry should be reasonably reflective of the length of time documented for the activity.
  For example, an entry stating, "Called Recipient X to remind her of her prenatal appointment" should not have a length of time of thirty minutes.
  A more reasonable notation would state: "Called Recipient X to remind her of her upcoming prenatal appointment. Answered Recipient X's questions

Do not erase or obliterate errors in established records. Instead, draw a line through the error so the words remain legible.

regarding transportation and child care for her other children. Also provided her with the name and telephone numbers of several child care providers in the area. Made plans with the recipient for a follow-up home visit."
- If unusual abbreviations and symbols are used routinely (e.g., abbreviations pertaining to internal policy or personal shorthand codes), maintain a key describing each one.

If a provider needs to reduce or terminate care coordination services for any reason, the provider should notify the recipient in advance and document this in the recipient's record.

Please refer to Appendix 14 of this handbook for a completed sample time log form.

Safeguarding Recipient Information

State and federal laws require that the personal information of all Medicaid recipients be safeguarded. However, when providing care coordination services, providers may need to obtain or release recipient information on behalf of the recipient. To comply with state and federal laws, providers may release recipient-specific information if:

- The recipient has granted written authorization to the provider.
- The recipient has signed and dated the authorization.

In cases where more stringent laws govern the release of certain personal information, providers are required to comply with those laws. It is the provider's responsibility to be aware of patient confidentiality laws.

For a model of a release of information form, please consult the Informed Consent to Release/Obtain Health Care Information Form in Appendix 12 of this handbook.

Please refer to HFS 104.01(3), Wis. Admin. Code, or to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional information on maintenance and confidentiality of Medicaid recipient records.

Duplication of Services

Prenatal Care Coordinators

A recipient should not require PNCC services from more than one provider. Although Medicaid does not deny claims for concurrent services, both providers are notified of the overlap. It is the providers' responsibility to eliminate the overlap by communicating with the recipient and with each other to determine which provider will continue to provide PNCC services. The recipient's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.

Other Care Coordinators

When multiple family members have care coordinators (case managers), the care plan must identify the role of each care coordinator. Coordinators may not duplicate services. This requirement applies whether or not Medicaid covers the other care coordinator's services.

Reduction or Termination of Ongoing Care Coordination Services

If a provider needs to reduce or terminate care coordination services for any reason, the provider should notify the recipient in advance and document this in the recipient's record. A decision that services can be reduced or terminated should be mutually agreed upon by the provider and recipient. The recipient's file must include a statement, signed and dated by the recipient, indicating agreement with the decision to terminate services. Changes in the care plan should always be discussed with the recipient/guardian/parent.

In circumstances when the provider is unable to obtain a signature from the recipient for the termination of services (for example, the recipient consistently misses meetings with the provider and does not follow through on

referrals, but indicates she wants to continue receiving PNCC services), the recipient's file must include documentation of all attempts to contact the recipient through telephone logs and returned or certified mail. The provider is encouraged to provide the recipient with the names and addresses of other PNCC providers.

If a provider terminates ongoing PNCC services for any reason, the recipient's case is closed. However, there is no limit to the number of times a provider may reopen a recipient's case. The provider is required to document in the recipient's record why the case has been closed and reopened.

Other Limitations

The following related limitations apply to PNCC services in addition to the other limitations stated in this handbook:

1. Prenatal care coordination services are available to recipients who are inpatients in hospital or nursing facilities if:
   - The services do not duplicate discharge planning services that the hospital or nursing facility is required to provide.
   - The service is provided during the 30 days prior to discharge.
2. Wisconsin Medicaid will only reimburse ongoing care coordination and monitoring services *once* per recipient per month of service. The units billed are the sum of the time for the month.

Noncovered Services

The following services are not covered under the Medicaid PNCC benefit:

1. The provision of diagnostic, treatment, or other direct services, except for health education and nutrition counseling. Direct services include, but are not limited to, diagnosis of a physical or mental illness and administration of medications.
2. Recipient vocational training.
3. Legal advocacy by an attorney or paralegal.
4. Ongoing care coordination and monitoring services that are not based on the recipient's current care plan.
5. Ongoing care coordination and monitoring services that are not necessary to meet the PNCC benefit goal.
6. Transportation (provider or recipient mileage or travel time).
7. Interpreter services.
8. Missed appointments (no shows).

There is no limit to the number of times a provider may reopen a recipient's case.

Billing Information

Claim Submission

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided.

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Electronic Billing

Prenatal care coordination (PNCC) providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic billing:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claim Submission

Providers submitting paper claims must use the HCFA 1500 claim form (dated 12/90). Appendices 2 and 3 of this handbook contain completed samples of HCFA 1500 claim forms for PNCC services. Refer to Appendix 1 of this handbook for HCFA 1500 claim form completion instructions.

Wisconsin Medicaid denies claims for PNCC services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. Providers may obtain these forms from any vendor that sells federal forms.

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments Unit
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at *www.dhfs.state.wi.us/medicaid/*.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Medicaid a higher fee for the same service than that charged to a private-pay patient. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge and the maximum allowable fee established by the Department of Health and Family Services (DHFS).

The maximum allowable fee is the amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. Refer to Appendix 19 of this handbook for a copy of the Wisconsin Medicaid maximum allowable fee schedule for PNCC services.

To obtain subsequent maximum allowable fee schedules, or to ensure you have the most recent fee schedule, you may:

- Purchase a paper schedule by using the order form located in the Claims Submission section of the All-Provider Handbook or by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Road
  Madison, WI 53784-0006

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook. Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

Procedure Codes

All claims submitted to Wisconsin Medicaid must include procedure codes. Allowable HCFA Common Procedure Coding System (HCPCS) codes for PNCC services are listed in the shaded box on this page and in Appendix 4 of this handbook. Claims or adjustments received without the appropriate HCPCS codes are denied.

Diagnosis Codes

Claims submitted for PNCC services must include either diagnosis code V23.9 (unspecified high-risk pregnancy) or V22.2 (regular pregnancy).

Use diagnosis code:

- V23.9 when billing on behalf of recipients who score 40 points or more on the Pregnancy Questionnaire (i.e., those who are determined eligible to receive services).

It is vital that providers use the correct procedure codes, diagnosis codes, and modifiers when billing for PNCC services:

Procedure Codes

- W7090 Risk Assessment.
- W7091 Initial Care Plan Development.
- W7092 Ongoing Care Coordination and Monitoring.
- W7093 Health Education/Nutrition Counseling - Individual.
- W7094 Health Education/Nutrition Counseling - Group.

Diagnosis Codes

- V23.9 Unspecified high-risk pregnancy.
- V22.2 Regular pregnancy.

Use V23.9 when billing for:

- Recipients who score 40 or more points on the Pregnancy Questionnaire (initial risk assessment).
- Procedure codes W7091, W7092, W7093, or W7094.

Use V22.2 when billing for:

- Recipients who score fewer than 40 points on the Pregnancy Questionnaire (initial risk assessment).

Remember to use a modifier to indicate the recipient's risk assessment score when billing for procedure code W7090. Use the modifier "SP" with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. Please refer to Appendix 4 of this handbook for the appropriate modifiers.

- V23.9 when billing procedure codes W7091-W7094.
- V22.2 when billing on behalf of recipients who score fewer than 40 points on the Pregnancy Questionnaire (i.e., those who are assessed but determined ineligible to receive services).

Use the modifier "SP" with all prenatal care coordination procedure codes for subsequent pregnancies within 185 days of previous pregnancies.

Wisconsin Medicaid will deny claims if providers use other diagnosis codes when billing for PNCC services.

Time Units

When billing for risk assessment (W7090) and initial care plan development (W7091), always bill for one unit.

Round time units to the nearest tenth of an hour when billing for ongoing care coordination and monitoring (W7092) and health and nutritional counseling (W7093 and W7094).

Refer to Appendix 6 of this handbook for more information on rounding guidelines for PNCC services.

Modifiers

Claims submitted for risk assessments (procedure code W7090) must include a modifier indicating the recipient's total risk assessment score.

Allowable modifiers are listed in Appendix 4 of this handbook. Claims for risk assessments that do not include the appropriate modifier are denied.

Modifier for Second Pregnancy

In some circumstances, a confirmed subsequent pregnancy may require the provision of PNCC services within 185 days of the provision of services for an earlier pregnancy. Use the modifier "SP" with a PNCC procedure code if the date of service falls within 185 days of the date of service for the same procedure code billed for an earlier pregnancy. For instance, use the modifier "SP" when billing for the initial care plan development (W7091) for a recipient's subsequent pregnancy if the date of service falls within 185 days from the date the same service was billed for a previous pregnancy.

Use the modifier "SP" with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. When billing for the second risk assessment, the modifier representing the risk assessment score must also be used.

Wisconsin Medicaid will deny claims for services provided within 185 days from the previous dates of service if the claims are not accompanied by the "SP" modifier.

Follow-Up to Claim Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status (R/S) Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.

To be reimbursed for additional ongoing care coordination time that may have been omitted from the original claim, providers are required to file an Adjustment Request Form.

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Refer to the Online Handbook
for current policy

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

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Refer to the Online Handbook
for current policy

Appendix 1

HCFA 1500 Claim Form Completion Instructions for Prenatal Care Coordination Services

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Providers are not required to bill commercial health insurance for prenatal care coordination services.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1— Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid ID number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 10 — Is Patient's Condition Related to (not required)

Element 11— Insured's Policy, Group, or FECA Number (not required)

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the appropriate diagnosis code as follows:

- Enter V23.9 (unspecified high-risk pregnancy) if the Pregnancy Questionnaire indicates a high-risk pregnancy (a score of 40 or more points on the Pregnancy Questionnaire). Procedure codes W7091-W7094 are only allowable if V23.9 is indicated.
- Enter V22.2 (regular pregnancy) if the Pregnancy Questionnaire indicates a pregnancy that is not high risk (a score of fewer than 40 points on the Pregnancy Questionnaire).

Element 22 — Medicaid Resubmission (not required)

Element 23 —- Prior Authorization Number (not required)

Element 24A — Date(s) of Service

For ongoing care coordination and monitoring (W7092) and health education/nutrition counseling for an individual (W7093) or group (W7094), if the service was performed on more than one date of service within the month, indicate the last date the service was performed. If billing for more than one month of activities, or more than one procedure code, use one detail line for each month's activities with the date of service determined as described below. Refer to Appendix 2 in this handbook for a completed sample claim form that shows more than one month's activities billed on the same claim form.

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the ***last*** date of service in MM/DD/YY or MM/DD/YYYY format in the "From" field.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code for each service. Enter 0 (other) if the place of service occurred in more than one location. Refer to Appendix 5 of this handbook for Medicaid-allowable POS codes.

Element 24C — Type of Service

Enter "9" as the single-digit type of service code.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code (refer to Appendix 4 of this handbook for a list of Medicaid-allowable procedure codes). Claims received without an appropriate procedure code are denied by Wisconsin Medicaid.

Modifiers

Enter the appropriate two-digit procedure code modifier in the "Modifier" column of Element 24D when billing the initial risk assessment (Pregnancy Questionnaire), or for all procedures provided for a subsequent pregnancy within 185 days of the same procedures provided for a previous pregnancy. Refer to Appendix 4 of this handbook for definitions of modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of hours billed on each line. Round to the nearest 0.1 hour. Appendix 6 of this handbook lists the rules for rounding. Always enter "1.0" when billing procedure codes W7090 and W7091.

Element 24H - EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** a HealthCheck referral and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due

Enter the balance due. This will be the same amount as appears in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 2

Completed Sample HCFA 1500 Claim Form

APPROVED OMB-0938-0008

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE ☐ (Medicare #) P | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): **609 Willow St.**

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: **Anytown** | STATE: **WI**

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: **55555** | TELEPHONE (Include Area Code): **(XXX)XXX-XXXX**

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V23.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 15 99		3	9	W7090	09	1	XX	XX 1				
2 01 15 99		3	9	W7091		1	XX	XX 1				
3 01 20 99		4	9	W7092		1	XX	XX 0.8				
4 01 20 99		3	9	W7094		1	XX	XX 1.2				
5 02 10 99		3	9	W7094		1	XX	XX 0.5				
6 02 28 99		4	9	W7092		1	XX	XX 1				

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XX.XX

29. AMOUNT PAID $

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

Appendix 3

Completed Sample HCFA 1500 Claim Form - Second Pregnancy

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V 23.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 20 99		3	9	W7090	SP 20	1	XX XX	1.0				
2 04 22 99		3	9	W7091	SP	1	XX XX	1.0				
3 04 29 99		3	9	W7092	SP	1	XX XX	0.4				
4 05 10 99		3	9	W7093	SP	1	XX XX	0.5				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 123JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XX.XX

29. AMOUNT PAID $

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

Appendix 4

Medicaid-Allowable Procedure Codes and Modifiers for Prenatal Care Coordination Services

Procedure Codes

Procedure	Description
W7090	Risk Assessment (See modifiers below)*
W7091	Initial Care Plan Development*
W7092	Ongoing Care Coordination and Monitoring*
W7093	Health Education /Nutrition Counseling - Individual*
W7094	Health Education/Nutrition Counseling - Group*

Risk Assessment (Pregnancy Questionnaire) Score Modifier

The risk assessment (Pregnancy Questionnaire) must be billed using the appropriate two-digit modifier to indicate the recipient's total risk assessment score. Claims for risk assessments that are submitted without a modifier are denied. The modifiers in the gray cells represent modifiers for recipients who do not qualify for prenatal care coordination (PNCC) services. Providers do not need to use modifiers with other PNCC procedure codes, except as noted below.

Score	Modifier	Score	Modifier	Score	Modifier	Score	Modifier
00-09	00	80-89	08	160-169	16	240-249	24
10-19	01	90-99	09	170-179	17	250-259	25
20-29	02	100-109	10	180-189	18	260-269	26
30-39	03	110-119	11	190-199	19	270-279	27
40-49	04	120-129	12	200-209	20	280-289	28
50-59	05	130-139	13	210-219	21	290-299	29
60-69	06	140-149	14	220-229	22	300 or greater	30
70-79	07	150-159	15	230-239	23		

*Subsequent Pregnancy (SP) Modifier

When billing for services provided within 185 days of a previous pregnancy, all procedure codes require the modifier "SP" (for example, when billing for a care plan for a subsequent pregnancy, procedure code W7091 requires the modifier "SP" if the date of service is within 185 days of the first care plan). When billing for the second risk assessment (Pregnancy Questionnaire), the modifier representing the risk assessment score must also be used.

Appendix 5

Medicaid-Allowable Place of Service Codes and Type of Service Code for Prenatal Care Coordination Services

PLACE OF SERVICE (POS) CODES

POS	Description
0	Other
1	Inpatient Hospital
3	Office or Clinic
4	Home

Enter 0 (other) if the place of service occurred in more than one location.

TYPE OF SERVICE (TOS) CODE

TOS	Description
9	Other

Appendix 6

Rounding Guidelines for Prenatal Care Coordination Services

Time units are calculated based on rounding accumulated hours of service for the month to the nearest tenth of an hour.

The following chart illustrates the rules of rounding and gives the appropriate billing unit:

Accumulated Time (in Minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
etc.	

A unit of service (1.0) for ongoing care coordination and monitoring services (W7092) is one hour. Use the chart above to determine the appropriate unit when billing for a fraction of an hour. For example, bill 1.8 units to represent 1 hour and 48 minutes of ongoing care coordination services.

Do not use these guidelines when billing for procedure codes W7090 (risk assessment) or W7091 (care plan development). Always enter "1.0" unit for these procedure codes. Wisconsin Medicaid does not reimburse these procedure codes by the hour.

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for current policy

Appendix 7

Medicaid Guidelines and Performance Measurements for Prenatal Care Coordination

The following pages provide guidelines with which prenatal care coordination (PNCC) agencies are required to comply when providing PNCC services. The document is divided into seven sections:

I. Prenatal Care Coordination Administration.
II. Pregnancy Questionnaire Administration.
III. Care Plan Development.
IV. Ongoing Prenatal Care Coordination and Monitoring.
V. Nutrition Counseling.
VI. Basic Health Information and Health Education.
VII. Postpartum Services.

Benefit guidelines are listed in the left-hand column of each page, while performance measurements are in the right-hand column. Wisconsin Medicaid uses the performance measurements to determine if the provider is complying with the benefit guidelines. If a guideline is not met, the provider is required to have written documentation that it has a reasonable alternative in place.

I. Prenatal Care Coordination Administration

GUIDELINE The provider must:	PERFORMANCE MEASUREMENT
I.A. Develop a plan which addresses the hiring and ongoing support and training of staff who can provide quality services that are family-centered and culturally appropriate.	**I.A.** The provider's plan to hire, support, and train staff to provide services that are family-centered and culturally appropriate must be documented and available for review. Documentation of staff training includes the name of the employee, date of training, and the employee's signature.
I.B. Develop and implement an outreach plan to inform potentially eligible pregnant women about the availability of PNCC services. At a minimum, the plan must: • Identify the provider's target population (for example, teens only, all eligible recipients in the county, recipients in specific ZIP codes). • Outline the strategies that will be used to inform eligible recipients, the local community, social service providers, schools, local health care providers, and other appropriate agencies and organizations about the availability of PNCC services. Outreach efforts could also include community presentations, informational brochures, posters, billboards, television ads, or newspaper articles.	**I.B.** The provider is required to have an outreach plan available for review. The plan also must be specific to the target population and address strategies to inform eligible pregnant women about PNCC services.
I.C. Establish written procedures to ensure that care coordinators include recipients, to the full extent of their ability, in all decisions regarding appropriate services and providers.	**I.C.** Written procedures that meet the stated guidelines are available for review.
I.D. Develop and implement internal policies and procedures for ensuring that quality services are provided in accordance with Medicaid rules. At a minimum, these policies and procedures address: • Patient confidentiality. These policies must include clear statements regarding the type of information that can be released, the time period for which the authorization is valid, and the agencies or individuals to whom the information can be released.	**I.D.** Written policies and procedures that meet the stated guidelines are available for review. Documentation of all activities that meet the stated guidelines is also available for review. Provider records indicate paraprofessional supervision every 30 days, at a minimum.

GUIDELINE (I.D. Cont.)	PERFORMANCE MEASUREMENT
• Accuracy, legibility, and completeness of records (for example, the accurate scoring of Pregnancy Questionnaires, the legibility of care plans and other written information, and documentation of all contacts with, or on behalf of, a recipient). • Procedures to ensure that priorities established in individual care plans are addressed in a timely manner. • Procedures to ensure that recipients are offered services that are sufficient in intensity. The procedures must include well-defined criteria for increasing or decreasing the intensity of services. • Procedures to ensure that timely and appropriate referrals are made and there is follow up on all referrals. Unless otherwise stated, follow up on referrals must be made within two weeks of the referral. • Ongoing staff training and support, including adequate supervision and support of paraprofessionals. Provide face-to-face supervision of paraprofessionals every 30 days, at a minimum. • Appropriate staff-to-client ratio. Ensure that care coordinators have an adequate amount of time to spend with each recipient. The number of clients per care coordinator will vary depending on the needs of the recipients on their caseload. • The provision of services by culturally competent staff. • The provision of services that are family centered. • Procedures to ensure that staff are following the provider's policies and procedures for the provision of services. The policies and procedures must clearly identify: • The staff responsible for oversight of the policies and procedures. • Steps for prioritizing, monitoring, and correcting problem areas.	

GUIDELINE	PERFORMANCE MEASUREMENT
I.E. Establish written procedures to ensure that a qualified professional reviews and signs all assessments completed by paraprofessional staff.	**I.E.** The provider has written procedures requiring the review by and signature of qualified professionals of all Pregnancy Questionnaires completed by paraprofessionals.
I.F. Develop a written plan for providing timely, non-disruptive, translator services for recipients who are hearing impaired and for recipients who do not speak or understand English. If the provider does not have an interpreter on staff, the provider must maintain a current list of interpreters who are "on call" to provide interpreter services. Do not use family members as interpreters when administering Pregnancy Questionnaires or for the initial care plan development. Do not use children as interpreters.	**I.F.** The provider has a written plan that meets the stated guidelines available for review. If the interpreter is not a staff member, the provider has a current list of "on call" interpreters available for review.
I.G. Develop written procedures for scheduling recipients for the initial assessment, initial care plan development, ongoing care coordination and monitoring services, and health and nutrition education, if appropriate. The schedule should allow adequate time with each individual to address her problems, develop a plan of action, and provide adequate education. If possible, schedule the initial assessment within 10 working days after the request for a service by a pregnant woman, or after receiving a referral. The procedures must also include guidelines for staff regarding the time frame within which the initial contact must be scheduled after the Pregnancy Questionnaire and care plan are completed.	**I.G.** Written procedures that clearly outline the provider's plans for scheduling the initial assessment, the initial care plan development, and ongoing care coordination and monitoring services must be available for review.
I.H. Develop written procedures for following up with recipients who fail to keep appointments (care coordination, social service, prenatal or other appointments). Include time frames within which the recipient must be contacted and the steps designed to help the recipient keep future appointments.	**I.H.** Written procedures that meet the stated guidelines are available for review.
I.I. Maintain a current list of appropriate community resources (for referral purposes). The list includes, but is not limited to, the following services and agencies: • Adoption. • AIDS/HIV.	**I.I.** A current list of appropriate community resources - including, but not limited to, the services and agencies stated in the guidelines - and addresses, telephone numbers, and any associated costs is on file.

GUIDELINE	PERFORMANCE MEASUREMENT
(I.I. Cont.)	

- Adult protective services.
- Alcohol, tobacco, and other drug abuse.
- Child welfare services.
- Children with special health care needs program.
- Day care centers.
- Domestic/family violence.
- Early childhood intervention programs (for example, Head Start, Birth to 3).
- Education.
- Employment/job training.
- Family planning.
- Food pantries/other food services.
- Special Supplemental Food Program for Women, Infants, and Children (WIC) programs.
- Housing and shelters for the homeless.
- Legal assistance.
- Social services (e.g., family/marriage counseling, family support services, clothing for newborns).
- Parenting education (including fathers).
- Perinatal loss/grief counseling.
- Respite/family resource centers.
- Transportation.

The list(s) must include the description of services offered, name of agency, address, telephone number, contact person, and any costs associated with the services.

I.J. Establish working relationships (for the purpose of referrals) with key community agencies, social services providers, HMOs, and Medicaid primary care providers. If possible, develop written agreements that address the specific procedures to be followed for making referrals and for obtaining information on the outcome of the referrals from these agencies and providers. Ensure that staff are aware of these agreements.

Medicaid HMOs are required to sign a Memorandum of Understanding (MOU) with all PNCC providers in their service area.

I.J. The provider's file includes written agreements or documentation that show that the provider has made good faith efforts to develop effective working relationships with key health and social services providers. The provider has on file a current MOU with each HMO in the county.

GUIDELINE	PERFORMANCE MEASUREMENT
I.K. Establish written procedures regarding the release of recipient-specific information. Recipients may sign a general release of information. However, providers must obtain specific approval to release sensitive information about the recipient.	**I.K.** The provider has written policies regarding the release of recipient-specific information. The policies specifically address the release of sensitive information.

II. PREGNANCY QUESTIONNAIRE ADMINISTRATION

The provider must administer the Medicaid-approved assessment tool (the Pregnancy Questionnaire) to determine eligibility for the benefit. The assessment tool is designed to identify the recipient's strengths and needs. In addition to the Pregnancy Questionnaire, the provider may use any commercial or self-designed form to conduct a more detailed assessment.

Providers may consult the Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire for detailed information on administering the questionnaire. Refer to Appendix 16 for information on obtaining the Guidance Manual for the Pregnancy Questionnaire.

All recipients must have a completed copy of the Pregnancy Questionnaire in their file.

Note: The Pregnancy Questionnaire includes several questions to which the recipient may object. Prior to administering the Pregnancy Questionnaire, explain the assessment and care planning process, acknowledge the intrusiveness of some of the questions and explain why you need to ask the questions. If necessary, share your agency's confidentiality policies with the recipient, including who will have access to the information provided.

GUIDELINE

The provider must:

II.A. Administer and score the Pregnancy Questionnaire in its entirety unless the recipient objects to a particular question or section, or the information is unavailable.

II.B. Review and finalize the Pregnancy Questionnaire in a face-to-face meeting with the recipient. The staff completing the Pregnancy Questionnaire must sign and date it. A qualified professional must review and sign all Pregnancy Questionnaires completed by paraprofessional staff.

II.C. Inform recipients who score 40 or more points on the Pregnancy Questionnaire that they are eligible to receive PNCC services.

If the recipient is not interested in receiving services, try to determine the reason. Give the recipient a written copy of the agency's address and telephone number and ask the recipient to call or stop by if she changes her mind.

II.D. Inform recipients who score less than 40 points on the Pregnancy Questionnaire that they are not eligible to receive PNCC services.

Based on the recipient's identified needs, refer her to other community resources as appropriate. Give the recipient a written copy of the agency's telephone

PERFORMANCE MEASUREMENT

II.A. The recipient's file includes a completed and scored Pregnancy Questionnaire. If the questionnaire is not completed in its entirety, there is documentation that explains why.

II.B. The recipient's file includes documentation that the Pregnancy Questionnaire was reviewed and finalized in a face-to-face visit. The Pregnancy Questionnaire is signed and dated. The recipient's file also includes documentation that a qualified professional reviewed and signed all Pregnancy Questionnaires completed by paraprofessional staff.

II.C. The recipient's file documents that the recipient was offered PNCC services.

If the recipient is not interested in receiving services, the reason is documented. The file includes documentation that the recipient received a written copy of the provider's address and telephone number and was asked to call if she changes her mind about receiving services.

II.D. The recipient's file includes documentation that the recipient was referred to other community resources as appropriate. The file also documents that the recipient was asked to contact the provider if she has a significant negative change in her family, medical, social, or economic status while she is still pregnant.

GUIDELINE (II.D. Cont.)	PERFORMANCE MEASUREMENT (II.D. Cont.)
number and ask her to call or stop by if she has a significant negative change in her family, medical, social, or economic status while she is still pregnant. Also, the provider may reassess the recipient if someone, such as a health care professional, a school, or a social worker, refers her back to the provider. The provider may use the same Pregnancy Questionnaire if the reassessment or update is within 12 months of the initial assessment. Changes to the Pregnancy Questionnaire must be clearly identified (for example, use a different color of ink, cross out old response). Do not erase or totally obliterate the original response. Re-sign and date the Pregnancy Questionnaire.	Changes to the Pregnancy Questionnaire are legible and clearly identified. The Pregnancy Questionnaire is signed and dated.
II.E. Use a new Pregnancy Questionnaire for assessments administered after 12 months of the initial assessment.	**II.E.** The recipient's file includes a new Pregnancy Questionnaire if more than 12 months have elapsed since the initial assessment.

III. CARE PLAN DEVELOPMENT

The Pregnancy Questionnaire must be completed prior to the development of the care plan. The provider is not required to use a specific care plan format. However, the care plan must be based on the results of the Pregnancy Questionnaire.

GUIDELINE	PERFORMANCE MEASUREMENT
The provider must:	
III.A. Develop a written individualized care plan for each recipient scoring 40 or more points on the Pregnancy Questionnaire. Develop only one care plan for each recipient.	**III.A.** The recipient's file includes an individualized care plan if the recipient scored 40 or more points on the Pregnancy Questionnaire.
III.B. Include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate.	**III.B.** The recipient's file includes documentation that the recipient and, when appropriate, the recipient's family and other supportive persons actively participated in the development of the care plan.
The recipient and provider who developed the care plan must sign and date the plan.	The recipient and the provider have signed and dated the care plan.
III.C. Inform the recipient that the care plan can be changed at any time, and as often as necessary. Provide the recipient with information on how to request changes to the care plan, including the name and telephone number of the person to contact to initiate the change.	**III.C.** The recipient's file includes documentation of the stated guideline.
III.D. Ensure that the care plan includes the following: • Identification and prioritization of all strengths and problems identified during the initial assessment, including those related to health and nutrition education. • Identification and prioritization of all services to be arranged with the recipient, including the names of the service providers (including health care providers). • A description of the recipient's informal support system, including collaterals, and activities planned to strengthen it if necessary. • Appropriate referrals and planned follow up. • Expected outcome of each referral. • Progress or resolution of identified priorities. • Documentation of unmet needs and gaps in service. • Planned frequency, time, and place of contacts with the recipient.	**III.D.** The recipient's file includes a care plan that meets the stated guidelines.

GUIDELINE (III.D. Cont.)	PERFORMANCE MEASUREMENT
• Identification of individuals who participated in the care plan development. • The recipient's responsibility in the plan's implementation. If there are other care coordinators involved with the recipient, the care plan must address any needed collaboration or coordination. This requirement applies whether or not Medicaid covers the other care coordinators' services. The recipient's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.	
III.E. At a minimum, review and update the recipient's care plan every 60 days or sooner if the recipient's needs change. If necessary, update the recipient's care plan during each visit. All updates to the care plan must be signed or initialed and dated by the provider and the recipient.	**III.E.** The recipient's file includes documentation that the care plan was updated at least every 60 days. All updates to the care plan are signed or initialed and dated by the provider and the recipient.
III.F. Provide the recipient with the written name and telephone number of: • The person who will provide the ongoing care coordination services. If necessary, introduce the recipient to the care coordinator if he or she is different from the person who administered the assessment and developed the care plan. • The person to contact in urgent situations or as backup when the care coordinator is unavailable.	**III.F.** The recipient's file includes a copy of, or documentation stating that the provider gave to the recipient, written information identifying the name and telephone number of the care coordinator and of the person to contact as back-up.

IV. ONGOING PRENATAL CARE COORDINATION AND MONITORING

All recipients must have a care plan in their file that predates the delivery of ongoing PNCC services, except for in urgent situations. In such cases, the provider is required to document the urgent situation. The provider is required to document all recipient and collateral contacts. The documentation must include the following:

- The recipient's name.
- The date of the contact.
- The full name and title of the person who made the contact.
- A clear description of the reason for and nature of the contact.
- The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
- Where or how the contact was made.

Prenatal care coordination ongoing services must be based on the care plan.

GUIDELINE **PERFORMANCE MEASUREMENT**

PSYCHOSOCIAL SERVICES

The term "psychosocial" refers to those concerns about relationships and support systems, fears about personal safety or safety of other family members, fears about past or current physical or substance abuse, depression or other mental health problems, worries about ability to meet basic needs for food and shelter, and significant stress about ability to cope with the current pregnancy.

Psychosocial services should be provided by professional staff who are qualified by education, training, and experience to provide the level of service the recipient needs.

Psychosocial services are provided to assist the pregnant woman in:

- Resolving relationship problems that may adversely affect her health and the outcome of her pregnancy.
- Identifying and accessing other services that will support her efforts to maintain a healthy pregnancy, continue positive health behaviors and provide a safe home for herself and her children.
- Understanding and dealing with the social-emotional aspects of pregnancy and parenting.
- Evaluating behaviors that may interfere with having a healthy pregnancy and infant, such as substance abuse, poor nutrition, and high-risk sexual behavior.

GUIDELINE	PERFORMANCE MEASUREMENT
IV.A. On an ongoing basis, the provider must: • Determine which services identified in the care plan have been or are being delivered. • Determine if the services are adequate for the recipient's needs. • Provide supportive contact to ensure that the recipient is able to access services, is actually receiving services, or is engaging in activities specified in the care plan. • Monitor the recipient's satisfaction with the service. • Ask the recipient to evaluate the quality, relevance, and desirability of the services to which she has been referred. • Identify changes in the recipient's circumstances that would require an adjustment in the care plan.	**IV.A.** The recipient's file includes documentation that indicates the provider offered ongoing services as stated.
IV.B. Provide the recipient with information on community resources and referrals to other agencies when appropriate. Whenever possible, provide written referrals. Written referrals must include: • The care coordinator's name, address, and telephone number. • The recipient's name. • The date that the referral is made. • The name, address, and telephone number of the agency/provider to which the recipient is being referred. • The reason for the referral.	**IV.B.** The recipient's file indicates that the provider made available information on community resources and provided referrals as appropriate. A copy of all written referrals is maintained (or noted, if verbal) in the recipient's file.
IV.C. When referring the recipient for services, the care coordinator must: • Ensure that the recipient understands the reason and need for the referral. • Inform the recipient of all available options for obtaining the needed service. • Explain any costs involved or limitation in the service. • Assist the recipient in learning how to access the service for which the referral was made, including the appropriate use of contact name, telephone number, and address.	**IV.C.** The recipient's file includes copies of referrals, consent for release of information, and documentation of the coordinator's follow-up on all referrals with the recipient and the service provider.

GUIDELINE (IV.C. Cont.)	PERFORMANCE MEASUREMENT
• Follow up with the service agency, including appropriate advocacy on behalf of the recipient to ensure that services are provided. Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance.	
IV.D. Ensure that the intensity and frequency of contacts with the recipient corresponds to the level of need and/or risk identified by the Pregnancy Questionnaire. For example, schedule frequent face-to-face visits if the recipient is in crisis, if there is violence in the home, or if the recipient is a first-time parent with no support system. If necessary, call or visit the recipient daily or weekly. At a minimum, contacts or visits should occur no less than every 30 days. If possible, schedule more frequent visits during the early months of pregnancy.	**IV.D.** The recipient's file includes documentation that contacts with the recipient correspond to the level of need/risk and includes the date, time, location, and length of recipient contact, progress and/or resolution of identified problems, and signature of the professional reviewer. The recipient's file includes documentation supporting contacts with the recipient that are less frequent than the stated guidelines.
IV.E. Assist the recipient in accessing and appropriately using the health care delivery system. For example, ensure that the recipient: • Can identify her primary/obstetric care provider, clinic, and HMO. • Has her health care providers' telephone numbers and addresses and knows where to find them. • Knows the proper procedures for obtaining medical information or health care after hours. • Understands how to obtain specialty care, for example, mental health/substance abuse (alcohol and other drug abuse) treatment. • Knows when to use the hospital emergency room. • Knows how to schedule, reschedule, and cancel appointments. Assist the recipient in obtaining information as appropriate.	**IV.E.** The recipient's file includes documentation of the recipient's knowledge, deficiencies, and information provided as stated in the guidelines.
IV.F. Refer the recipient for counseling and support in the grief process when there is an early pregnancy loss (before 20 weeks gestation).	**IV.F**. The recipient's file includes documentation and follow up on the referral.

GUIDELINE	PERFORMANCE MEASUREMENT
IV.G. If the recipient indicates a desire to have an elective abortion, refer her to an appropriate medical provider for counseling. Inform the recipient that Wisconsin Medicaid does not cover care coordination services following an elective abortion.	**IV.G.** The recipient's file includes documentation of the referral.
IV.H. Refer recipients with complex psychosocial needs to additional community or mental health services. If the recipient exhibits behavior that may be dangerous to herself or others, immediately refer her to her health care or mental health provider in the community. Ensure follow up within 24 hours.	**IV.H.** The recipient's file includes appropriate referrals and documentation of timely follow-up on the referrals. Recipient's file also documents follow-up within 24 hours, if appropriate.
IV.I. Reassess the recipient's psychosocial risk status at least once each trimester and update the care plan as necessary. The assessment should include the recipient's strengths, weaknesses, support system, environment, actual and potential stressors, attitude toward the pregnancy, and past experiences with pregnancy.	**IV.I.** The recipient's file includes documentation of a periodic assessment. The care plan is updated as necessary.

V. NUTRITION COUNSELING

Wisconsin Medicaid covers nutrition counseling if the need for it is identified in the Pregnancy Questionnaire and it is included in the recipient's individualized care plan. Pregnant women identified with nutrition-related needs may require a more in-depth nutritional assessment, nutrition education, and counseling by a registered/certified dietitian or other qualified professional.

GUIDELINE

V.A. Assess the recipient's knowledge and understanding of basic nutrition and dietary practices and how these factors could affect the pregnancy outcome for both her and the fetus. If possible, conduct the assessment during the first visit. Ensure that the care plan addresses the recipient's specific education needs.

Provide or refer the recipient for education on the following topics as needed:

- Recommended weight gain and weight gain goals.
- Recommended dietary intake and meal patterns.
- Suggestions to improve intake of:
  - √ Calcium-rich foods.
  - √ Iron-rich foods and foods that enhance iron absorption.
  - √ Folate-rich foods.
- Use of vitamin and mineral supplements and over-the-counter medicines.
- Avoidance of self-imposed diets and food practices that can be harmful.
- Dietary interventions for common problems of pregnancy:
  - √ Nausea and vomiting in early pregnancy.
  - √ Heartburn.
  - √ Constipation.
- Promotion and support of breastfeeding.
- Resources for food, food budgeting, preparation, and storage, including referral and follow up on WIC Program participation.
- Safe water source: refer for testing if lead, nitrates, or fluoride level might be a problem, and refer for dietary fluoride supplements when necessary.

PERFORMANCE MEASUREMENT

V.A. The recipient's file includes documentation of the assessment. The recipient's care plan addresses the recipient's specific education needs. A check-off list is permissible.

GUIDELINE	PERFORMANCE MEASUREMENT
V.B. Conduct periodic reassessments throughout the pregnancy. All assessments must be signed and dated.	**V.B.** The recipient's file includes documentation of periodic reassessments. The assessments are signed and dated.
V.C. Refer recipients with more intensive nutritional-related needs to a dietitian if necessary. Problems indicating a need for referral to a registered/certified dietitian include but are not limited to: • Pre-pregnancy weight less than 20 Body Mass Index (BMI). • Pre-pregnancy weight greater than 26.0 BMI. • Inappropriate weight gain based on weight gain recommendations of the Institute of Medicine, 1990. • Anemia: hematocrit < 30.0%, or hemoglobin < 10.0 g/dL. • Pregnant woman's own history of childhood lead poisoning, or current blood lead level > 10 ug/dL within the last 12 months. • Previous obstetrical complications: anemia, pregnancy-induced hypertension, fetal loss, premature delivery, inadequate weight gain, low-birth-weight infant, small-for-gestational-age infant, high-birth-weight infant. • Current medical/obstetrical complications: diabetes, hypertension, renal disease, liver disease, cancer, cardiopulmonary disease, PKU, thyroid disease, gastrointestinal disease (e.g., parasites, short gut), hyperemesis gravidarum, severe infection, anesthesia/surgery/trauma within six months. • Psychological problems: current or past history of eating disorders, depression influencing appetite or eating, mental retardation, mental illness. • Dietary factors: inadequate diet, milk allergy, lactose intolerance, self-imposed dietary restrictions, inappropriate use of supplements and over-the-counter medications, insufficient resources to obtain, store, and prepare food to achieve an adequate dietary intake. • Age 17 years or less at time of conception. • 16 months or less between end of last pregnancy and conception. • Multiple gestation. • Smokes, uses alcohol or illicit drugs. • Breastfeeding another child during current pregnancy. • Pica (eating nonfood substances).	**V.C.** The recipient's file includes documentation of the specific reasons for referral to a registered/certified dietitian. The file also includes documentation of timely follow up with the dietitian to ensure the recipient is receiving nutrition care.

GUIDELINE	PERFORMANCE MEASUREMENT
V.D. Ensure that printed booklets and handouts obtained for distribution to recipients are appropriate for recipient's reading level and culture.	**V.D.** The provider has printed nutritional material that is appropriate for its target population.

VI. BASIC HEALTH INFORMATION AND HEALTH EDUCATION

Wisconsin Medicaid covers health education if the need for it is identified in the Pregnancy Questionnaire and it is included in the recipient's individualized care plan. Pregnant women identified with health education-related needs may require in-depth health education and counseling by a qualified professional.

GUIDELINE

VI.A. Assess the recipient's knowledge and understanding about her medical status and health practices and the impact on her pregnancy outcome.

Reassess the recipient periodically and provide ongoing education if necessary.

VI.B. Ensure the recipient's care plan includes the identified health education needs, strategies for addressing them, and reasonable goals.

VI.C. Provide basic health information to the recipient. Ensure that the information is easy to understand, culturally appropriate, and shared in a non-threatening and non-judgmental manner.

The intent of providing basic information about pregnancy is to help the woman positively adjust to her new condition. At this level the emphasis is not on behavior or lifestyle change but information sharing. Basic health information about prenatal care and pregnancy could include the following topics:

- Importance of continuous prenatal care.
- Normal changes due to pregnancy as it relates to each trimester.
  - √ Maternal anatomy and physiology.
  - √ Fetal development.
  - √ Emotional issues.
- Self-help strategies for common discomforts related to pregnancy.
- Self-care during pregnancy.
- Pregnancy complications.
  - √ Symptoms and self-detection of preterm labor.
  - √ Bleeding, infections during pregnancy, rupture of the bag of waters.
  - √ Emergency arrangements.

PERFORMANCE MEASUREMENT

VI.A. The recipient's file includes documentation of the assessment. A check-off list is permissible if it identifies specific educational areas of need.

The recipient's file also includes documentation of periodic reassessments.

VI.B. The recipient's care plan addresses identified needs, strategies for addressing them, and reasonable goals.

VI.C. The recipient's file includes documentation of the information provided.

GUIDELINE	PERFORMANCE MEASUREMENT
(VI.C. Cont.) • Understanding the dangers of over-the-counter medicines, prescription drugs, tobacco, alcohol, illicit drug use, and environmental and occupational hazards as they relate to pregnancy. • Preparation for labor, delivery, and postpartum discharge: √ Hospital arrangements. √ Support person to participate during labor and delivery. • Preparation for the baby. • Infant care, including nutrition and breastfeeding. • Family Planning.	
VI.D. Provide or refer recipients for in-depth health education services if necessary. Ensure that the educational interventions address those high-risk medical conditions and health behaviors that can be alleviated or improved through education. Include the following topics as appropriate: • Education/assistance to stop smoking. √ Decrease smoking alternative. √ Effects of smoking on mother and fetal development. • Education/assistance to stop alcohol consumption. √ Emphasize importance of no alcohol during pregnancy. √ Effect of alcohol on fetal development. • Education/assistance to stop use of illicit or street drugs. √ Emphasize no safe limit. √ Effects of drugs on fetal development. • Education/assistance to stop high-risk sex practices. • Education on the safe use of over-the-counter/ prescription drugs. • Education on environmental/occupational hazards related to pregnancy. √ Potential exposure to hazard in recipient's own environment. √ Effects on fetal growth and development. √ Efforts to minimize exposure. • Lifestyle management. √ Relaxation techniques. √ Building self-esteem.	**VI.D.** The recipient's file must include documentation of the need for more in-depth education. The file must also describe the type of education provided and the recipient's progress in meeting established goals. The file includes documentation of follow-up on referrals.

GUIDELINE	PERFORMANCE MEASUREMENT
(VI.D. Cont.) √ Learning coping strategies and decision-making skills. √ Communication skills with health care providers, family, peers, etc. • Reproductive health. √ Human sexuality. √ Environmental/occupational hazards. • Anticipatory guidance on childbirth, health and child growth and development. Refer the recipient for additional support or information as needed. Ensure timely follow up on all referrals.	
VI.E. Ensure that printed booklets and handouts obtained for distribution to recipients are appropriate for recipients' reading level and culture.	**VI.E.** The provider has printed material that is appropriate for its target population.

VII. POSTPARTUM SERVICES

Prenatal care coordination services continue during the postpartum period (the first 60 days following delivery).

GUIDELINE	PERFORMANCE MEASUREMENT
During the postpartum period, providers should:	
VII.A. Make at least one face-to-face contact. If possible, make at least one home visit.	**VII.A.** The recipient's file includes documentation of the contact.
VII.B. Update the recipient's care plan within 30 days after delivery. Address any negative changes in the recipient's postpartum medical and/or psychosocial condition with the recipient.	**VII.B.** The recipient's file indicates any necessary updates and follow-ups.
VII.C. Refer the recipient for counseling and support if she has a stillbirth. Ensure timely follow up on the referral.	**VII.C.** The recipient's file includes documentation of the referral and follow-up.
VII.D. Refer the recipient to the Infant Death Center of Wisconsin if there is a sudden, unexpected infant death. Ensure timely follow up on the referral.	**VII.D.** The recipient's file includes documentation of the referral and follow-up.
VII.E. Refer the recipient for additional support and assistance in learning how to care for her child if the child is identified as having a special health care need (for example, spina bifida, cleft lip, cerebral palsy) or a medical risk condition (for example, low birth weight, prematurity). Ensure timely follow up.	**VII.E.** The recipient's file includes documentation of the identified problem, referrals, and follow-up.
VII.F. Assess the recipient's knowledge and understanding of basic postpartum care. Provide information as necessary. At a minimum, include the following topics in the assessment: • Personal hygiene. • Nutrition during breastfeeding, including influence of tobacco, alcohol, and other drugs. • Postpartum nutrition if formula feeding. • Guides to successful breastfeeding, breast care, and routine self-breast checks. • Physical activity and exercise. • Recognition of minor gynecologic problems. • Family planning. • Prevention of sexually transmitted diseases. • Continuity of basic primary and reproductive health care.	**VII.F.** The recipient's file includes documentation of the assessment, information or referral provided, and any follow-up.

GUIDELINE	PERFORMANCE MEASUREMENT
VII.G. Assess the recipient's interpersonal relationship with the infant. The assessment could include the recipient's strengths, weaknesses, support system, social environment, stresses, attitude toward the infant, and past experiences with parenting. Refer the recipient as appropriate.	**VII.G.** The recipient's file includes documentation of the assessment, information or referral provided, and any follow-up.
VII.H. Assess the recipient's knowledge and understanding regarding appropriate newborn care and feeding practices and how these factors affect growth and development. Provide information or refer the recipient to a qualified professional as appropriate. At a minimum, include the following topics in your assessment: • Infant's hunger and fullness cues. • Infant nutrition and appropriate feeding practices. • Successful breastfeeding. • Food and/or formula preparation and storage. • Bathing, skin and cord care, and diaper rash prevention. • Normal growth and development. • Taking infant's temperature, treatment of nausea, vomiting, dehydration, and fever. • Infant nurturing and stimulation. • Effects of secondhand smoke on infant health and nutrition. • Injury prevention and safety, including car seats, falls, poisoning, choking, sleep positions. • Appropriate use of infant's primary health care provider versus the emergency room.	**VII.H.** The recipient's file includes documentation of the assessment, information or referral provided, and any follow-up.
VII.I. Encourage the recipient to choose a primary health care provider for the baby. Assist her in obtaining information regarding appropriate providers. Refer her to her HMO if appropriate.	**VII.I.** The recipient's file includes documentation of the referral and follow-up.
VII.J. Inform the mother about the importance of timely immunization and regular well-child checkups. Assist her with making initial appointments, if needed.	**VII.J.** The recipient's file includes documentation of information provided, referrals given, and follow-up.
VII.K. Assess the recipient's knowledge of the steps involved in obtaining appropriate and reliable child care.	**VII.K.** The recipient's file includes documentation of the assessment, information provided, referrals given, and follow-up.

GUIDELINE	PERFORMANCE MEASUREMENT
(VII.K. Cont.) Provide information or refer the recipient for assistance if deficiencies are found in the following areas: • Knowledge regarding available resources for checking provider references. • Evaluating child care settings for safety. • Obtaining financial assistance for child care. • Appropriate monitoring of the child care provider. • Reporting suspected child abuse or neglect by the child care provider.	
VII.L. Refer women who require services beyond the postpartum period to other community resources before discharge from the PNCC program. Follow up on any referrals prior to the 60th day after delivery. Document the last date of service (the date the recipient is discharged).	**VII.L.** The recipient's file includes documentation of PNCC postpartum contacts, referrals, follow-up, and discharge from the program. The recipient's file also indicates the date of delivery.

Appendix 8

Pregnancy Questionnaire

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1105 (Rev. 1/00)

STATE OF WISCONSIN

This form consists of six (6) two-ply pages. This is page 1.

Agency Name: _____
Agency Telephone Number: _____
EDC: _____

PREGNANCY QUESTIONNAIRE

A. GENERAL INFORMATION

1. Mother's Name and Address: *(Please print)*

   _____
   Last Name First Middle

   _____
   Street Address

   _____
   City State Zip Code

2. Mother's date of birth: _____

3. Age: _____ **<18=(40) 18–20=(15) >40=(20)**

4. Medicaid ID#: _____

5. Telephone number:
   (home) _____
   (work) _____
   ❒ No phone, or phone is often disconnected. **= (15)**

6. How can we contact you?
   ❒ Call home ❒ Call work
   ❒ Write home ❒ Other: _____

7. Are you:
   ❒ Single (never married, separated, divorced, widowed) **= (10)**
   ❒ Married

8. Your race/ethnic origin:
   ❒ White ❒ African-American
   ❒ Hispanic ❒ American Indian
   ❒ Southeast Asian ❒ Other: _____

9. Do you speak English?
   ❒ Very well
   ❒ A little
   ❒ Not at all

10. Do you read English?
    ❒ Very well
    ❒ A little **= (10)**
    ❒ Not at all **= (15)**

11. Are you in a WIC Program?
    ❒ No Location: _____
    ❒ Yes ❒ I was denied
    ❒ I just applied ❒ I don't know about WIC

12. What are your sources of income? *(Please check all that apply.)*
    ❒ Self ❒ Parents
    ❒ Partner/Spouse ❒ Alimony
    ❒ Child support payments
    ❒ Unemployment benefits
    ❒ Other: _____

13. Are you employed?
    ❒ No
    ❒ Yes
    ❒ I am a student
    If you are employed, what is your occupation?
    _____
    If you are employed, how many hours do you usually work in a week? _____

14. What was the last grade you finished in school? _____
    8 yrs. or less = (20) >8 yrs. but <12 yrs. = (15)
    If in school now do you attend regularly?
    ❒ No
    ❒ Yes
    ❒ I am working on GED or have completed it.

15. Have you in the past, or are you currently, receiving special educational services or exceptional education services?
    ❒ No
    ❒ Yes **= (10)**

16. Where do you live?
    ❒ House/Mobile Home
    ❒ Apartment
    ❒ Homeless (includes shelter, hotel, motel) **= (20)**
    ❒ With other family members or friends **= (10)**

17. How many times have you moved in the last year?
    _____ **≥ 5 times = (10)**

18. Name address, and telephone number of parent, guardian, or person to contact in an emergency:
    _____
    _____
    Street Address
    _____
    City State Zip Code
    Telephone number: _____
    What relation is this person to you? _____

B. ABOUT THIS PREGNANCY

1. How far along are you now?
   ____ weeks (or) ____months
   ❒ I don't know

2. How far along were you when you started seeing a medical provider (doctor, nurse midwife or nurse practitioner) for prenatal care?
   ____ weeks (or) ____months
   ❒ I haven't seen anyone yet **13-15 wks. = (5)**
   ❒ I have an appointment **15-23 wks. = (10)**
   ≥24 wks. = (20)

3. Have you seen your medical provider at least monthly for this pregnancy?
   ❒ No **= (5)**
   ❒ Yes

4. Did this pregnancy come less than a year after your last pregnancy?
   ❒ No
   ❒ Yes **= (20)**

5. Are you pregnant with more than one baby?
   ❒ No
   ❒ Yes **= (10)**
   ❒ I don't know

6. Have you had any early signs of labor?
   ❒ No
   ❒ Yes **= (20)**

7. Have you gone to the emergency room or hospital for this pregnancy?
   ❒ No
   ❒ Yes **If visit was pregnancy related = (5)**

8. Would you like more information or help with any of these things?
   ❒ The baby's growth
   ❒ How to eat right during pregnancy
   ❒ What to expect during labor and delivery
   ❒ Breastfeeding
   ❒ How to take care of your infant or older children
   ❒ Family planning
   ❒ Other: _____

C. YOUR MEDICAL HISTORY

1. Do you have, or have you ever had any of these conditions? *(Please check the boxes that apply to you.)*
   ❒ Asthma and taking medication
   ❒ Chlamydia or gonorrhea (clap) **= (20)**
   ❒ Anemia (i.e., "low blood or iron" of pregnancy)
   ❒ Chronic kidney disease **= (20)**
   ❒ Diabetes **= (20)**
   ❒ Epilepsy or seizures **= (5)**
   ❒ Exposure to TB in your household
   ❒ Heart Disease **= (15)**
   ❒ Eating Disorder **= (10)**
   ❒ Hepatitis B **= (5)**
   ❒ High blood pressure during pregnancy (e.g., preeclampsia, toxemia) **= (20)**
   ❒ Kidney/bladder infections
   ❒ Mental health problems **= (10)**
   ❒ Physical or sensor disabilities (e.g., deaf or blind) **= (10)**
   ❒ Genetic disease (e.g., sickle cell, cystic fibrosis, PKU, hemophilia) **= (20)**
   ❒ Syphilis **= (20)**
   ❒ Genital herpes **= (20)**
   ❒ Other medical problem. If so, list them here:
   _____

2. How many times have you been pregnant before this pregnancy? _____ times **≥ 5 times = (20)**
   ❒ Never

3. Have you had any miscarriages?
   ❒ No
   ❒ Yes _____ How many? **≥ 3 = (10)**

4. Have you had any abortions?
   ❒ No
   ❒ Yes _____ How many? **≥ 3 = (10)**

(If this is the first time you have ever been pregnant, skip the questions below and answer the questions in Part D. Thank you.)

5. Have you had twins, or multiple births?
   ❒ No
   ❒ Yes

6. Have you ever had a C-section?
   ❒ No
   ❒ Yes **= (5)**

Key: > = *greater than*
< = *less than*

Points *(subtotal)*_____

7. Were any of your babies born more than 3 weeks early?
   - ☐ No
   - ☐ Yes How many?_____ = (20)

8. Did a doctor ever say you had premature labor that required bed rest, medication, and/or hospitalization?
   - ☐ No
   - ☐ Yes How many?_____ = (20)

9. Have you had a stillborn baby (born dead after 20 weeks), or that died soon after birth?
   - ☐ No
   - ☐ Yes How many?_____ = (20)

10. Did any of your babies weigh less than 5½ pounds at birth?
    - ☐ No
    - ☐ Yes How many?_____ = (20)

11. Did any weigh more than 10 pounds at birth?
    - ☐ No
    - ☐ Yes How many?_____ = (5)

12. Did any stay more than one day in a special care nursery?
    - ☐ No
    - ☐ Yes How many?_____ = (20)

13. When did you start prenatal care during your last pregnancy?
    - ☐ I did not continue with that other pregnancy
    - ☐ I did not get any prenatal care = (15)
    - ☐ 1st - 3rd month
    - ☐ 4th - 6th month = (10)
    - ☐ 7th - 9th month = (10)

D. TOBACCO, ALCOHOL, MEDICINES AND OTHER DRUGS

1. During the 3 months before you were pregnant, on average, how many cigarettes did you smoke a day?
   - ☐ More than 2 packs a day
   - ☐ 1 ½ or 2 packs a day
   - ☐ About a pack a day
   - ☐ About a half pack a day
   - ☐ About 4 or 5 cigarettes a day
   - ☐ I don't smoke

2. On average, how many cigarettes do you smoke a day now?
   - ☐ More than 2 packs a day = (20)
   - ☐ 1 ½ or 2 packs a day = (20)
   - ☐ About a pack a day = (20)
   - ☐ About a half pack a day = (20)
   - ☐ About 4 or 5 cigarettes a day (or 2 to 6) = (20)
   - ☐ I live with someone who smokes = (10)
   - ☐ I don't smoke

*We would like to ask you a few questions about drinking. It will help us take better care of you and your baby. Think back to 3 months **before** you became pregnant. Be sure to include beer, wine, and liquor in your answers to these questions.*

3. How many drinks does it take to make you feel high? _____ drinks > 2 = (20)
   - ☐ I never drink

4. How much can you hold? _____ drinks > 2 = (20)
   - ☐ I never drink
   - ☐ I don't know

5. Have people annoyed you by criticizing your drinking?
   - ☐ No
   - ☐ Yes = (20)
   - ☐ I never drink

6. Have you ever felt you ought to cut down on your drinking?
   - ☐ No
   - ☐ Yes = (20)
   - ☐ I never drink

7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
   - ☐ No
   - ☐ Yes = (20)
   - ☐ I never drink

8. **Since you became pregnant,** about how many days in a month do you have 3 or more drinks? (If none, write zero.) _____ days per month
   1 or more=(20)

9. **Since you became pregnant,** about how many days in a month do you have one or more drinks? (If none, write zero.) _____ days per month

10. Have you taken any prescription drugs since you became pregnant?
    - ☐ No
    - ☐ Yes

(Please list them here.)

_____

_____

Key: > = *greater than*
< = less than

Points *(subtotal)*_____

11. Have you taken any over-the-counter drugs since you became pregnant?
    - ❒ No
    - ❒ Yes

    (Please list them here.)

    _____

    _____

12. Have you ever injected a non-prescribed drug?
    - ❒ No *(Skip to question 15)*
    - ❒ Yes **= (20)**

13. Number of different persons with whom you shared intravenous drug needles or syringes, or "works" within the last:

    10 years _____ last 12 months _____

14. Do you think any of these persons were infected with HIV (the AIDS virus)?
    - ❒ No
    - ❒ Yes **= (20)**
    - ❒ I don't know

15. How often did you smoke marijuana or hash during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*
    - ❒ Several times a week **= (20)**
    - ❒ Several times a month **= (20)**
    - ❒ Occasionally, or rarely **= (20)**
    - ❒ Never

16. How often did you use cocaine or crack during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*
    - ❒ Several times a week **= (20)**
    - ❒ Several times a month **= (20)**
    - ❒ Occasionally, or rarely **= (20)**
    - ❒ Never

17. How often did you use heroin, speed, acid, amphetamines, PCP, inhalants, etc. during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*
    - ❒ Several times a week **= (20)**
    - ❒ Several times a month **= (20)**
    - ❒ Occasionally, or rarely **= (20)**
    - ❒ Never

E. NUTRITION

1. How much did you weigh before you became pregnant this time? _____ pounds
   How tall are you? _____ ft. _____ inches

   BMI <20 or >29 = (10)
   BMI >26 or <30 = (10)

2. What do you weigh now? _____

   Weight loss or no weight gain by second trimester = (10)
   Weight gain that falls above or below the appropriate weight gain grid shaded area = (5)

3. Have you ever vomited to control your weight or vomited to feel better after eating too much?
   - ❒ No
   - ❒ Yes

4. Do you vomit often now?
   - ❒ No
   - ❒ Yes **= (10)**

5. Are you having any of the following symptoms now:

Nausea	❒ No	❒ Yes
Heartburn	❒ No	❒ Yes
Constipation	❒ No	❒ Yes

6. When you were not pregnant, did you feel that your weight and your body shape were:
   - ❒ About right
   - ❒ Overweight/too large
   - ❒ Underweight/too small

7. Are you on a special diet now?
   - ❒ No
   - ❒ Yes Kind:_____

8. 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?
   - ❒ No
   - ❒ Yes **= (10)**

9. During the past month did you miss any meals or not eat when you were hungry because there wasn't enough food or money to buy food?
   - ❒ No
   - ❒ Yes **= (10)**

10. Do you have a working stove and refrigerator?
    - ❒ No **= (5)**
    - ❒ Yes

Key: > = *greater than*
< = less than

Points *(subtotal)*_____

Appendix 8
(Continued)

F. RELATIONSHIPS

1. How do you feel now about being pregnant?
   - ❒ Very happy
   - ❒ Unsure--a little bit happy and a little bit unhappy
   - ❒ Very upset about it = (10)

2. How does your husband or partner feel now about you being pregnant?
   - ❒ Very happy
   - ❒ Unsure--a little bit happy and a little bit unhappy
   - ❒ Very upset about it = (10)
   - ❒ He doesn't know I'm pregnant = (10)

3. How often did you feel depressed during the last week?
   - ❒ Rarely (less than 1 day)
   - ❒ Some of the time (1-4 days)
   - ❒ Most or all of the time (5-7 days) = (20)

4. How many living children do you have? _____

5. How many of them are living in your household now?
   _____

6. Within the last 12 months, have any of your children been taken from you?
   - ❒ No
   - ❒ Yes = (10)

7. Have you had sexual contact with any of following:

HIV Infected partner?	❒ No	❒ Yes = (40)	❒ Not Sure
An IV drug user?	❒ No	❒ Yes = (40)	❒ Not Sure
A bisexual partner?	❒ No	❒ Yes = (40)	❒ Not Sure
A hemophiliac?	❒ No	❒ Yes = (40)	❒ Not Sure

8. Have you given or received money or drugs for sex?
   - ❒ No
   - ❒ Yes = (40)

9. Does your partner have a problem with alcohol or other drugs?
   - ❒ No
   - ❒ Yes = (5)

10. Does anyone else in your family have a problem with alcohol or other drugs?
    - ❒ No
    - ❒ Yes = (5)

    What relation is this person to you?
    _____

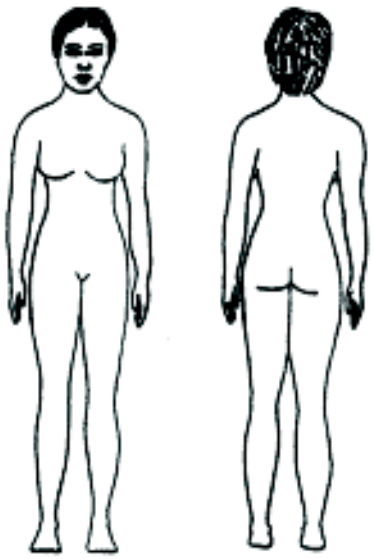
11. Have you **ever** been emotionally, verbally or physically abused by your partner or someone close to you?
    - ❒ No
    - ❒ Yes = (10)

12. Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone close to you?
    - ❒ No
    - ❒ Yes

13. Since you have been pregnant, were you hit, slapped or kicked, or otherwise physically hurt by someone?
    - ❒ No
    - ❒ Yes = (10)

    If yes, by whom?_____

Mark the place on the picture of the woman to show where you have been hurt by your partner or someone close to you.



Adapted from the March of Dimes

14. Has anyone forced you to have sexual contact?
    - ❒ No
    - ❒ Yes = (10)

    If yes, by whom?_____

Key: > = *greater than*
< = less than

Points *(subtotal)*_____

15. Have other family members been sexually assaulted or abused?
    - ❒ No
    - ❒ Yes

16. Are you afraid of your partner or anyone else?
    - ❒ No
    - ❒ Yes = **(10)**

17. Is there a gun in your home?
    - ❒ No
    - ❒ Yes

18. Is there someone you can talk to when you a have a problem?
    - ❒ No = **(10)**
    - ❒ Yes

19. How many people can you really count on when you need help?
    - ❒ No one = **(10)**
    - ❒ 1 - 2 persons
    - ❒ 3 or more persons

    List:_____

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

G. WORRIES

1. Which of these things worry you a lot? *(Check the ones that are big problems.)*
    - ❒ Money problems = **(1)**
    - ❒ Labor and delivery
    - ❒ Transportation = **(1)**
    - ❒ Losing this baby = **(1)**
    - ❒ My job = **(1)**
    - ❒ Caring for this baby
    - ❒ My partner's job, or unemployment = **(1)**
    - ❒ Caring for my other children = **(1)**
    - ❒ Housing problems/getting evicted = **(1)**
    - ❒ Getting child care = **(1)**
    - ❒ My partner's drinking or drug use = **(1)**
    - ❒ My health = **(1)**
    - ❒ My own drinking or drug use = **(1)**
    - ❒ My own safety = **(1)**
    - ❒ Worry about my relationship with my partner= **(1)**
    - ❒ Worry whether this baby will be all right = **(1)**
    - ❒ My partner is in jail = **(5)**

2. How often do you have problems getting transportation?
    - ❒ Very seldom
    - ❒ Occasionally
    - ❒ Quite often = **(5)**
    - ❒ Most of the time = **(15)**

    Please write down here anything else that worries you a lot:

Staff Signature/Date

Points **(subtotal)**_____

Total ***(all pages)***_____

Key: > = *greater than*
< = less than

Appendix 9

Instructions for Completing the Pregnancy Questionnaire

As much as possible, please ask the questions exactly as they are stated on the Pregnancy Questionnaire. This is especially important when you ask the alcohol-related questions (D.3 through D.9). If the woman appears not to understand what you are asking, you may rephrase the question (except for questions D.3 through D.9). However, please be very careful not to change the meaning of the questions.

You are required to complete and score the entire questionnaire, unless the woman refuses to answer a particular question(s).

Providers may consult the Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire for additional, detailed information on administering the questionnaire. Refer to Appendix 16 of this handbook for information on obtaining the manual.

SECTION A. GENERAL INFORMATION
The purpose of this section is to identify socio-demographic risk factors.

1. Name and address.
Record the woman's name and address.

2&3.*Date of birth and age.
Verify consistency of answers.

4. Medicaid Identification Number.
Record the woman's Medicaid number.

5.* Telephone number.
Check "No phone" if she only has a work number.

6. How can we contact you?
Check all that apply.

7.* Are you single (never married, separated, divorced, widowed) or married?
If the woman indicates that her marriage is not stable, check single.

8. Your race/ethnic origin.
Check the appropriate box.

9. Do you speak English?
Check the appropriate box.

10.*Do you read English?
Check the appropriate box.

11. Are you in a WIC program?
Check the appropriate box.

12. What are your sources of income?
Check only those that are consistent sources.

13. Are you employed?
If she is both a student and employed, check both.

14.*What was the last grade you finished in school? If in school now, do you attend regularly?
Record the last grade completed and check the appropriate box.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

Appendix 9
(Continued)

15.*Have you in the past, or are you currently receiving special education services or exceptional education services?
Check "yes" no matter what type of special or exceptional education service(s) she received or is receiving.

16.*Where do you live?
Check the appropriate box.

17.*How many times have you moved in the last year?
Include temporary relocations that were not visits. For example, include a three-week stay with a family member/friend while looking for a place to live. Do not include a two-month stay with an ill family member or friend.

18. Name, address, and telephone number of parent, guardian, or person to call in an emergency.
Record the information the woman provides.

SECTION B. ABOUT THIS PREGNANCY
The purpose of this section is to obtain information about risk factors related to the adequacy of care and to identify early signs of complications.

1. How "far along" are you now?
Record the information provided.

2.* How far along were you when you started seeing a health care provider for prenatal care?
Record the information provided.

3.* Have you seen your health care provider at least monthly for this pregnancy?
Check the appropriate box.

4.* Did this pregnancy come less than a year after your last pregnancy?
Check the appropriate box.

5.* Are you pregnant with more than one baby?
Check "yes" only if a health care provider gave her confirmation.

6.* Have you had any early signs of labor?
Check the appropriate box.

7.* Have you gone to the emergency room or hospital for this pregnancy?
Check "yes" only if the visit was pregnancy-related.

8. Would you like more information or help with any of these things?
Check all that apply. Write down any additional information.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

SECTION C. MEDICAL HISTORY

The purpose of this section is to obtain information about the woman's medical and child bearing history and to identify past or current medical conditions that may influence the outcome of her pregnancy.

1.* Do you have, or have you ever had, any of these conditions?
For the medical conditions, check only if she indicates that a health care provider confirmed the condition.

2.* How many times have you been pregnant before this pregnancy?
Record the number of confirmed pregnancies.

3.* Have you had any miscarriages?
Record the number of miscarriages.

4.* Have you had any abortions?
Record the number of induced abortions.

5. Have you had twins or multiple births?
Check the appropriate box.

6.* Have you ever had a C-Section?
Check the appropriate box.

7.* Were any of your babies born more than 3 weeks early?
Check the appropriate box.

8.* Did a doctor ever say you had premature labor that required bed rest, medication, and/ or hospitalization?
Check the appropriate box.

9.*Have you had a stillborn baby (born dead after 20 weeks), or that died soon after birth?
Check the appropriate box.

10.*Did any of your babies weigh less than $5^{1/2}$ pounds at birth?
Check the appropriate box.

11.*Did any weigh more than 10 pounds at birth?
Check the appropriate box.

12.*Did any stay more than one day in a special care nursery?
Check the appropriate box.

13.*When did you start prenatal care during your last pregnancy?
Check the appropriate box.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

SECTION D. TOBACCO, ALCOHOL, MEDICINES, & OTHER DRUGS

The purpose of this section is to obtain information about the woman's use of tobacco, alcohol, illicit drugs or medication.

1. During the 3 months before you were pregnant, on average, how many cigarettes did you smoke a day?
Check the appropriate box.

2.* On average, how many cigarettes do you smoke a day now?
Check the appropriate box.

Do not rephrase Questions D.3 through D.9.

3.* How many drinks does it take to make you feel high?
"High" is subjective. Accept her interpretation.

4.* How much can you hold?
"Hold" is subjective. Accept her interpretation.

5.* Have people annoyed you by criticizing your drinking?
Check the appropriate box.

6.* Have you ever felt you ought to cut down on your drinking?
Check the appropriate box.

7.* Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Check the appropriate box.

8.* Since you became pregnant, about how many days in a month do you have 3 or more drinks?
Record the number of days.

9. Since you became pregnant, about how many days in a month do you have one or more drinks?
Record the number of days.

10. Have you taken any prescription drugs since you became pregnant?
Check the appropriate box.

11. Have you taken any over-the-counter drugs since you became pregnant?
Check the appropriate box.

12.*Have you ever injected a non-prescribed drug?
Check the appropriate box.

13. Number of different persons with whom you shared intravenous drug needles or syringes, or "works" within the last 10 years...last 12 months.
Record the number of persons for each.

14.*Do you think any of these persons were infected with HIV (the AIDS virus)?
Check the appropriate box.

15.*How often did you smoke marijuana or hash during the 3 months before you found out that you were pregnant?
Check the appropriate box.

16.*How often did you use cocaine or crack during the 3 months before you found out that you were pregnant?
Check the appropriate box.

17.*How often did you use heroin, speed, acid, amphetamines, PCP, inhalants, etc., during the 3 months before you found out that you were pregnant?
Check the appropriate box.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

SECTION E. NUTRITION

The purpose of this section is to obtain information about the woman's current nutritional status.

1.* How much did you weigh before you became pregnant this time? How tall are you?
Record the woman's pre-pregnancy weight and height. (To assess and categorize the woman's pre-pregnancy weight, use the Body Mass Index Grid in the Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire.)

2.* What do you weigh now?
Record the woman's weight.

3. Have you ever vomited to control your weight or vomited to feel better after eating too much?
Check the appropriate box.

4.* Do you vomit often now?
"Often" is subjective. Accept her response.

5. Are you having any of the following symptoms now:
Nausea, Heartburn, Constipation
Check the appropriate box.

6. When you were not pregnant, did you feel that your weight and your body shape were: about right, overweight/too large, underweight/too small?
Check the appropriate alternative.

7. Are you on a special diet now?
Check the appropriate box.

8.* 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?
Check "yes" if she indicates that she has eaten nonfood items just before or during the pregnancy.

9.* During the past month did you miss any meals or not eat when you were hungry because there wasn't enough food or money to buy food?
Check the appropriate box.

10.*Do you have a working stove and refrigerator?
Check "no" if one or the other is not working.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

SECTION F. RELATIONSHIPS

The purpose of this section is to obtain information about the woman's social support network (husband, partner, parents, other family, friends, and neighbors), her feelings of self-worth, competency, and personal safety.

1.* How do you feel now about being pregnant?
Check the appropriate box.

2.* How does your husband or partner feel now about you being pregnant?
Check the appropriate box.

3.* How often did you feel depressed during the last week?
Check the appropriate box.

4. How many living children do you have?
Record the number of children.

5. How many of them are living in your household now?
Record the number of children living in the household.

6.* Within the past 12 months, have any of your children been taken from you?
Check the appropriate box.

7.* Have you ever had sexual contact with any of the following: HIV-infected partner, IV drug user, bisexual partner, hemophiliac?
Check the appropriate box.

8.* Have you given or received money or drugs for sex?
Check the appropriate box.

9.* Does your partner have a problem with alcohol or other drugs?
"Problem" is subjective. Accept her response.

10.*Does anyone else in your family have a problem with alcohol or other drugs? What relation is this person to you?
Check the appropriate box. Include persons who are not "blood" relatives but who were raised as relatives.

11.*Have you ever been emotionally, verbally, or physically abused by your partner, or someone close to you?
Check the appropriate box.

12. Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone close to you?
Check the appropriate box.

13.*Since you have been pregnant, were you hit, slapped, or kicked, or otherwise physically hurt by someone?
Check the appropriate box.

Note: Individuals whose employment brings them into contact with children under the age of 18 are required by law (Wisconsin Child Abuse Act) to report, to their county child protection/ social service agency, any suspected abuse or neglect or a belief that abuse or neglect will occur.

14.*Has anyone forced you to have sexual contact?
Check the appropriate box.

15. Have other family members been sexually assaulted or abused?
Check the appropriate box.

16.*Are you afraid of your partner or anyone else?
Check the appropriate box.

17. Is there a gun in your home?
Check the appropriate box.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

18.*Is there someone you can talk to when you have a problem?
Check "yes" if the person is a consistent source. For example, their hairdresser or the mail carrier would not count.

19.*How many people can you really count on when you need help?
Check the appropriate box.

20. What do you do to deal with your problems?
Record the response.
This open-ended question provides the woman with an opportunity to share her strengths.
Understanding her strengths will help you develop a realistic care plan with her.

SECTION G. WORRIES

The purpose of this section is to identify areas of worry for the pregnant woman.

1.* Which of these things worry you a lot?
Check only those items that are significant problems.

2.* How often do you have problems getting transportation?
This question relates to transportation to carry out activities of daily living, including:

- Grocery shopping.
- Medical and nonmedical appointments.
- Visits to obtain/maintain a support system.

Additional worries.
Allow the woman to identify any additional concerns. Although answers are not scored, this will allow both of you to understand all the issues she is facing during her pregnancy.

Please note:
All of the questions are integral to assessing the woman's situation. The questions marked with an asterisk (*) are scored on the Pregnancy Questionnaire.

Appendix 10

Pregnancy Questionnaire Summary (Sample Format)

(For the Prenatal Care Coordinator to complete)

Mother's name (last, first, middle): Please print. _____

Mother's date of birth: _____ Medicaid ID #: _____

TOTAL ASSESSMENT SCORE: _____

Summary of needs identified in the Pregnancy Questionnaire:

- ☐ Health education needs (teenaged or older mom)
- ☐ Difficulty reading English (preferred language? _____)
- ☐ WIC referral
- ☐ Child support difficulty
- ☐ Employment needs
- ☐ School needs
- ☐ Housing needs
- ☐ Client unable to get prenatal care
- ☐ Lack of knowledge regarding pregnancy, labor & delivery, infant health care, general health positive habits
- ☐ Health education needs (first-time mom)
- ☐ Medical conditions identified that make this pregnancy at risk
- ☐ Poor previous pregnancy experience
- ☐ Tobacco and/or alcohol use
- ☐ Nutrition education needs
- ☐ Insufficient funds for food
- ☐ Conflict/violence in the home
- ☐ Poor support system
- ☐ Suspected abuse: ☐ physical ☐ sexual ☐ emotional
- ☐ Family has urgent health needs
- ☐ Child care needs
- ☐ Transportation needs
- ☐ Other _____

Name of staff who completed the Pregnancy Questionnaire: _____

Position: _____ Date of screening: _____

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Appendix 11

Referral Form (Sample Format)

Client's Name: _____ Date of Referral: _____
Medicaid ID Number:_____ Address_____
Birthdate:_____ _____
Telephone Number:_____ _____

Referral To: [*Service provider's name, address, and telephone number*]

_____

_____

_____

Referred By: [*Service provider's name, address, and telephone number*]

_____

_____

_____

Reason for Referral: _____

_____

_____

_____

Authorization: I, _____ [*Client's Name*], give my permission to _____ [*Service Provider's Name*], to release this information to _____ [*Care Coordination Provider's Name*]. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of client/parent or guardian: _____

Date: _____

Service Provider's Reply (summary of findings, diagnosis, recommendations, comments, as appropriate):

Signature: _____ Date: _____

Appendix 12

Informed Consent to Release/Obtain Health Care Information Form (Sample Format)

Agency Name: _____ Telephone Number: _____

Address: _____

_____

Client's Name: _____ Medicaid ID Number: _____

Address: _____ Date of Birth: _____

_____

Telephone Number: _____

I, _____ (*print client's name*), give consent for _____ (*print name of care coordination provider)* to release health/social services information to, and obtain information from, _____ (*print name of other provider/agency to which, or from which, you are requesting information)* for the person named above. The information is to be used to assist me in monitoring and coordinating health care and social services.

The information to be disclosed includes:

_____

_____

_____

Do not disclose the following information:

_____

_____

_____

This authorization shall be valid from the signature date until _____ (*print the date*), and may be revoked by me at any time (except as it has already been used).

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Appendix 13
Care Plan (Sample Format)

Recipient Name _____ Medicaid ID number _____ Agency Name _____

Psychosocial Assessment	Yes	No
1. Recipient Very Concerned About Pregnancy		
2. Poor Previous Pregnancy Experience		
3. Poor Support System		
4. Depression, Other Mental Health Issues		
5. Drugs/Alcohol/Tobacco Usage		
6. Religious/Ethnic/Cultural Factor Affecting Pregnancy		

Recipient's Chief Concern	Yes	No		Yes	No
7. Conflict/Violence in the Home			13. Child Care Needs		
8. Unable to get Prenatal Care			14. Housing Needs		
9. Family has Urgent Health Needs			15. Transportation Needs		
10. Insufficient Funds for Food			16. School Needs		
11. Difficulty Obtaining Food Stamps			17. Employment Needs		
12. Difficulty Enrolling in WIC			18. Child Support Difficulty		

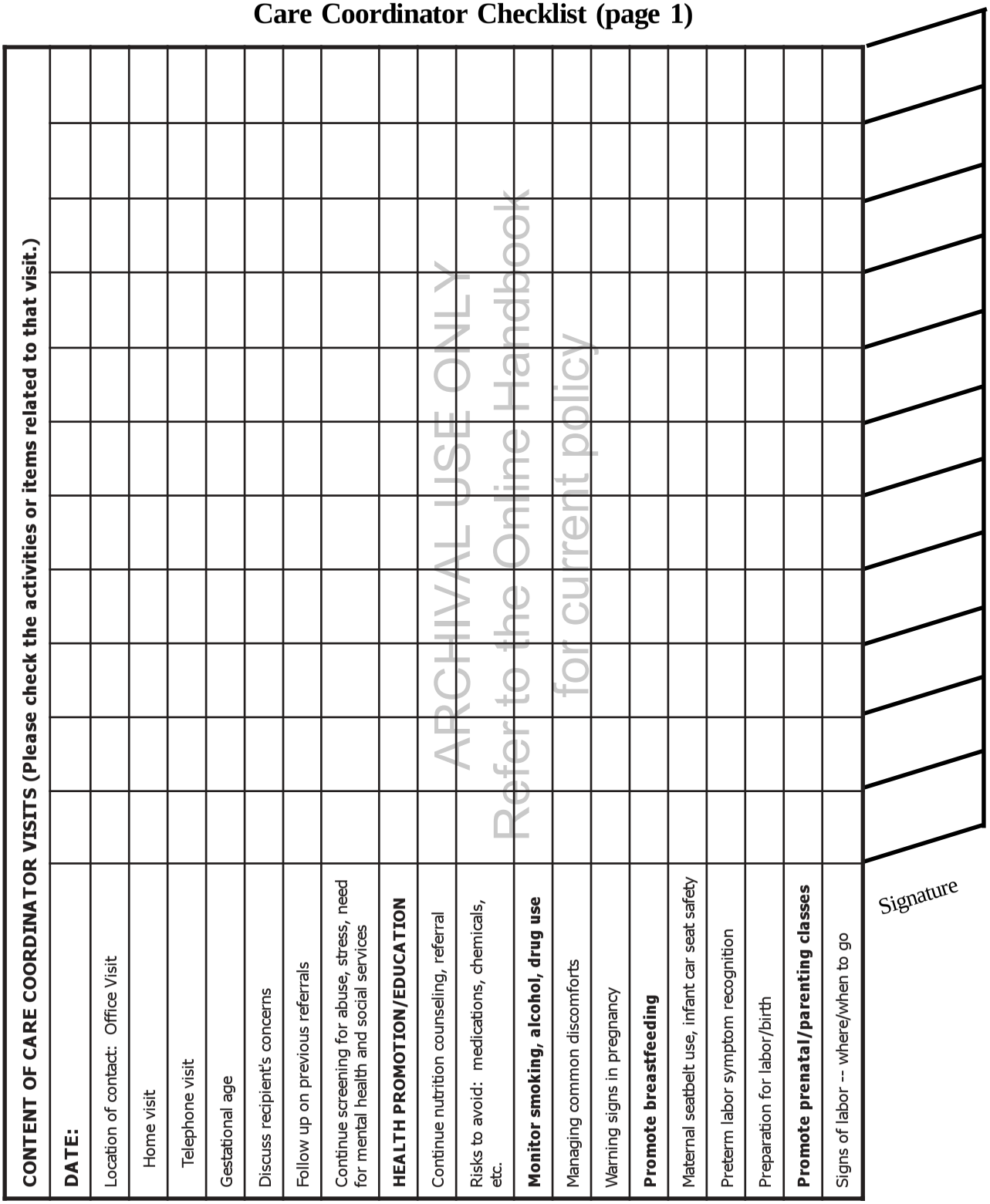
PREGNANCY OUTCOME
Date
Pregnancy Ended _____
Postpartal/Family Planning Visit _____
Postpartal/WIC Certification _____
Infant Certified for WIC _____
HealthCheck Referral _____
Closed for Care Coordination Services _____

Problems/Concerns	Date Detected	Gestational Age	Actions Taken	Resolved/Improved?
POSTPARTUM VISITS AND INFANT CARE REFERRAL				

Appendix 13
(Continued)

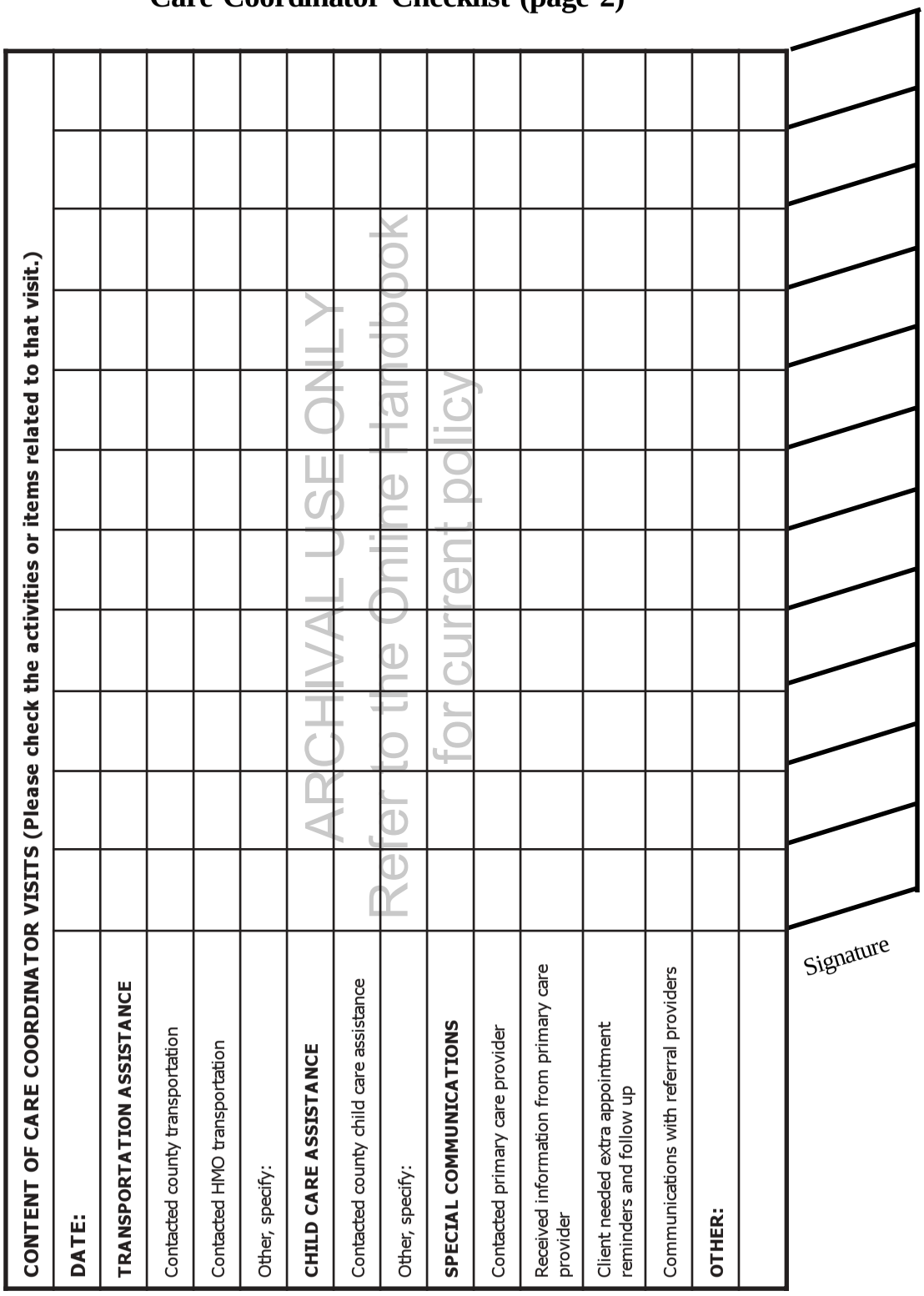
Recipient's name: _____ Medicaid ID number:_____ Agency name:_____

Care Coordinator Checklist (page 1)



CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)																					
DATE:																					
Location of contact: Office Visit																					
Home visit																					
Telephone visit																					
Gestational age																					
Discuss recipient's concerns																					
Follow up on previous referrals																					
Continue screening for abuse, stress, need for mental health and social services																					
HEALTH PROMOTION/EDUCATION																					
Continue nutrition counseling, referral																					
Risks to avoid: medications, chemicals, etc.																					
Monitor smoking, alcohol, drug use																					
Managing common discomforts																					
Warning signs in pregnancy																					
Promote breastfeeding																					
Maternal seatbelt use, infant car seat safety																					
Preterm labor symptom recognition																					
Preparation for labor/birth																					
Promote prenatal/parenting classes																					
Signs of labor -- where/when to go																					
Signature																					

Care Coordinator Checklist (page 2)



CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)																
DATE:																
TRANSPORTATION ASSISTANCE																
Contacted county transportation																
Contacted HMO transportation																
Other, specify:																
CHILD CARE ASSISTANCE																
Contacted county child care assistance																
Other, specify:																
SPECIAL COMMUNICATIONS																
Contacted primary care provider																
Received information from primary care provider																
Client needed extra appointment reminders and follow up																
Communications with referral providers																
OTHER:																

Signature

Appendix 14

Prenatal Care Coordination Monthly Time Log for Ongoing Care Coordination and Monitoring (Completed Sample Format)

Client (Last, First, MI): Recipient, Im A.	**Month:** 02 **Year**: 99
Wisconsin Medicaid ID Number: 1234567890	**Care Coordinator--** **Name**: Jayne Smith **Title**: Registered Nurse
Agency: Care Coordination Agency	

Description Codes (to be used in the second column below)
RF=Recipient Contact - Face-to-Face **CF=Collateral Contact - Face-to-Face**
RT=Recipient Contact - Telephone **CT=Collateral Contact - Telephone**
S=Staffing/Consultations **R=Recordkeeping**

Date	Code	Place of Service	Hours	Minutes	Documentation of Activities/Signature
2/3/1999	RF	Recipient Home	1		Discussed care plan and arrangements for transportation for prenatal checkup, discussed recipient concerns about pregnancy, housing, clothing for recipient. *J.S., R.N.*
2/4/1999	CT	Office		15	Talked to sister of recipient, confirmed appointment and transportation to WIC office/nutrition counseling. *J.S., R.N.*
2/5/1999	R	Office		15	Chart notations related to 2/3-2/4 contact with recipient. *J.S., R.N.*
2/12/1999	S	Office		15	Discussed case with PNCC supervisor. *J.S., R.N.*
2/21/1999	RF	Office	1	30	Prenatal health education (one-on-one with recipient) pregnancy anatomy/physiology: body changes, discomfort management, danger signs, fetal development. *J.S., R.N.*

Monthly Total 3 hrs., 15 min. **Total Units 3.3**
Refer to Appendix 6 of this handbook for rounding guidelines

Appendix 15

Memorandum of Understanding (Sample Format)

Health Care Provider and Prenatal Care Coordination Agency

Prenatal care coordination (PNCC) is a service covered by Wisconsin Medicaid for all recipients. Successful provision of this service to individual recipients requires cooperation, coordination, and communication between the health care provider and the PNCC agency. The PNCC agency is responsible for outreach, risk assessment, care planning, care coordination, and follow up to support high-risk women. The health care provider is responsible for providing medically necessary services.

The health care provider and the PNCC provider agree to facilitate effective communication between agencies, work to resolve interagency coordination and communication problems, and inform staff from both the health care provider and the PNCC agency about the policies and procedures for this cooperation, coordination, and communication.

Recognizing that these "clients-in-common" are at high risk for poor birth outcomes, the health care provider and the PNCC provider agree to cooperate in removing access barriers, coordinating care, and providing culturally competent services.

This agreement becomes effective on the date the PNCC agency is certified by Wisconsin Medicaid or on the date when both the HMO and the PNCC agency have signed, whichever is later. It remains in effect until it is cancelled in writing with two weeks' notice by either signer.

Name of Health Care Provider or HMO	**Name of PNCC Agency**
Authorizing Signature	Authorizing Signature
Title	Title
Date	Date

Appendix 16

Prenatal Care Coordination Resource Guide

Resources Available Directly from State Agencies

1. Division of Health Care Financing Publications *- Available from the Division of Health Care Financing at the address listed below. There is no charge for the documents below.*

Title	Document #
Pregnancy Questionnaire (Risk Assessment Form)	HCF 1105
Guidance Manual for the Pregnancy Questionnaire	POH 1043
HealthCheck Brochure (Spanish)	POH 1007S
HealthCheck Brochure (Hmong)	POH 1007H
HealthCheck Brochure (English)	POH 1007
HealthCheck Poster (81/2 x 14)	POH 1041
HealthCheck Check Stuffer/Handbill	POH 1041A
HealthCheck Stickers	POH 1041C

Available from: Division of Health Care Financing
Bureau of Fee-for-Service Health Care Benefits
Attn: Forms Manager
P. O. Box 309
Madison, WI 53701-0309

2. Division of Public Health Publications *- Available from the Department of Health and Family Services Forms Center at the address listed on the next page. There is minimal or no charge for the documents below.*

Family Health Resource Catalog (a list of maternal and child health education materials)	PPH 4536
If I'm Pregnant, Can the Chemicals I Work with Harm my Baby?	DPH 7074
Prenatal Weight Gain Grid	DOH 4056
Planning a Healthy Pregnancy: Self Care Handbook	PPH 9322
Planning a Healthy Pregnancy: Self Care Handbook (Spanish)	PPH 9322-S

Title	Document #
Caring for Your Baby: A Newborn and Infant Care Handbook	PPH 9321
Caring for Your Baby: A Newborn and Infant Care Handbook (Spanish)	PPH 9321-S
Healthy Start Brochure (Spanish)	PPH 0054
Healthy Start Brochure (English)	PPH 0051
Healthy Start Poster (Spanish)	PPH 0055
Healthy Start Poster (English)	PPH 0051A

Available from: Department of Health and Family Services Forms Center
P.O. Box 7850
Madison, WI 53701-7850

Resources Available from Other Organizations

3. Children's Trust Fund *- There is no charge for these documents.*

- Information on child abuse and neglect

- Positive Parenting Kit (parenting booklet that gives insightful hints on how to "catch your kid being good")

Available from: Children's Trust Fund
110 E. Main St., Suite 614
Madison, WI 53703
(800) 262-9922 extension "KIDS" or (608) 266-6871

Hotline Phone Numbers

1. Wisconsin First Step/Children with Special Health Care Needs.....(800) 642-7837

2. Maternal and Child Health Hotline ..... (800) 722-2295
   (Provides information on services for women and children throughout Wisconsin, including WIC, Healthy Start, and HealthCheck)

3. Wisconsin AIDS Hotline ..... (800) 334-2437
   Milwaukee Area ..... (414) 273-2437

4. Wisconsin Medicaid Recipient Hotline ..... (800) 362-3002
   Madison Area ..... (608) 221-5720

Appendix 17

Information Regarding Transportation to Medical Appointments

Although transportation is not a covered service for prenatal care coordination (PNCC) providers, providers often assist recipients with making transportation arrangements. This appendix contains information to help providers understand the transportation options.

Three types of transportation are possible for eligible recipients to and from Medicaid-covered services:

- Common carrier vehicles.
- Specialized medical vehicles (SMVs).
- Ambulances.

All providers may be asked to verify that a Medicaid recipient received Medicaid-covered services at their site on a particular date.

Common Carrier Vehicles

A common carrier is any mode of transportation (for example, taxi, bus, car, or van) other than an ambulance or SMV approved by the county or tribal agency to a Medicaid-covered service.

Common Carrier Transportation for Fee-for-Service Recipients

If the county or tribal human or social services department authorizes common carrier transportation, it will either arrange for transportation or reimburse recipients for a portion of travel costs to and from Medicaid-covered services. Recipients are required to contact their human or social services department *before* the trip.

Prenatal care coordination providers who assist recipients with transportation arrangements are encouraged to find the least expensive, but most appropriate, means of transportation. The human or social services department has the right to pick the least expensive transportation and may choose to cover transportation to the closest medical provider who can provide the service. The recipient may be authorized to use her car, or a friend's car, and be reimbursed for mileage. Providers should refer recipients to their human or social services department for additional information.

There is no recipient copayment for this mode of transportation.

Common Carrier Transportation for Some Medicaid HMO Enrollees

At the time of the publication of this handbook, all Medicaid HMOs in Milwaukee County have contracts to provide common carrier transportation for their Medicaid enrollees. Transportation through the HMO is also limited to a trip to and from Medicaid-covered services. A few other counties also subcontract with some Medicaid HMOs for common carrier transportation services.

If a Medicaid recipient enrolled in an HMO is in a county other than Milwaukee County, refer her to the local county or tribal human or social services department. The county or tribal human or social services department authorizes transportation services for HMO enrollees the same as for fee-for-service recipients as described earlier in this appendix.

Specialized Medical Vehicles

Transportation by common carrier meets the needs of most recipients. However, Wisconsin Medicaid covers transportation by an SMV if the recipient meets all of the following criteria:

- The recipient is legally blind, or indefinitely or temporarily disabled.
- Cannot use any other means of transportation, as documented in writing by a physician.

If the recipient does not have a documented disability, refer her to the local county or tribal human or social services department for transportation by common carrier.

Transportation by an SMV is available only for trips to and from a Medicaid-covered service. Providers should refuse to sign the certification form if they believe the person is not qualified for SMV transportation or if the recipient has not been sufficiently evaluated to determine the need for SMV transportation.

For long-distance travel (more than 40 miles urban, more than 70 miles rural), the provider needs to get prior authorization from Wisconsin Medicaid before the trip. Recipients may call Recipient Services at (800) 362-3002 or (608) 221-5720 for a list of Medicaid-certified SMV providers in their area or for additional information.

Recipients enrolled in a Medicaid HMO should contact the HMO directly.

There is a $1 recipient copayment per one-way trip.

Ambulance Transportation

Wisconsin Medicaid covers ambulance transportation only when the recipient cannot be transported by any other means to emergency medical care as the result of illness or accident. In non-emergency situations, Wisconsin Medicaid covers ambulance transportation when the recipient's medical condition prevents transportation to Medicaid-covered services by any other means. A physician's prescription is required prior to the trip, indicating that an ambulance transfer is necessary.

There is a $2 copayment for non-emergency ambulance service.

Reimbursement

Ambulance and SMV transportation for HMO recipients is included in Medicaid HMO contracts. For fee-for-service recipients, Wisconsin Medicaid reimburses ambulance and SMV providers directly for their services.

Appendix 17
(Continued)

Quick-Reference Transportation Services Guide

	Common Carrier	Specialized Medical Vehicles	Emergency Ambulance	Non-emergency Ambulance
Who is eligible	All recipients	Legally blind, indefinitely or temporarily disabled	Seriously ill or injured	Recipients whose medical condition precludes transport by any other means
Authorized/ certified by	County/ tribal agency	Physician/ physician extender*	Not needed	Physician/ physician extender**
Contact	County/ tribal agency	SMV company	Ambulance company	Ambulance company
Copayment	No copayment	$1 copayment per one-way trip	No copayment	$2 copayment per trip

*Physician extender includes physician assistants, nurse midwives, and nurse practitioners.
**Physician extender includes dentists, physician assistants, nurse midwives, and nurse practitioners.

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Appendix 18

Comprehensive Agency Outreach and Case Management Plan Requirements

Per HFS 105.52, Wis. Admin. Code, an agency must submit an outreach plan to receive certification for providing prenatal care coordination (PNCC) services. To be approved, the plan must, at a minimum:

1. Document that the agency is located in the area it will serve.

2. Document that the agency employs at least one qualified professional with at least two years' experience coordinating services for at-risk or low-income pregnant women.

3. Indicate that a qualified professional will be on staff, under contract, or available in a volunteer capacity to supervise the risk assessment and ongoing care coordination and monitoring. Qualified professionals include:

   - A nurse practitioner licensed as a certified nurse pursuant to s. 441.06, Wis. Stats., and currently certified by the American Nurses' Association, the National Board of Pediatric Nurse Practitioners and Associates, or the Nurses' Association of the American College of Obstetricians and Gynecologists' Certification Corporation.
   - A nurse midwife certified under HFS 105.201, Wis. Admin. Code.
   - A public health nurse meeting the qualifications of HFS 139.08, Wis. Admin. Code.
   - A physician licensed under ch. 448, Wis. Stats., to practice medicine or osteopathy.
   - A physician assistant certified under ch. 448, Wis. Stats.
   - A dietitian certified or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association with at least two years of community health experience. (Per proposed rule change, the following is also acceptable: A dietitian certified by the State of Wisconsin [CD] or registered by the American Dietetic Association [RD] with at least 2 years of community health experience.)
   - A certified nurse with at least two years of experience in maternity nursing and/or community health service.
   - A social worker with at least a bachelor's degree and two years of experience in a health care or family services program.
   - A health educator with a master's degree in health education and at least two years of experience in community health services.

4. Document that the agency has on staff, under contract, or available in a volunteer capacity an individual(s) with the expertise necessary to provide health education and nutrition counseling. The individual must be a qualified professional as defined above and have the demonstrated ability, based on education or at least one year of experience, to provide health education and nutrition counseling.

5. Document that the agency has a variety of techniques to identify low-income pregnant women. For example, the agency could indicate that it has developed or is in the process of developing a working relationship with local health care and social service providers, Women, Infants and Children Supplemental Nutrition Program (WIC), the local human or social services department, an Early Identification of Pregnancy program, and the local high school.

6. Identify the name, address, and the telephone number of the following local resources:

   - WIC.
   - Maternal and child health services.
   - The county, city, or combined city and county public health agency.
   - Child day care services.

- Mental health and substance abuse (alcohol or other drug abuse) prevention and treatment agencies.
- The county protective service agency.
- Domestic abuse agencies.
- Translator and interpreter services, including services for the hearing impaired.
- Family support services.
- Transportation services (for example, local county transportation or volunteer services).

7. Document that the agency has identified Wisconsin Medicaid-certified primary health care providers (e.g., certified nurse midwives, nurse practitioners, physicians) in the agency's locality, has referral relationships with them, and the providers have agreed to serve the recipients.

   Agencies located in counties with Wisconsin Medicaid HMOs must have on file a signed copy of a Memorandum of Understanding (MOU) with each HMO.

8. Document that the agency has experience dealing with the racial/ethnic group(s) with which it intends to work. This documentation could include one or more of the following:

   - Records showing the racial and ethnic breakdown of the population that the agency served in the past.
   - Records showing the agency has developed, implemented, and evaluated programs specifically targeted toward the ethnic/racial group(s).
   - Records showing the agency has provided health care services in a geographic area where a significant percentage of the population was the same as the agency's targeted racial or ethnic group(s).
   - Evidence that the agency's board of administration has a significant amount of representation from the targeted group(s).
   - Letters of support from minority health service organizations which represent the target groups.
   - Evidence of the agency's ability to address pertinent cultural issues such as cultural norms and beliefs, language, outreach, networking, and extended family relationships.

9. Describe the agency's ability to arrange for supportive services provided by other funding sources such as county transportation, county protective services, interpreter services, child care services, and housing. This documentation should include the methods, techniques, and contacts which will be used to offer and provide assistance in accessing these services.

10. Document that the agency has the capability to provide ongoing PNCC and monitoring of high-risk pregnant women to ensure that all necessary services are obtained.

These requirements are the standard certification expectations. Agencies may apply for certification if they do not meet these standards. Application approval in such cases depends on the agency's demonstration that it has developed reasonable alternative means to assure adequacy and quality of the PNCC services.

Appendix 19

Medicaid Maximum Fee Schedule for Prenatal Care Coordination Services

The following reimbursement rates are effective as of July 1, 2000. The reimbursement rates are subject to change. To obtain the most current reimbursement rates in the future, providers may:

- Purchase a paper schedule by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Road
  Madison, WI 53784-0006

- Download an electronic version from Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/* using instructions found in the Claims Submission section of the All-Provider Handbook.

The following limitations apply:

- The limit for prenatal care coordination (PNCC) services (W7090-W7094) is $868.60 per recipient, per pregnancy.
- The limit for ongoing care coordination and monitoring, health education, and nutrition counseling (procedure codes W7092-W7094) is $774.02 per recipient, per pregnancy.

Maximum allowable fees are effective as of July 1, 2000.

Procedure Code	Procedure Description	Maximum Allowable Fee
W7090	Risk Assessment	$47.29
W7091	Initial Care Plan Development	$47.29
W7092	Ongoing Care Coordination and Monitoring	$31.52
W7093	Health Education/Nutrition Counseling - Individual	$31.52
W7094	Health Education/Nutrition Counseling - Group	$6.30

Providers are required to bill their usual and customary charges for services provided.

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed claim

A Medicaid or Medicare claim that has at least one service that is reimbursable.

Ambulatory prenatal care

Care and treatment for a pregnant woman and her fetus to protect and promote the woman's health and the healthy development of the fetus.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

Collateral

A collateral is anyone who has direct supportive contacts with the recipient. Collaterals include family members, friends, service providers, guardians, housemates, or school officials.

Concurrent care

Evaluation and management services provided by two or more physicians to a recipient during an inpatient hospital or nursing home stay.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Health Care Financing Administration (HCFA) and Wisconsin Medicaid.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and HCFA policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Emergency services

Those services which are necessary to prevent the death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Family-centered care

Family-centered care refers to a provider's or agency's ability to:

- Treat recipients with dignity and respect.
- Communicate and share information with recipients in ways that are affirming and useful.
- Allow recipients and their families to build on their strengths by participating in experiences that enhance feelings of control and independence.
- Collaborate between providers, recipients, and families in policy and program development, professional education, and delivery of care.

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. An agency housed within the U.S. Department of Health and Human Services (DHHS), HCFA administers Medicare, Medicaid, related quality assurance programs, and other programs.

HCPCS

HCFA Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Health Care Financing Administration (HCFA) in order to supplement CPT codes.

High risk for adverse pregnancy outcome

A situation where a pregnant woman requires additional prenatal care services and follow up because of medical or nonmedical factors that significantly increase the probability of having a preterm birth, a low-birth-weight baby, or other negative birth outcome.

HMO

Health Maintenance Organization. Provides health care services to enrolled recipients.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for all medical diagnoses required for billing. Available through the American Hospital Association.

Low birth weight

A birth weight less than 2500 grams (5.5 pounds).

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03 (96m), Wis. Admin. Code, a Medicaid service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

POS

Place of service. A single-digit code which identifies where the service was performed.

Preterm birth

A birth before the gestational age of 37 weeks.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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