GRANTEE UPdate

January 12, 2009

The Update is a bi-weekly Web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

Stay Healthy in the New Year!

Diseases to watch for in 2009 include Hantavirus

As the New Year approaches, the Iowa Dept. of Public Health (IDPH) urges Iowans to take steps to stay healthy in 2009. Influenza season is entering its most active months; in addition, recent cases of norovirus, shigellosis and hantavirus offer opportunities to remind Iowans that good hygiene and disease prevention are the best ways to avoid illness.

The best prevention against influenza is receiving a yearly flu shot. The flu is a respiratory illness caused by viruses. It spreads easily from person to person and can cause mild to severe illness. The flu comes on suddenly and symptoms may include fever, headache, tiredness, cough, sore throat, nasal congestion, and body aches. Illness typically lasts two to seven days. Influenza is preventable:

- If you or your school-aged children haven't gotten the flu shot yet, do it now. The influenza vaccine is available for children as young as 6 months old. The flu vaccine is the best defense against getting influenza.
- Wash your hands frequently. If you cannot wash your hands, you may use alcohol-based hand sanitizer as long as hands are not visibly soiled.
- Stay home from work or school when you are ill with the flu, and encourage others to do the same.
- Stay away from people you know are ill. Maintain at least a three-foot distance from someone coughing and sneezing.

continued on next page

Stay Healthy in the New Year! *continued*

Hantavirus is a respiratory disease caused by a virus carried by rodents, such as mice. People become infected after breathing in airborne particles of urine, droppings or saliva from infected rodents. There have been seven cases of hantavirus in Iowa. Most cases in the U.S. have been associated with rodent-infested homes, cabins or other buildings. To protect yourself against hantavirus, it's important to follow these rodent removal and clean-up guidelines:

- Use bleach solution or household disinfectant to wet down dead rodents, rodent nests, or rodent urine and feces. This will decrease the chance of virus particles going into the air, where they can be breathed in.
- Wear rubber gloves when removing dead rodents, rodent nests, or rodent urine and feces.
- Wash your hands with soap and water after cleanup.
- Open doors and windows for good ventilation while cleaning.

For information on hantavirus, visit www.idph.state.ia.us/adper/common/pdf/epifacts/hantavirus.pdf.

Norovirus causes nausea, vomiting, diarrhea, and cramps. Outbreaks have been associated with food and water, but most norovirus infections are spread from person to person, especially among family members. Shigellosis results in severe diarrhea which can be bloody and fever. Shigella is easily spread from person to person. To prevent both norovirus and shigella:

- Anyone who is ill with diarrhea, vomiting or fever should stay home and not work with food, the elderly, in health care or child care.
- Good hand washing must be done every time people use the toilet, change a diaper, or before they eat or prepare any food.
- Infants and children must also have their hands washed after diapers have been changed or after using the toilet, and before eating.

For more information on norovirus, visit www.idph.state.ia.us/adper/common/pdf/epifacts/norovirus.pdf.
For information on shigella, visit www.idph.state.ia.us/adper/common/pdf/epifacts/shigellosis.pdf.

The 10 Safest States for Kids: A Parents Magazine Report

From October 2007 to January 2008, Parents magazine analyzed state-level data on more than 30 injury violence prevention criteria that impact a child's safety. The data were supplied by leading organizations, including the American Academy of Pediatrics, the Centers for Disease Control and Prevention, the Federal Bureau of Investigation and Safe Kids Worldwide.

According to this analysis, the top safest states for children are: Connecticut; Rhode Island; New Jersey; New York; California; Maine; Pennsylvania; Massachusetts; Maryland; and Oregon.

To view the report, go to www.parents.com/preschoolers/health/other-safety-issues/the-10-safest-states-for-kids.

Program Management

Bureau of Family Health Grantee Committee Meeting

The next Bureau of Family Health Grantee Committee is scheduled for January 15, 2009 from 9-11:30 a.m. via the ICN. A listing of ICN sites and meeting materials are available on pages 7-66 of **The Update**. *This is a required meeting for Bureau of Family Health contract agencies*.

Coventry Medicaid HMO Terminating Contract

The Bureau of Family Health has received notification from the Iowa Department of Human Services (DHS) that the Coventry Medicaid Health Maintenance Organization (HMO) will be terminating their contract with Iowa DHS effective February 1, 2009. Four counties in Iowa are currently covered by Coventry for their Medicaid population - Black Hawk, Bremer, Butler and Grundy counties. The termination will impact services provided by three of our Title V Maternal and Child Health agencies - Black Hawk County Health Department, Allen Memorial Hospital and North Iowa Community Action Organization. Coventry is the only remaining Medicaid HMO in Iowa.

Termination of the Medicaid HMO coverage impacts responsibility for the provision of care coordination services. Iowa Medicaid's HMO agreement specifies that care coordination will be provided by the HMO. However, upon termination of this agreement, the Title V agencies will assume responsibility for care coordination services for the Medicaid maternal and child health clients.

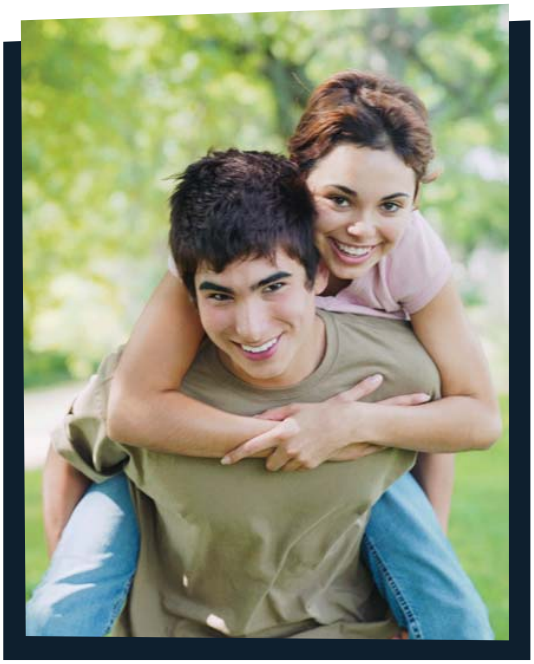
DHS has stated that all of the current HMO enrollees will go into the MediPASS program effective February 1, 2009. Initial letters may go out to clients as soon as the week of December 29, 2008. The map found on page 67 of **The Update** shows the number of Coventry Medicaid HMO clients in the impacted counties. These numbers represent total clients, not just the maternal and child health populations.

If you have questions, please contact Carol Hinton at (515) 281-6924/chinton@idph.state.ia.us or Janet Beaman at (515) 281-3052/jbeaman@idph.state.ia.us.

W O R T H N O T I N G

Teen Sex: Get the Facts

Save the Date... February 25, 2009



A Statewide Adolescent Sexual Health Education Conference will be held at the Kirkwood Center for Continuing Education in Cedar Rapids, Iowa on Wednesday, February 25, 2009. "Teen Sex: Get the Facts" is provided to offer medically accurate and scientifically-based information concerning adolescent sexual health.

Who should attend? All concerned about teen sexual health: educators, nurses, social workers, counselors, parents, physicians, faith leaders and teens are invited to attend!

Cost: $65 registration fee (includes breakfast, lunch and afternoon snack). More to come on professional continuing education credits being offered.

Contact: Conference brochure will be distributed soon! If you would like to pre-register, find out more, or ensure you or a colleague receive registration information, please contact Toni Overton at toverton@equippingyouth.org or call (319) 861-2747.

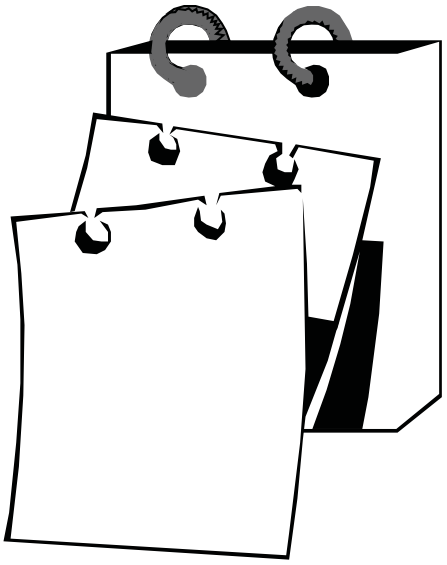
Alabama Public Health Training Network

The Alabama Public Health Training Network Video Communications and Distance Learning Division has unveiled a new Web site.

The site, www.adph.org/alphtn, has been redesigned and is now more user-friendly. Along with a simple registration process, the new site also includes a more in-depth look at the department, staff and satellite and Web cast conferences.

Visit the new site to learn more about FREE Web-based seminars!

CALENDAR OF EVENTS



*January 15, 2009

Bureau of Family Health Grantee Committee Meeting
ICN
For more information, contact Heather Hobert Hoch at (515) 281-6880 or hhobert@idph.state.ia.us.

February 10-11, 2009

Early Childhood Iowa Congress
Airport Holiday Inn, Des Moines
For more information, go to www.state.ia.us/earlychildhood/ECI_Congress/index.html.

February 12, 2009

Early Childhood Iowa Day on the Hill
State Capitol, Des Moines
For more information, go to www.state.ia.us/earlychildhood/ECI_Congress/index.html.

*April 7-8, 2009

2009 Public Health Conference
Scheman Conference Center, Ames
For more information, contact Andrew Connet at (515) 281-7184 or aconnet@idph.state.ia.us.

*Required meeting

Bureau of Family Health: 1-800-383-3826
Teen Line: 1-800-443-8336
Healthy Families Line: 1-800-369-2229
FAX: 515-242-6013

NAME	***PHONE***	***E-MAIL***
Beaman, Janet	281-3052	jbeaman@idph.state.ia.us
Borst, M. Jane *(Bureau Chief)*	281-4911	jborst@idph.state.ia.us
Brown, Kim	281-3126	kbrown@idph.state.ia.us
Clausen, Sally	281-6071	sclausen@idph.state.ia.us
Connet, Andrew	281-7184	aconnet@idph.state.ia.us
Dhooge, Lucia	281-7613	ldhooge@idph.state.ia.us
Doyle Scar, Angie	242-5980	adoyle@idph.state.ia.us
Ellis, Melissa	281-7044	mellis@idph.state.ia.us
Goebel, Patrick	281-3826	pgoebel@idph.state.ia.us
Hageman, Gretchen	281-7585	ghageman@idph.state.ia.us
Hinton, Carol	281-6924	chinton@idph.state.ia.us
Hobert, Heather	281-6880	hhobert@idph.state.ia.us
Hodges, Jenny	281-4926	jhodges@idph.state.ia.us
Hummel, Brad	281-5401	bhummel@idph.state.ia.us
Johnson, Marcus	242-6284	mjohnson@idph.state.ia.us
Jones, Beth	281-7044	bjones@idph.state.ia.us
Miller, Lindsay	281-7721	lmiller@idph.state.ia.us
Monsma, Alison	281-7368	amonsma@idph.state.ia.us
Montgomery, Juli	242-5593	jmontgom@idph.state.ia.us
O'Hollearn, Tammy	242-5639	tohollea@idph.state.ia.us
Pearson, Analisa	281-7519	apearson@idph.state.ia.us
Peterson, Janet	242-6388	jpeterso@idph.state.ia.us
Piper, Kim	281-6466	kpiper@idph.state.ia.us
Schulte, Kelly	281-8284	kschulte@idph.state.ia.us
Trusty, Stephanie	281-4731	strusty@idph.state.ia.us
Wheeler, Denise	281-4907	dwheeler@idph.state.ia.us

Area code is 515

BFH Grantee Committee Meeting
January 15, 2009
9 a.m. – 11:30 a.m.
ICN

*BFH Required Meeting

Agenda

9:00 a.m.	**Call to Order**	
	Introductions & Roll Call	*Gloria Witzberger*
	Approval of Minutes	*Gloria Witzberger*
9:15 a.m.	**Announcements**	
	Department Updates	*Jane Borst*
	2009 Public Health Conference	*Andrew Connet*
9:30 a.m.	**Budget/Legislative Update**	*Julie McMahon*
9:45 a.m.	**Public Health Modernization**	*Joy Harris*
9:55 a.m.	**IDPH/LPH Contracting Issues Workgroup**	*Edie Nebel/Julie Schilling*
10:10 a.m.	**CCNC Training Changes**	*Analisa Pearson*
10:20 a.m.	**Launching into 2009: Billing IDPH for Outreach/Informing & Care Coordination**	*Janet Beaman/ Marcus Johnson/ Steph Trusty*
11:30 a.m.	**Agenda Items for Next Meeting**	*Gloria Witzberger*
	Adjournment	

*This is a required meeting for Bureau of Family Health contractors (Maternal Health, Child Health, and Family Planning).

BFH GRANTEE COMMITTEE MEETING
Date: October 8, 2008
Time: 8:15-9:30 a.m.
Gateway Hotel and Conference Center, Ames

Members Present:

Allen Memorial Hospital: Sandy Kahler*

American Home Finding: Tom Lazio*, Tracey Boxx-Vass

Black Hawk County Child Health Department: Rhonda Bottke*, Marsha Platt

Child Health Specialty Clinics: Rae Miller*

Community Health Services of Marion County: Kim Dorn*, Kate Roy

Community Opportunities, Inc. (d/b/a New Opportunities): Paula Klocke*, Rebecca Mollus

Crawford County Home Health Agency: Kim Davis*, Heather Muenchrath

Crittenton Center: Sue Griffith*, Staci Bland

Grinnell Regional Medical Center: Vicki Nolton*

Hawkeye Area Community Action Program: Gloria Witzberger*, Kim Ott, Ethel Kerd

Hillcrest Family Services: Sherry McGinn*, Cynthia Kaczinski

Johnson County Dept. of Public Health: Annette Scheib*, Chuck Dufano, Eileen Tosh

Lee County Health Dept.: Michele Ross*

MATURA Action Corporation: Mary Groves*

Mid-Iowa Community Action: Pat Hildebrand*, Lindsey Drew, Janelle Durlin, Kate Pergande

Mid-Sioux Opportunity, Inc.: Cindy Harpenau*, Kim Schroeder

North Iowa Community Action Org.: Lisa Koppin*

Northeast Iowa Community Action: Lori Egan*

Scott County Health Dept.: Amy Thoreson*, Tiffany Kennedy, Leslie Scanlan

Siouxland Community Health Center: Ivy Guthridge*, Mary Bachman

Southern Iowa Family Planning: Vicki Palm*

St. Luke's Family Health Center: Val Campbell*

Taylor County Public Health: Joan Gallagher*

Unity Health System: Mary Odell*

Upper Des Moines Opportunity, Inc.: Kristal Shirk*

Visiting Nurse Assoc. of Dubuque: Nan Colin*, Elaine Sampson, Molly Schulte

Visiting Nurse Services: Bev Kaduce*, Missie Larson, Becky Simer, Terri Walker

Washington County PHN Service: Edie Nebel*

Webster County Public Health: Kari Prescott*

*Voting Representative

Minutes

Handouts included: Agenda, April 1, 2008 Meeting Minutes, Meeting Calendar

Gloria Witzberger, Chair **Notes Taken by BFH Staff**

TOPICS	KEY DISCUSSION POINTS/OUTCOMES
Call to Order **Introductions & Roll**	***Gloria Witzberger*** • Gloria called the meeting to order at 8:15 a.m. • Roll call to identify voting members from each agency.
Announcements **Introduction of Chair**	***Gloria Witzberger*** • Gloria introduced herself as the new chair of the Grantee Committee, effective October 1, 2008.

Introduction of Vice Chair	***Gloria Witzberger*** • Gloria introduced Val Campbell, St. Luke's Family Health Center, as the new vice chair of the Grantee Committee.
Approval of Minutes	***Gloria Witzberger*** • Motion made by Cindy Harpenau to approve the April 1, 2008 meeting minutes. Motion seconded by Val Campbell. Minutes approved.
Federal Audit Update	***Janet Beaman*** • The federal Payment Error Rate Measurement (PERM) project is underway in Iowa. This is a project undertaken by the Centers for Medicare and Medicaid Services to measure improper payments made in the Medicaid and SCHIP programs. • The federal auditors have identified 245 records to be sampled for review in Iowa. The sampling is across all Iowa Medicaid provider types. As a result, your agency's records may or may not be included in the sample. • If your agency receives a request for records under the PERM audit, please notify the Bureau of Family Health so we are aware of any Screening Center or Maternal Health Center involvement. You may contact the following: ▪ Janet Beaman – jbeaman@idph.state.ia.us or (515) 281-3052 ▪ Carol Hinton – chinton@idph.state.ia.us or (515) 281-6924 ▪ Marcus Johnson – mjohnson@idph.state.ia.us or (515) 242-6284 ▪ Steph Trusty – strusty@idph.state.ia.us or (515) 281-4731
2009 Public Health Conference	***Andrew Connet*** • The 2009 Iowa Public Health Conference will be held April 7-8 at the Scheman Conference Center in Ames.
Agency Contact Information and FFY09 Meeting Schedule	***Gloria Witzberger*** • Gloria asked that agencies review the contact information in their meeting packets and provide changes to Heather Hobert Hoch. • Grantees have approved FFY09 meeting dates. Grantees will meet January 15, 2009 via the ICN, in-person, at the 2009 Public Health conference, and June 18, 2009 via the ICN.
Budget/Legislative Update	***Julie McMahon*** • Appropriations Committee for HHS met on March 31 to set the budget. Meetings are ongoing now to review. Unspent dollars as of June 30, 2008 are targeted to be rolled over as part of the new budget. Budget will be status quo if money is rolled forward. • Health care reform budget creates a big "if" regarding the budget outcome. The revenue estimating conference to be held April 4 will finalize the direction of the final budget. • Health care reform bill has huge implications. • Discussions are ongoing on children's health care coverage. There are barriers to enrollment. Child advocates are working on these issues. • There is no new money designated for IDPH. Some agencies received

	money from IANEPCA for medical home demonstration purposes. • Carryover has been in the 20-30 percent range. HCCI would like Empowerment to direct funds to Child Care Nurse Consultant positions.
MCH Administrative Manual – 3rd Edition	***Lucia Dhooge*** • Handout: Human Services [441] Adopted and Filed. Rules will become effective April 1, 2008. Clarifying documentation requirements; checklists of documentation requirements (to be used interim rules. Until CMS responds, we keep doing what we have been doing. • Program and a hospital-based program to also pilot the process.
CH Agency Action Plan Updates	***Tracy Rodgers*** • CAReS export project is not ready for roll out. Key features: see Medicaid claims for a child; enter time in and time out; report of children in the agency's medical home.
Workgroup Reports **Communications**	***Heather Hobert Hoch*** • Workgroup will begin addressing issues to improve communication with grantees through the bureau Web page, newsletter, Grantee Committee Meetings and Fall Seminar.
Grant Monitoring	***Grantee Representative*** • Grantee representative provided an overview of Grant Monitoring Workgroup's first meeting. After the contract is signed – how is the grant managed? • What are our deliverables? – Policy for site visitation, including agency notification, timeline, schedule, documentation and follow-up – Core site visit team – four MCH consultants that are responsible for all site visits, working with the agency assigned consultant. Core team will share best practice agency-to-agency, document visits, and arrange visits according to policy. Builds consistency. Core team members will still have own agency(ies) as lead. Core team member will partner with assigned consultants for visit. Use site visit checklist developed by consultant committee. – Post- visit survey – Survey Monkey? – Documentation Access Database - lead consultant responsible for documentation ASAP after visit – Mid-year reporting - Mid-year review of action plans and indicator goals done with consultants and agency leadership. Year-end report would then be just a final report of indicators and action plans (met/not met). – Response to application review - when are responses due, and what accountability to state is there? (Similar to fed grants)
Contract Expectations	***Grantee Representative*** • Grantee representative provided an overview of Contract

Consultation/TA	Expectation's priorities: Establish expectations/timelines for consultants to provide feedback to contractors on contract reports and requirements and explore opportunities for reporting efficiencies; and Communicate with contractors to provide explanation/background for contract requirements and common expectations. ***Grantee Representative*** • Grantee representative provided an overview key action steps identified by group: MCH/FP Grant 101 training; MCH/FP Program Orientation UP FRONT; Regular onsite visits (Develop schedule) – goal to build relationships; Consistent notification to grantee when the state staff is out of the office; Customer Satisfaction training of state staff.
Agenda Items for Next Meeting/Adjournment	***Gloria Witzberger*** • The next BFH Grantee Committee Meeting will be held on January 15, 2009 via the ICN. • Meeting adjourned at 9:30 a.m.

Child Health Services Summary

The following summary applies to child health services provided for both Medicaid and non-Medicaid children. For complete guidelines for services, refer to the EPSDT *Care for Kids* Information and Care Coordination Handbook, the I-Smile Oral Health Coordinator Handbook, and the Medicaid Screening Center Manual. The following information is based upon Medicaid and Child Health program guidelines as known to date. Information is presented in the following categories: Informing and Care Coordination, Local Medical Transportation, and Direct Care Services.

Informing and Care Coordination

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Informing	Explaining the services available under Medicaid's EPSDT program to families of newly eligible children. It consists of: ♦ initial inform: first contact made on behalf of a newly eligible child – typically written communication ♦ inform follow-ups: attempts to make personal contact with the family (phone, face-to-face, written) ♦ inform completion: personal contact made with the family via phone or face-to-face to dialogue about the services available under EPSDT and needs of the family. Inform newly eligible clients within 30 days of the beginning of each month. Informing involves use of CAReS Newly Eligible Report.	In CAReS: Document the initial inform, inform follow-ups, and inform completion for each Medicaid eligible child in the family. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. The informing service does not end with the mailing of an initial inform letter/packet. Inform follow-ups are expected, and inform completion is the ultimate goal of the service. 2. Inform completion consists of direct dialogue with the family and cannot be accomplished through written communication or by leaving phone messages. 3. If a family hangs up prior to explaining EPSDT services, the informing service would not be considered complete. This would be considered an inform follow-up. 4. The entirety of the inform completion contact is part of informing. Do not bill care coordination for any portion of this contact. 5. Informing is not a service repeated month after month for a family. Use Qweb labels to avoid providing/billing this service to a family too frequently.	Bill cost of initial inform to IDPH for the family (not per child). Include supporting documentation. The initial inform billing includes the initial inform and inform follow-up activity. Bill cost of inform completion to IDPH for the family (not per child). Include supporting documentation. Inform completion consists of direct dialogue with the family about the services available under EPSDT and needs of the family. If there is more than one child in the family, submit the claim under the youngest child's name.
For more information on informing services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Re-informing	Providing the informing service anew at a later time for families that 1) could not be reached after multiple attempts or 2) refused care coordination services. Consists of ♦ Initial re-inform ♦ Re-inform follow-ups ♦ Re-inform completion Re-informing involves use of 2 CAReS reports: 1. Re-inform - Previously Unable to Locate (Client's last discharge reasons was 'Unreachable/Unavailable'.) 2. Re-inform - Previously Refused Care Coordination (Client's last care coordination services was 'Care Coordination Refusal'.)	In CAReS: Document the initial re-inform, re-inform follow-ups, and re-inform completion for each Medicaid eligible child in the family. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. The re-informing service does not end with the mailing of an initial re-inform letter/packet. Re-inform follow-ups are expected, and re-inform completion is the ultimate goal of the service. 2. Re-inform completion consists of direct dialogue with the family and cannot be accomplished through written communication or by leaving phone messages. 3. If a family hangs up prior to explaining EPSDT services, the re-inform service would not be considered complete. This would be considered a re-inform follow-up. 4. The entirety of the re-inform completion contact is part of re-informing. Do not bill care coordination for any portion of this contact. 5. Re-informing is provided ♦ every 6 months if the child is under age 2 at time of discharge as unreachable/unavailable or refusal of care coordination ♦ annually for children age 2 or over at time of discharge as unreachable/unavailable or refusal of care coordination.	Bill cost of initial re-inform to IDPH for the family (not per child). Include supporting documentation. The initial re-inform billing includes the initial re-inform and re-inform follow-up activity. Bill cost of re-inform completion to IDPH for the family (not per child). Include supporting documentation. Re-inform completion consists of direct dialogue with the family about the services available under EPSDT and needs of the family. If there is more than one child in the family, submit the claim under the youngest child's name.
For more information on re-informing services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Care coordination	Linking a client to the health care system (medical, dental, mental health). It includes: ♦ Providing information about available health and support services based upon family needs ♦ Answering questions about health care coverage ♦ Assisting with establishing medical and dental homes ♦ Advocating for the child and family as they navigate the health care system ♦ Reminding families that well child screenings are due. This involves use of 2 CAReS Reports: 1. Periodicity Screen – Agency Home Report (Clients due for a well child screen in agency home.) 2. Periodicity Screen – Clients Not Located Report (Clients due for a well child screen who haven't been in an agency home.) ♦ Assisting with scheduling appointments ♦ Follow-up to assure that clients received services ♦ Assisting with missed appointments ♦ Assisting families with referrals for further care ♦ Arranging support services such as medical transportation, translation/interpreter services, or child care	In CAReS: ♦ Document care coordination under the Informing and Care Coordination Services category ♦ Mark "Physical Exam Referral" if the care coordination results in a referral for a well child exam in the medical home. ♦ Document dental care coordination under the Dental Services category. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. Time in and time out including a.m. and p.m. 6. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. Care coordination involves phone or face-to-face contacts with the family or provider(s) of behalf of child. 2. Written correspondence can be sent to remind families that well child screens are due. However, this is not billable care coordination. 3. When providing direct care services, any care coordination related to the direct care is considered part of the direct care service. Do not bill this activity separately as care coordination. For example, ▪ Reporting lab results to the family or medical home from tests conducted at the Title V agency are not billable care coordination. ▪ Arranging an appointment for treatment services following a well child screen provided by the Title V agency is not billable care coordination. 4. Care coordination may not be billed for activities that are a part of the inform completion contact. 5. Care coordination services for clients under a TCM program are to be referred to the assigned case manager.	Bill cost of care coordination service to IDPH per client. Include supporting documentation that contains the number of minutes spent on each care coordination service. Do not bill IDPH for sending written reminders of periodic screens. Selected Early ACCESS service coordination activities may also be billed to IDPH as care coordination. (See the Early ACCESS Medicaid Matrix.)
For more information on care coordination services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook. For guidance on Early ACCESS service coordination activities, see the Early ACCESS Medicaid Matrix.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Home visit for care coordination	Home visit made for the purpose of providing care coordination services. This includes care coordination for a medically necessary condition to: ♦ Provide information about health care services. ♦ Coordinate access to care ♦ Assist in making health care appointments ♦ Make referral appointments ♦ Coordinate access to needed support services (transportation, translation/interpreter, and child care) ♦ Follow-up to assure services were received. A home visit may also be made by an RN to follow-up on a blood lead level equal to or greater than 15 µg/dL. This includes: ♦ A skilled assessment and instructions to the family ♦ Assistance with making and keeping follow-up appointments ♦ Reminding caregiver to notify child's lead case manager if the family moves ♦ Reminding caregiver to inform the child's current and future health care providers of elevated blood lead level	In CAReS: Document the care coordination service. Select "home visit" as the interaction type. Mark "Physical Exam Referral" if the care coordination results in a referral for a well child exam in the medical home. Include in CAReS: 1. Date of service 2. Place of service 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. Time in and time out including a.m. and p.m. 6. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. Use only face-to-face time to determine minutes of service. Do not include travel time when determining minutes of service. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill child health care coordination for any part of this maternal health visit. 3. If the purpose of the home visit is to provide direct care services, home visit for care coordination cannot also be billed. If the purpose of the home visit is for nursing or social work services, use codes S9123 for the home visit for nursing services or S9127 for the social work home visit. (See guidelines below.) 4. Care coordination services for clients under a TCM program are to be referred to the assigned case manager.	Bill cost of home visit for care coordination to IDPH per client. Include supporting documentation that contains the number of minutes spent on each care coordination service (face-to-face time only). Selected Early ACCESS service coordination activities may also be billed to IDPH as home visit for care coordination. (See the Early ACCESS Medicaid Matrix.)
For more information on the home visit for care coordination, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook. For guidance on Early ACCESS service coordination activities, see the Early ACCESS Medicaid Matrix.				

Local Medical Transportation

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Medical transportation	Transportation to local (in-town) medical, dental, mental health services. Includes transportation parking fees and tolls.	In CAReS: Document under Health Screening Services category. Mark "Transportation to Health Provider" for in-town transportation services. Include in CAReS: 1. Date of service 2. Who provided the service (e.g. name of cab company) 3. Address of where recipient was picked up 4. Destination (medical provider's name and address) 5. Invoice of cost 6. Mileage if transportation is paid per mile If the Title V agency keeps a service log containing the above information, the service note must include a reference to this record.	1. Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received. 2. This does not include out-of-town transportation. Out of town transportation is paid through the county DHS office. The client obtains approval and forms for reimbursement of out-of-town transportation from the local DHS office.	Code A0110: Non-emergency bus (per round trip) Code A0100: Non-emergency taxi (per round trip) Code A0130: Non-emergency wheel chair van (per round trip) Code A0090: Non-emergency by volunteer (per mile) Code A0120: Non-emergency mini-bus or non-profit transportation system (per round trip) Code A0170: Parking fees, tolls Bill actual cost of transportation for the date the transportation was provided to the health related appointment.
For more information on transportation services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook and Medicaid's Screening Center Manual.				

Direct Care Services

Direct care services provided by a Title V agency are identified in the agency needs assessment and are approved per the annual application for child health services submitted to IDPH.

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Health screening (well child exam)	The initial or periodic well child screen per the Iowa Recommendations for Scheduling *Care for Kids* Screenings (Periodicity Schedule) and as described in the Medicaid Screening Center Manual.	In CAReS: Under Health Screening Services category, mark "Physical exam – Direct" for well child screens provided by the child health agency. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	When providing direct care services, any care coordination related to the direct care is considered part of the direct care service. Do not bill this activity separately as care coordination. For example, ▪ Reporting lab results to the family or medical home from tests conducted at the Title V agency could not be billed as care coordination. It is considered part of the direct care. ▪ Arranging an appointment for treatment services following a well child screen provided by the Title V agency could not be billed as care coordination. It is considered part of the direct care.	Initial screen: Code 99381: 0-12 mo Code 99382: 1-4 yr Code 99383: 5-11 yr Code 99384: 12-17 yr Code 99385: 18-21 yr Periodic screen: Code 99391: 0-12 mo Code 99392: 1-4 yr Code 99393: 5-11 yr Code 99394: 12-17 yr Code 99395: 18-21 yr Use modifier U1 for a screen that results in a referral for treatment. Use diagnosis code V20.2 for children ages 0-18. Use diagnosis code V70.5 for children ages 19-20.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Oral Health Services	Services: ♦ Initial oral screen ♦ Periodic oral screen ♦ Child prophylaxis ♦ Adult prophylaxis ♦ Sealant (per tooth) ♦ Bitewing x-ray, single film ♦ Bitewing x-ray, two films ♦ Bitewing x-ray, four films ♦ Oral evaluation and counseling with primary caregiver for patient under 3 yr of age ♦ Topical fluoride varnish – therapeutic application for moderate to high caries risk patients ♦ Nutritional counseling for the control and prevention of oral disease ♦ Oral hygiene instruction	In CAReS: Mark appropriate service under the "Dental Services" category. Include in CAReS: 1. Time in and time out including a.m. and p.m. for timed based services (Codes D1310 and D1330.) 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. When providing direct oral health services, any care coordination related to the direct care is considered part of the direct care service. Do not bill this activity separately as care coordination. For example: • After completing an oral health screen, making arrangements for a referral to a DDS for follow-up and treatment cannot be billed separately as care coordination. 2. If an initial screen is provided, use only Code D0150. When providing subsequent screens, use either D0120 or D0145 as appropriate. 3. Code D0145 is billable only for children under three years of age if counseling with the primary caregiver is provided during a screen. 4. For Codes D1310 and D1330, a minimum of 8 minutes must be provided to bill the service. 5. For both sealant applications and bitewing films, report the number of teeth sealed or the number of bitewing films taken, not the number of clients that will receive the service.	Codes: ♦ D0150: Initial oral screen ♦ D0120: Periodic oral screen ♦ D1120: Prophy (age 12 yr. and younger) ♦ D1110: Prophy (age 13 yr. and older) ♦ D1351: Sealant per tooth (posterior teeth up to age 18) ♦ D0270: Single bitewing film ♦ D0272: Two bitewing films ♦ D0274: Four bitewings films ♦ D0145: Oral evaluation and counseling with caregiver (child under age 3) ♦ D1206: Topical fluoride varnish (moderate to high caries risk) ♦ D1310: Nutritional counseling for control and prevention of oral disease (15 minute unit) ♦ D1330: Oral hygiene instruction (15 minute unit)
For more information on oral health direct care services, refer to the I-Smile Handbook and Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Immunizations	Administration of immunizations	In CAReS: Under Health Screening Services category, mark "Immunization". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart, IRIS, or Master Index Card for full description of services provided. In client-based chart, IRIS, or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2). Assure entry in IRIS.	Typically VFC vaccine is used (at no cost). If a child needs vaccine outside of the VFC cohort, Medicaid can be billed for the vaccine.	Code 90471 for initial administration of vaccine (single or combination), subcutaneous or intramuscular Code 90472 for subsequent administrations of vaccine (single or combination) on same day as Code 90471 or Code 90473. Code 90473 for administration of one vaccine (single or combination) by intranasal or oral means. Bill the appropriate administration code(s) and the code(s) for the VFC vaccine (at $ 0).
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Blood draw	Collection of venous blood by venipuncture Collection of capillary blood specimen Handling or conveyance of specimen for transfer to a laboratory	In CAReS: Under Health Screening Services category mark "Lab-Lead". Include in CAReS: 1. Specify if venipuncture, capillary draw, or handling/conveyance to lab. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2). If a CLPPP, assure entry in STELLAR.	A blood lead draw and handling/conveyance cannot both be billed. Only one of the three codes can be billed. Note that venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3. Referral to the Child Health agency for Early Access service coordination will be made by the responsible CLPPP.	Code 36415 for venous draw. Code 36416 for capillary draw. Code 99000 for handling and conveyance to lab. Select only one of the above codes for billing.
Blood lead analysis	Lab analysis of blood lead level using the Lead Care II	In CAReS: Under Health Screening Services category mark "Lab-Lead". Include in CAReS: 1. Specify use of Lead Care II. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2). If a CLPPP, assure entry in STELLAR.	The Lead Care II is the only CLIA waived testing device approved by IDPH. **Child Health agencies using the Lead Care II must report the results of all blood lead testing electronically to the Bureau of Lead Poisoning Prevention.** If a blood lead test result of 15 µg/dL or higher is obtained from a Lead Care II, a venous sample must be drawn and sent to a reference lab for a confirmatory test.	Code 83655 The capillary blood draw (Code 36416) can be billed in addition to the blood lead analysis when using the Lead Care II. Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3. Referral to the Child Health agency for Early Access service coordination will be made by the responsible CLPPP.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Other lab services	Urinalysis Hematocrit level Hemoglobin level Tuberculosis skin test	In CAReS: Under Health Screening Services category, mark the appropriate service. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	If hemoglobin testing is covered by the WIC program, it cannot be billed to Medicaid.	Code 81002: UA Code 85014: Hct Code 85018: Hgb Code 86580: TB
Visual acuity	Screening test of visual acuity, quantitative, bilateral. The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart).	In CAReS: Under Health Screening Services category, mark "Vision". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	This vision screening service cannot be billed in addition to a preventive office visit (initial or periodic health screening).	Code 99173
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Speech audiometry	Speech Audiometry – threshold only	In CAReS: Under Health Screening Services category, mark "Hearing". Include in CAReS: 1. Specify the speech audiometry service provided 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).		Code 92555
Developmental screen	Developmental screening with interpretation and report. This serves to identify children who may need more comprehensive evaluation. Use recognized instruments such as: ♦ Parent's Evaluation of Developmental Status (PEDS) ♦ Ages and Stages Questionnaire	In CAReS: Under Health Screening Services category, mark "Developmental Screen". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2). Include: • Date of service • Name / copy of screening tool • Results and interpretation • Referrals / action taken • First name, last name, credentials, signature of service provider	Do not use E & M for the following activities which are included in the scope of the developmental screening service: • Explaining the purpose of a developmental screen • Interpretation of results of the screen • Anticipatory guidance and • If indicated, referral to Level II screening	Code 96110
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Nutrition counseling	Medical nutrition therapy - initial nutrition assessment and intervention, face-to-face with the individual Nutrition reassessment and intervention, face-to-face with individual	In CAReS: Under Health Screening Services category, mark "Nutrition Assessment". Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. Use for medically necessary nutrition services beyond those provided through the WIC program. 2. For Codes 97802 and 97803, a minimum of 8 minutes must be provided to bill the service. 3. See guide sheet in MCH Administrative Manual. Assure that criteria for providing nutrition counseling services are met.	Code 97802: Initial nutrition assessment & counseling (15 minute unit) Code 97803: Nutrition reassessment and counseling (15 minute unit)
Home visit for nursing services	Home visit made for the purpose of providing nursing services including: ♦ Medical history ♦ Nursing assessment ♦ Nursing services	In CAReS: Under Health Screening Services category, mark "Nursing Assessment". Select "home visit" as the interaction type. Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A home visit for care coordination service cannot also be billed for any portion of the home visit for nursing services. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for nursing services in addition. 3. This code is based upon an **hourly** unit of service.	Code S9123 (per hour)
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Social work home visit	Home visit made for the purpose of providing social work services including: ♦ Social history ♦ Psycho-social assessment ♦ Counseling services provided	In CAReS: Under Health Screening Services category, mark "Social Work Assessment". Select "home visit" as the interaction type. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A home visit for care coordination service cannot also be billed for any portion of the home visit for social work services. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for social work services in addition.	Code S9127 This is an encounter code and is not based upon a timed unit.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Evaluation and Management	Evaluation and management (E & M) for an office visit with an established client. Examples include but are not limited to E & M pertaining to: ♦ Follow-up visits subsequent to a full well child screen (on a date following the screen) ♦ Lead risk assessment, education about lead poisoning, and follow-up instructions when doing a blood lead draw ♦ Reviewing immunization records, explaining the need for immunizations, and providing anticipatory guidance and follow-up instructions when preparing to administer vaccine	In CAReS: Under the Health Screening Service category, mark "Evaluation & Management". Select "clinic visit" as the interaction type. Enter service documentation notes: • Specify what the E & M is related to (e.g. well child screen, lead test, or immunization) • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client based chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	E & M is a clinical encounter direct care service. This code cannot be used for: ♦ Providing care coordination services ♦ E & M on the same day as a full well child screen ♦ Explaining the purpose of a developmental screen, interpretation of the screen, anticipatory guidance, and referral to Level II screening when conducting a developmental screen. (These activities are already included in the code 96110.)	Code 99211 This encounter code can only be used once per day per client.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Billing Child Health Services
(For services beginning February 1, 2009)

Service	Code		Billable to	Maximum Established Reimbursement Rate*	
Initial inform/re-inform (per family) (includes inform/re-inform follow-ups)	-------		IDPH	$14.59	
Inform/re-inform completion (per family)	-------		IDPH	$21.88	
Care coordination (per 15 min) (Title V & Title XIX clients)	-------		IDPH	$8.23	
Home visit for care coordination (per 15 min) (Title V & Title XIX clients)	-------		IDPH	$16.07	
Health screening	Initial	Periodic	IME	Initial	Periodic
0-12 mo	99381	99391		$92.47	$75.46
1-4 yr	99382	99392		$99.24	$83.30
5-11 yr	99383	99393		$98.57	$82.97
12-17 yr	99384	99394		$109.70	$93.87
18-21 yr	99385	99395		$106.35	$91.52
Initial oral screen	D0150		IME	$20.32	
Periodic oral screen	D0120		IME	$14.14	
Prophylaxis age 12 yr and under	D1120		IME	$24.95	
Prophylaxis age 13 yr and older	D1110		IME	$36.38	
Sealant per tooth	D1351		IME	$20.79	
Single film bitewing	D0270		IME	$9.35	
Two film bitewing	D0272		IME	$16.63	
Four film bitewing	D0274		IME	$24.95	
Oral evaluation and counseling to caregiver (child under age 3)	D0145		IME	$20.32	

*IME capped reimbursement rates were taken from the Screening Center Fee Schedule updated 7/1/2008.
IDPH Bureau of Family Health - January 2009

Service	Code	Billable to	Maximum Established Reimbursement Rate*
Topical fluoride varnish	D1206	IME	$14.55
Nutritional counseling for control and prevention of oral disease (per 15 min)	D1310	IME	$16.30
Oral hygiene instruction (per 15 min)	D1330	IME	$16.30
Immunization administration (initial)	90471	IME	$5.30
Immunization administration (subsequent)	90472	IME	$5.30
Immunization administration (intranasal or oral)	90473	IME	$13.43
Venous blood draw	36415	IME	$3.32
Capillary blood draw	36416	IME	$3.30
Handling and conveyance to lab	99000	IME	$3.32
Blood lead analysis	83655	IME	$17.92
Urinalysis	81002	IME	$3.80
Hct	85014	IME	$3.15
Hgb	85018	IME	$3.15
TB	86580	IME	$7.61
Visual acuity	99173	IME	$2.18
Speech audiometry	92555	IME	$10.56
Developmental screen	96110	IME	$59.49
Nutrition counseling initial assessment (per 15 min)	97802	IME	$7.95
Nutrition counseling reassessment (per 15 min)	97803	IME	$15.83

*IME capped reimbursement rates were taken from the Screening Center Fee Schedule updated 7/1/2008.

Service	Code	Billable to	Maximum Established Reimbursement Rate*
Home visit for nursing services (per hour)	S9123	IME	$54.44
Home visit for social work services	S9127	IME	$69.65
Evaluation and management	99211	IME	$16.04
Medical transportation (bus-round trip)	A0110	IME	--------
Medical transportation (taxi-round trip)	A0100	IME	-------
Medical transportation (wheel chair van-round trip)	A0130	IME	--------
Medical transportation (volunteer per mile)	A0090	IME	--------
Medical transportation (mini bus or non-profit system)	A0120	IME	--------
Medical transportation (parking tolls, fees)	A0170	IME	--------

*IME capped reimbursement rates were taken from the Screening Center Fee Schedule updated 7/1/2008.

Time and Service Input Form

Client ID: ____________________

Admission ID: _______________

Client's name *(first, middle, last)* ____ Maiden name ________________

Birth date ____/____/____ Social Security # ______________________________ Medicaid ID # ________________

County of service: ____

Primary Payment Source: *(enter option from payment source table below)* ___________________________________

Secondary Payment source: *(check all that apply)*

☐ CHAMPUS	☐ HawkI	☐ Medipass	☐ State Papers
☐ county funds	☐ HMO	☐ OB indigent	☐ Title V
☐ Covenant	☐ Iowa Health Solutions	☐ presumptive eligibility	☐ uninsured
☐ eligible/not receiving Title XIX	☐ John Deere	☐ private insurance	☐ unknown
☐ Emergency Medicaid	☐ Medicaid/Title XIX	☐ self-pay/sliding scale	☐ other
☐ grant funds	☐ Medicare	☐ SSI	specify _____________

Enter services and time below. More than one service may be entered for a date. Services are listed by service category in the chart on the next page.

Date	**Service** *(see list)*	**Interaction Type** (1) home visit (2) office visit (3) oral health visit (4) phone	**Time In**	**Time Out**	**Other Planned Interventions or Comments**

Service Category	Code	Service
Oral Health Services	D0150	Initial screening evaluation
	D0120	Screening evaluation periodic
	D1110	Adult prophylaxis
	D1120	Child prophylaxis
	D1203	Fluoride Application child
	D1204	Fluoride Application adult
	D1206	Topical fluoride varnish
	D1310	Nutrition counseling prevent oral disease
	D1320	Tobacco counseling prevent oral disease
	D1330	Oral hygiene instruction
	D1351	Sealant, per tooth
Injection	90471	Administration fee for immunizations only
	90633	Hepatitis A pediatric /adolescent - 2 dose
	90649	Human Papilloma Virus - HPV
	90658	Influenza virus vaccine, age 3 years and older
	90707	Measles, mumps and rubella virus vaccine
	90710	Measles, mumps and rubella varicella (MMRV)
	90714	Tetanus,diphteria toxoids (TD) 7 years and older preservative free
	90715	Tetanus,diphteria toxoids and acellular pertussis
	90716	Varicella vaccine
	90718	Tetanus,diphteria toxoids absorbed (TD) 7 years and older
	90734	Meningococcal conjugated vaccine
	90743	Hepatitis B vaccine; adolescent (two doses)
	90744	Hepatitis B vaccine; pediatric/adolescent (three d
	90746	Hepatitis B vaccine; adult, 20 or older
	90782	Injection of medication
	90472	Administration oral or nasal
	J2790	Rhogam, RHO D Immune Globulin, Human INE
Care Coordination	H1002	Care Coordination
Health Education Services	H1003	Health Education
Social Work Services	H0046	Mental health services

Service Category	Code	Service
Maternity Care	99201	Self limited or minor approx 10 min.
	99202	Straightfoward low to mod. severity- 20 min
	99203	Low complexity to mod severity 30 min
	99204	Mod to high severity - 45min.
	99205	High complexity, mod to high severity - 60 min
	99211	Minimal problems 5 min
	99212	Self limited or minor approx 10 min.
	99213	Low to mod complexity- 15 min
	99214	Mod to high complexity - 25 min
	99215	Mod to high complexity - 40 min
	59425	Antepartum care only, 4 - 6 visits
	59426	Antepartum care only, 7 or more visits
	59430	Postpartum care only (separate procedure)
	59025	Non Stress Test
	81025	Urine Pregnancy Test, by Visual Color Co
Nutrition Services	S9465	Diabetes services
	S9470	Nutrition counseling dietitian
Home Visit	S9123	Nursing visit in the home
	S9127	Social work visit in home
Local Transportation	A0080	Non -emergency transportation vehicle provided by
	A0100	Non-emergency transportation - taxi
	A0110	Non - emergency transportation - bus
	A0130	Non - emergency transportation - wheelchair van
	A0160	Non- emergency transportation - caseworker/social
	A0170	Transportation - parking fee, tolls other
Maternity Services	99420	Medicaid prenatal risk assessment
Outreach	12345	Presumptive Eligibility Determination

Code G9006 Home Visit for Care Coordination

Application: When a home visit is required for follow-up of an elevated lead level or when care coordination is provided during a home visit for EPSDT.

Examples:

Lead Skilled Nursing Home Visit
Each child with a venous blood lead level greater than or equal to 15 ug/dL must receive a skilled home nursing visit which includes a **skilled assessment** and **instructions** to the family on lead poisoning and how to cope with it. This is an important opportunity to educate caregivers about the risks that an elevated blood lead level poses to their child, what they can do to eliminate their child's exposure to lead, and the importance of follow-up.

An RN must do the lead follow-up. This visit should include the following:

1. Assisting caregivers in making and keeping follow-up appointments for blood tests.
2. Reminding the caregiver to notify the child's case manager if the child moves to a new residence.
3. Reminding the caregiver to inform the child's current and future health care providers of the child that they child had an elevated blood lead level. This is important even when the child's blood lead level is no longer elevated.

In cases where the child's blood lead level does not drop quickly, repeated home nursing visits may be needed to assess any changes in the situation and to reinforce instructions previously given to the family.

Care Coordination when a Home Visit is Medically Necessary
In some situations it will be necessary to work one-on-one with a family in their home. Medically necessity may be due to a medical condition or when working with non-English speaking families and families without phones.

Care Coordination may involve

1. Providing information about available health care services,
2. Assisting clients in making health care appointments,
3. Making referrals,
4. Coordinating access to needed support services,
5. Coordinating access to health care, and
6. Following up to make sure that services were received.

Documentation in CAReS

All documentation should be completed prior to billing for the home visit. It is necessary to document:

1. The date of the home visit
2. Location of the visit
3. The reason for the home visit
4. Who you worked with in the home
5. Items identified in the assessment, issues addressed, input from family, services declined
6. The outcome of the visit, referrals, and further follow-up
7. Time in and time out including a.m. and p.m.
8. First name, last name, and credentials of the service provider if not entering their own data in CAReS. If paper forms are also used, they must include this information in addition to full signature.
9. Be sure to maintain an agency signature log.

2008 Maternal Health Summary of Services, Documentation and Codes

The following provides a summary of maternal health services provided for women through an IDPH Maternal Health Center. For guidelines for services, refer to the MCH Administrative Manual and the Medicaid Maternal Health Center Provider Manual as found on the Iowa Medicaid Enterprise (IME) Web page at http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/maternhc.pdf

DOCUMENTATION

Documentation for each encounter with a client must adhere to requirements in IAC 441-79.3(2). In Maternal Health centers, data from encounters is entered into the electronic record known as the Women's Health Information System (WHIS); however, WHIS is not a complete medical record. Specific information regarding the client visit must be entered in the client's medical record maintained in the agency.

INFORMATION REQUIRED FOR EACH ENCOUNTER BASED ON THE SERVICE PROVIDED

Description of service or office notes or narratives

- Complaint and symptoms; history; examination findings
- Assessments
- Clinical impression or diagnosis
- Individualized plan of care
- Specific procedures, diagnostic tests or treatments performed
- Laboratory tests
- Test orders
- Results
- Medication
- Supplies
- Client's progress, response to and changes in treatment, and revision of diagnosis.
- Specific Forms for assessments completed such as Form 470-2942, Prenatal Risk Assessment

INFORMATION NECESSARY TO SUPPORT EACH ITEM OF SERVICE REPORTED ON THE MEDICAID CLAIM FORM

- Name of client
- Name of provider agency
- Place of service*
- Complete date of the service including beginning & ending date if rendered over more than one day
- A record of the time to support the units billed specifying a.m. or p.m. (e.g. 11:30 a.m. – 12:10 p.m.)
- First and last name and professional credentials of the person providing the service
- Signature of person providing the service or the initials of the person if a signature log indicates the person's identity
- Specific procedures or treatments including nature, content, or units of service
- Name, dosage, and route of administration of medication dispensed or administered
- Any supplies dispensed as part of the service

When a service is reimbursed as units of time, where one unit equals 15 minutes, units are calculated as:

8-22 min = 1 unit
23-37 min = 2 units
38-52 min = 3 units
53-67 min = 4 units

Refer to the service code for value of a unit. For instance a nursing visit in the home equals one hour and a social work visit in the home is billed as an encounter rather than by units.

FUNDING SERVICES

Data in this table, related to funding, references Medicaid codes and requirements. Iowa Medicaid uses the HCFA Common Procedure Coding System (HCPCS). Services or charges cannot be fragmented for each procedure code billed. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

Maternal health centers must bill Medicaid for all Medicaid eligible women and are reimbursed on a fee-for-service basis. The amount billed should reflect the actual cost of providing the services. Maternal Health Centers may also bill other third party insurers, but are not required to do so (reference "Free care principle" of Title XIX, Section 1902(a)(11) (B)]. Documentation, including personnel time studies, must be available in the agency to demonstrate how costs are determined. The Medicaid fee schedule amount is the maximum payment reimbursed by Medicaid for each code.

Title V funds are utilized to fund services as described by the specific agency contract with the Iowa Department of Public Health.

Maternal health centers may bill IDPH starting February 1, 2009 for Presumptive eligibility determination, Title V and Title XIX care coordination, Title V and Title XIX hove visit for care coordination.

SUMMARY OF SERVICES

The following information is based upon Medicaid and Maternal Health program guidelines as of the date of this document.

SERVICES FOR ALL WOMEN

- Urine Pregnancy Test
- Prenatal Risk Assessment
- Prenatal and postpartum medical care.
- Health education services provided by a registered nurse
- Care Coordination
- Oral Health Services
- Transportation
- Immunizations
- Presumptive Eligibility Determination

Urine Pregnancy Test by visual color comparison/Urine test for determination of pregnancy.		
Documentation	Special Considerations	Code/Other funding sources
Enter results in WHIS.	Staff must demonstrate competency on the procedure per agency protocols and be able to distinguish color variations correctly.	81025 Urine Pregnancy Test by visual comparison Bill to IME

Presumptive Eligibility Determination (Service provide on or after 2/1/2009)		
Documentation	Special Considerations	Code/Other funding sources
Health Services Application Form and Case File required by DHS Document in Time and Service Input Form in WHIS. .	Agency must have an MOU with DHS prior to providing this service and then maintain a qualified provider status from DHS. Eligible clients must be pregnant and have an Iowa address. US citizenship is not a requirement. Staff provides education about presumptive eligibility and then assists the pregnant woman in completing the Health Services Application, form 470-2927 or the Spanish Health Services Application form 470-2927(S). This allows the qualified provider to make a presumptive eligibility determination.	No code Bill cost of Presumptive eligibility determination to IDPH per client. For service provided on or after 2/1/2009 Can bill for Title V and Title XIX clients.

Prenatal Risk Assessment Determine risk for pregnant Medicaid members upon initial entry into care using form 470-2942, *Medicaid Prenatal Risk Assessment*. Repeat at 28 weeks of care when a low-risk pregnancy is reflected or when an increase in the pregnant woman's risk status is indicated.		
Documentation	Special Considerations	Code/Other funding sources
Enter results on form 470-2942 found in WHIS. Maintain copy of the form 470-2942 risk assessment in medical record in the agency including date of service and location code for service.* Send a copy of the Risk Assessment to the client's primary medical/obstetrical care provider.	May only be billed by one provider unless additional assessment is required at a later date. If sharing responsibility for completing the form, establish a contract or MOA specifying payment agreement for services between collaborating parties. Also obtain sharing of information release from client. Additional assessments may be billed at a later date if client need is demonstrated. Note reason for additional assessment in medical record. To score the *Medicaid Prenatal Risk Assessment*, add the total score value on the left side and either the B1 column (initial visit score value) or the B2 column (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment. When a high-risk pregnancy is reflected, inform the woman and provide appropriate enhanced services as described in the individualized plan of care. (See Enhanced Services.) Complete the Medicaid Risk Assement for all clients even those who are not eligible for Medicaid. In WHIS if the client is not eligible for Medicaid put zero's in the spot for the Medicaid number.	99420 Completion of Medicaid Prenatal Risk Assessment Or Title V for uninsured/ underinsured with sliding fee scale Bill to IME

Maternity Care Antepartum care only 4 to 6 visits; Antepartum care only 7 or more visits; or Office/Outpatient Evaluation and Management of care services varying intensity. Includes:

- Problem-focused history;
- Problem-focused examination;
- Medical decision-making
- Counseling and
- Coordination of care
- Refer to the *PROCEDURE CODES AND NOMENCLATURE* found in the Maternal Health Screening Center Policy Manual for more detail.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) noted above.	Care must be provided by a physician NP, CNM, or PA. All services in the package must be provided in order to bill. Individual services may not be billed separately. Must be face to face.	Refer to the *PROCEDURE CODES AND NOMENCLATURE* found in the Maternal Health Screening Center Policy Manual for more detail. Antepartum care 59425 Antepartum care only; 4 to 6 visits 59426 Antepartum care only; 7 or more visits *New Patient*: Office/outpatient visit for the evaluation and management 99201 self limited or minor – approx 10 min. 99202 – Straightforward low to moderate severity- approx 20 minutes 99203 low complexity, moderate severity. Approx 30 minutes 99204 moderate to high severity Approx 45 min. 99205 high complexity, moderate to high severity. Approx 60 min Established Patient: Office/ outpatient visit for the evaluation and management 99211 minimal problems approx 5 minutes 99212 self limited or minor problems - Approx 10 minutes 99213 low to moderate complexity -Approx 15 minutes 99214 mod to high complexity - Approx 25 min 99215 mod to high complexity -Approx 40 minutes Bill to IME Title V for uninsured/ underinsured with sliding fee scale

Health Education Health education services provided by a registered nurse, which includes:

- Importance of continued prenatal care.
- Normal changes of pregnancy:
- Maternal changes
- Fetal changes
- Self-care during pregnancy.
- Comfort measures during pregnancy.
- Danger signs of pregnancy.
- Labor and delivery:
- Normal process of labor
- Signs of labor
- Coping skills
- Danger signs
- Management of normal labor
- Preparation for baby:
- Feeding
- Equipment
- Clothing
- Education on the use of over-the-counter drugs.
- Education about HIV prevention.

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) noted above. Must document time in and time out, specifying a.m. or p.m.	Provided by a Registered Nurse. These services are included in the prenatal and postpartum medical package and are not billable as separate services on the same date as the direct care visit. Brochures and pamphlets may be provided as reinforcement of face to face education. Any cost incurred is part of health education or other direct care service code and is included in the cost plan. Mailing brochures and pamphlets may not be billed as a separate service. To be billed to an individual client, Health education must be provided on a one on one basis not as part of a class.	H1003 Prenatal care at risk service education - Per 15 min unit with a maximum of 5 units per date of service. Bill to IME Or Title V funding may be billed individually or when provided as a class.

Care coordination services – all women Care coordination is the process of linking Medicaid clients to the health care system. Activities involve collecting information on the health needs of the client and assisting families to connect to services based on those needs. Services may include:

- Risk assessment.
- Arrangements for prenatal classes.
- Arrangements for delivery as appropriate.
- Referral to WIC.
- Referral to dental services.
- Referral to physician or mid-level practitioners.
- Referral for hepatitis screen.
- Referral for other services as necessary.
- Assist with transportation to receive prenatal and postpartum services that are not otherwise payable under the Medicaid program.
- Assisting families to obtain Medicaid services and completion of the DHS multi-program application as needed.
- Care coordination includes assisting clients in gaining access to services and monitoring to assure that needed services are received.

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Document assessment and referral in WHIS use the Time and Service Input Form. Documentation must adhere to requirements in IAC 441-79.3(2) noted above. Must document time in and time out, specifying a.m. or p.m.	Provided by a registered nurse or: A person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology A person with a degree in dental hygiene A licensed practical nurse or a paraprofessional working under the direct supervision of a health professional. One billing unit is equal to 15 minutes of service. Service may be provided via phone, or in the office setting. Documentation time may be included in the total time for care coordination if documentation is completed on the date of service. May not be billed when provided as an integral part of a direct care service that is provided on the same date. May be billed on the same date as a direct care service if service is provided by a separate provider for a separate issue. *Example, a dental service and an RN service for a high risk pregnancy issue may be billed on the same day.* Care coordination to low risk prenatal women is part of the direct care service package and is billed as such when provided on the same date as the direct care visit. All direct care services connected to the code must be provided for billing to occur.The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the mother or baby is considered part of this postpartum visit. Do not bill care coordination for any part of this maternal health visit. .	Formerly code H1002 for Title V or Title XIX clients. Bill cost of care coordination service to IDPH per client for services provided on or after 2/1/2009.

Oral Health Direct Care Services Dental hygiene services within the scope of practice defined by the Iowa Board of Board Dental Examiners. Services may include:

- Initial oral screen
- Periodic oral screen
- Child fluoride application
- Adult fluoride application
- Child prophylaxis
- Adult prophylaxis
- Topical fluoride varnish – therapeutic application for moderate to high caries risk clients
- Nutritional counseling for the control and prevention of oral disease
- Tobacco counseling for prevention of oral disease.
- Oral hygiene instruction
- Sealant (per tooth)
- Bitewing x-rays

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed for D1310, D1320 and D1330. For sealant applications reference the number of the tooth sealed.	Dental hygiene services within the scope of practice defined by the Iowa Board of Dental Examiners. Dental screenings, fluoride applications, nutritional counseling, tobacco counseling, and oral hygiene instruction may be provided by an agency registered nurse, nurse practitioner, or physician assistant who has participated in IDPH-approved oral health training. Non-dental health professionals must assure that they are working within their respective scopes of practice. When providing direct care oral health services, any care coordination related to the direct care is considered part of the direct care service. Do not bill care coordination separately. For example: After completing an oral health screen, making arrangements for a referral to a DDS for follow-up and treatment cannot be billed as care coordination. When providing fluoride varnish applications, the fluoride varnish code (D1206) should be used. Sealant applications are limited to ages 6-18 or those with a physical or mental disability. For Codes D1310, D1320 and D1330, a minimum of 8 minutes must be provided to bill the service.	Use Diagnosis code 528.9 with the following codes: D0150: Initial oral screen D0120: Periodic oral screen D1203: Fluoride (1-12 yr) D1204: Fluoride (13 and over) D1120: Prophy (1-12 yr) D1110: Prophy (13 and over) D1206: Topical fluoride varnish (mod to high caries risk) D1310: Nutritional counseling for control and prevention of oral disease (15 minute unit – maximum 4 units per date of service) D1320 Tobacco counseling for prevention of oral disease (15 minute unit) D1330: Oral hygiene instruction ((15 minute unit – maximum 4 units per date of service) D1351 Sealant per tooth (6-18 yrs, first and second permanent molars, permanent bicuspid and deciduous molars) D0270: Bitewing – single film D0272: Bitewing – two films D0274: Bitewing – four films Bill to IME

Transportation to receive prenatal and postpartum services that is not otherwise payable under the Medicaid program. Includes non-emergency medical, dental, mental health local transportation by:

- Vehicle provided by volunteer (individual or organization)
- Taxi
- Bus, intra or interstate carrier
- Wheelchair van
- Transported by caseworker or social worker
- Parking fees, tolls, other related costs
- Transportation for HMO clients

Documentation	Special Considerations	Code/Other funding sources
Include: Date of service Who provided the service Address of where recipient was picked up Destination (medical provider's name and address) Invoice of cost Mileage if transportation is paid per mile If a service log containing the above information is maintained, the service note must include reference to client record.	Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received. This does not include out-of-town transportation. Out of town transportation is paid for by the county DHS office. A transportation cost plan must be on file in the agency. A protocol or plan for transportation for non-Medicaid eligible women must be on file in the agency.	Use diagnosis code V68.9 with the following codes: A0080 Non-emergency transportation; vehicle provided by volunteer (individual or organization), with no vested interest Per round trip A0100 Non-emergency transportation; taxi Per round trip A0110 Non-emergency transportation; bus, intra or interstate carrier Per round trip A0130 Non-emergency transportation; wheelchair van Per round trip A0160 Non-emergency transportation, by caseworker or social worker Per round trip A0170 Transportation; parking fees, tolls, other Bill actual cost of transportation for the date the transportation was provided to the health related appointment to IME. For non-Medicaid eligible clients utilize local funding sources, community transportation services or volunteers.

Immunization Vaccine Administration:

- Initial administration of immunization subcutaneous, intramuscular
- subsequent immunization administration
- immunization administration, one vaccine intranasal or oral
- Vaccine – Non VFC/Billable Vaccines: Refer to the *PROCEDURE CODES AND NOMENCLATURE* found in the Maternal Health Screening Center Policy Manual for a listing of all applicable vaccines (F:2).

Documentation	Special Considerations	Code/Other funding sources
Document in WHIS, medical record, IRIS, Master Index Card as appropriate. Document in client's medical chart maintained in the agency Documentation must adhere to requirements in IAC 441-79.3(2) Include: Time in and time out specifying a.m. or p.m. First and last name of service provider & title / credentials Reference medical record, IRIS, or Master Index Card for full description of services provided. Assure entry in IRIS as appropriate.	Typically VFC vaccine is used (at no cost). If vaccine is provided outside of the VFC cohort, bill for the vaccine.	90471 initial administration of vaccine (single or combination), subcutaneous or intramuscular 90472 subsequent administrations of vaccine (single or combination) on same day as Code 90471 or Code 90473. 90473 administration of one vaccine (single or combination) by intranasal or oral means. Bill vaccine at cost. Refer to the *PROCEDURE CODES AND NOMENCLATURE* found in the Maternal Health Screening Center Policy Manual for a listing of all applicable vaccine codes (F:2). Bill to IME For VFC vaccine (at $ 0).

ENHANCED SERVICES/HIGH RISK WOMEN

Provided to women with high risk pregnancies in addition to the services listed above for low-risk women and include:

Development, oversight and monitoring of an individualized plan of care
More intense care coordination services
More intense health education services
Nutrition services/Diabetes Management by a Dietitian
Psychosocial services
Nursing visit in the home
Social Work visit in the home
A postpartum home visit

Following the Prenatal Risk Assessment, all high risk clients of the maternal health center **must have** an individualized plan of care for all services provided. The plan **must be** monitored regularly and revised as necessary based on needs assessments at each contact. Documentation of services provided shall include reference to the plan and notation when revisions are necessary based on goals met and emerging needs identified.

More Intense Care Coordination Developing an individualized plan of care based on the client's needs, including pregnancy, physical, mental, personal, and interpersonal issues. Developing the plan includes:
Counseling (such as coaching, supporting, education, listening, encouraging, and feedback)
Referral and assistance for obtaining other specified services, such as mental health and domestic abuse
Ensuring that the client receives all components as appropriate (medical, education, nutrition, psychosocial, and postpartum home visit)
Risk tracking

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Maintain a record of the time in and time out, specifying a.m. or p.m., per encounter to support the units billed Document in WHIS on Time and Services Input Form include time in and time out including am. and pm. Include interaction type as office or phone. Documentation must adhere to requirements in IAC 441-79.3(2) noted above.	Provided to women with high-risk pregnancies in addition to the services for low-risk women. Provided by a registered nurse or A person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology A person with a degree in dental hygiene A licensed practical nurse or a paraprofessional working under the direct supervision of a health professional. One billing unit is equal to 15 minutes of service. Service may be provided via phone, in the office setting. Documentation time may be included in the total time for care coordination if documentation is completed on the date of service. May not be billed when provided as an integral part of a direct care service that is provided on the same date. May be billed on the same date as a direct care service if service is provided by a separate provider for a separate issue. *Example, a dental service and an RN service for a high risk pregnancy issue may be billed on the same day.* The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the mother or baby is considered part of this postpartum visit. Do not bill care coordination for any part of this maternal health visit.	Formerly code H1002 for Title V or Title XIX clients. Bill cost of care coordination service to IDPH per client for services provided on or after 2/1/2009.

More Intense Health Education Education services of greater intensity that are not provided as part of Care Coordination or other service. The following topics should be provided based on documented risk assessment as specified in the individualized plan of care:

- High-risk medical conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, gestational diabetes, gum disease, chronic urinary conditions, genetic disorders, and anemia.
- Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension.
- Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases.
- Smoking cessation. Refer to Quitline Iowa at 800-784-8669 or on the Web at http://www.quitlineiowa.org/.
- Alcohol use.
- Drug use.
- Education on environmental and occupational hazards.
- High-risk sexual behavior.
- Oral Health

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed Documentation must adhere to requirements in IAC 441-79.3(2) noted above.	Provided by a registered nurse To be billed to an individual client, health education must be problem focused and provided on a one on one basis - not as part of a class. Referrals may be made to: Programs for stopping smoking or the use of alcohol or drugs. Psychosocial services for high-risk parenting issues or home situations, stress management, communication skills and resources, or self esteem.	H1003 Prenatal care at risk service education -per 15 minute unit with a maximum of 5 units per day. Bill to IME Title V funding (may be provided in a class setting)

Nutrition Services Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self reported dietary information. Discuss client's attitude about breastfeeding.

- At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- Development of an individualized nutritional care plan.
- Referral to food assistance programs, if indicated.
- Nutritional interventions:
- Nutritional requirements of pregnancy as linked to fetal growth and development.
- Recommended dietary allowances for pregnancy.
- Appropriate weight gain.
- Vitamin and iron supplements.
- Information to make an informed infant feeding decision.
- Education to prepare for the proposed feeding method and the support services available for the mother.
- Infant nutritional needs and feeding practices.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Need must be documented for	Provided by a licensed dietitian Services must be above and beyond WIC services. Services must be provided one on one based on a needs assessment and not provided as part of a class.	S9470 Nutrition counseling provided by a dietitian per encounter (one unit per date of service) Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee

service beyond WIC counseling		scale

Diabetes Management by a Dietitian Diabetes management		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above	Services must be provided by a Dietitian Service must be above and beyond services provided by WIC if the client is WIC eligible.	S9465 Diabetes Services provided by a dietitian per encounter (one unit per date of service) Bill to IME

Psychosocial Services
--A psychosocial needs assessment including a profile of the mother's:
- Demographic factors
- Mental and physical health history and concerns
- Adjustment to pregnancy and future parenting
- Environmental needs

--A profile of the mother's family composition, patterns of functioning, and support systems.
--An assessment-based plan of care.
--Risk tracking.
--Counseling and anticipatory guidance as appropriate.
--Referral and follow-up services.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above.	Psychosocial services must be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies. Psychosocial services provided by a Registered Nurse are billed as a nursing service such as H1003 or S9123. A social worker does not require a license to provide this service Services must be provided in an office setting.	H0046 Mental Health Services not otherwise specified Bill to IME Or Title V funding for uninsured/ underinsured based on a sliding fee scale

Fetal Non Stress Test (NST) A fetal non stress test shall be administered based on identified need as described in the clinic protocol.		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Include the reason the test was administered, pertinent information obtained during administration of the test (per training) and the date and time stamp for when the results were faxed to the client's physician along with other relevant communication with the client's primary provider.	The test must be administered by a Registered Nurse who has successfully completed training in the test administration. Test results must be sent to the client's physician along with communication with the provider's office that the test is being done and time results are being sent. Emphasize with the provider's staff that the test must be read by the provider on the same day as the test is administered. Request response on interpretation and any follow up communication or referral needed for the client.	59025 Fetal Non Stress Test Bill to IME

Nursing Visit In The Home Nursing visit in the home based on documented risk assessment and as specified in the individualized plan of care		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed	Must be provided by a Registered Nurse. May be provided pre or post partum Since the primary purpose of the home visit is to provide direct care services, the home visit for care coordination service for child health can not also be billed.	S9123 –Nursing Visit in home One unit of time equals one hour. No limit per day based on documentation of service provided. Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee scale.

Social Work Visit In Home Social Work visit in the home. Purpose of the visit is based on documented risk assessment and as specified in the individualized plan of care.		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above.	Must be provided by a Social Worker. May be provided pre or post partum. Since the primary purpose of the home visit is to provide direct care services, care coordination for child health can not also be billed.	S9127 Social Work Visit in the home One unit of time equals one encounter. Maximum of two encounters per pregnancy. Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee scale

Care Coordination Visit In The Home Care coordination visit in the home based on documented need		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. .Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Document in WHIS in the Time and Service Input Form must document interaction type as home visit. Include time in and time out, specifying a.m. or p.m. per encounter to support the units billed	In some situations it will be necessary to work one-on-one with a family in their home. Medically necessity may be due to a medical condition or when working with non-English speaking families and families without phones. Care Coordination may involve: • Providing information about available health care services, • Assisting clients in making health care appointments, • Making referrals, • Coordinating access to needed support services • Coordinating access to health care, and follow up to make sure that the needed services were received.	No Code/ Bill cost of care coordination home visit to IDPH per client. Includes Title V and Title XIX clients for service provided on or after 2/1/2009.

One to Two week Post Partum Home Visit This visit by a Registered Nurse shall include:

- An assessment of the mother's health status.
- Discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome.
- Family planning.
- A review of parenting skills including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant.
- An assessment of the infant's health.
- A review of infant care including feeding and nutritional needs, oral health, breast-feeding support, recognition of illness, accident prevention, immunizations, and well-child care.
- Identification and referral to community resources as needed.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed.	The postpartum home visit is made within two weeks of the child's discharge from the hospital (ideally in the first week) Must be provided by a Registered Nurse. If the purpose of the home visit is to provide direct care services, the home visit for care coordination service for child health can not also be billed. If unable to schedule in the first two weeks, complete no later than six weeks. If unable to complete in the time frame, discharge the mother and baby to an appropriate agency and the Child Health Screening Center Care Coordinator for completion of the visit.	S9123 –Nursing Visit in home One unit of time equals one hour. No limit Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee scale

* The place of service must be noted on the medical record. Below are selected codes and categories used in billing to specify the location of the service. Refer to the Maternal Health Provider Manual, G "Claim Form field number" 24B, for a full listing.

11	Office
12	Home
21	Inpatient hospitals
22	Outpatient hospitals
23	Emergency room – hospital
25	Birthing center
26	Military treatment facility
41	Ambulance – land
42	Ambulance – air or water
71	State or local public health clinic
72	Rural health clinic
99	Other unlisted facility

MCH Title V Grantee's Launching into 2009

Billing IDPH for
- *Outreach (MH) / Informing (CH)*
- *Care Coordination (MH and CH)*

Purpose of today's presentation

- To provide an ***overview*** of procedural changes regarding billing of outreach / informing and care coordination services to IDPH.
- Changes in billing procedures begin for services provided on and after ***February 1, 2009.***
- Essentially, expectations for service delivery and documentation have not changed.

Background

- Federal final interim regulation clarified the definition and requirements for targeted case management services.
- Iowa DHS and IDPH recognized that outreach/ informing and care coordination services do not meet newly defined criteria.
- The DHS-IDPH Administrative Services agreement that establishes IDPH as the payer allows agencies to continue to bill for these services.

Maternal Health

Maternal Health

- What Maternal Health services will be billed to IDPH? (See handout)
  - Outreach = presumptive eligibility
  - Care coordination for Title V and Title XIX clients (including oral health care coordination)
  - Home visit for care coordination for Title V and Title XIX clients

Maternal Health

- Billing Outreach (presumptive eligibility)
  - Agency must have a MOU with DHS and be qualified to make presumptive Medicaid eligibility determinations found under Iowa Administrative Code 75.1(30)
  - Contact Susan Trotter (DHS) with questions at 515-281-6177

Maternal Health

- Presumptive Medicaid Eligibility for Pregnant Women
  - Applications include forms 470-2927 and 470-2927(S) *Health Services Application*. These forms can be found and printed at: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Master/6-app.pdf
  - Date-stamp the front page of the application to show when it was received. The date received is the soonest presumptive eligibility can begin.

Maternal Health

- Presumptive Eligibility - Cautions
  - Must be an Iowa resident
  - Do not have to verify she is a United States citizen.
  - Do not have to provide proof of her income. Accept the woman's statements regarding her family income. If she is within income guidelines, we "presume" she is eligible.

Maternal Health

- Presumptive Eligibility - Cautions
- Call the DHS's Quality Assurance (QA) unit the day you make an eligibility determination or no later than the next day
  - Local – 281-6401
  - Toll free – 1-800-373-6306
- See handout for additional guidelines from DHS.

Maternal Health

- Presumptive Medicaid Eligibility Documentation - Case File and WHIS
  - Case File (see Handout)
  - WHIS Documentation on Time and Service Input Form (see Handout)
    - Client's name, ID, Medicaid ID (if applicable)
    - Payment Source
    - Date of Service
    - Service Provided

Maternal Health

- Billing care coordination
  - Links clients to the health care system – both medical and dental
  - No minimum number of minutes; Submit claims for all care coordination provided.
  - NEW!! 15 minute unit: Total all minutes and divide by 15 to determine number of units to be reimbursed.
  - Care coordination for both Title V and Title XIX clients will be paid on a fee-for-service basis.

Maternal Health

- Care coordination cautions
  - Do not submit claim for medical care coordination provided in conjunction with direct medical services.
  - Do not submit claim for dental care coordination provided in conjunction with direct oral health services.

Maternal Health

- Care coordination cautions
  - Do not submit claim for written communication to family.
  - Care coordination may be provided by phone or face-to-face.
  - Care coordination documentation must include:
    - Date of service
    - Place of service
    - Who you spoke with
    - Issues addressed, input from family, services declined, outcomes, referrals
    - Time in and time out including a.m. and p.m.
    - First name, last name, and credentials of service provider

Maternal Health

- Billing home visit for care coordination – Care coordination services provided in a home setting
  - Do not include travel time in number of minutes
  - 15 minute unit: Total all minutes and divide by 15 to determine number of units to be reimbursed
  - Home visit for care coordination for Title V and Title XIX clients will be paid on a fee-for-service basis
  - WHIS documentation on Time and Service Input Form - must document interaction type as home visit.

Maternal Health Tools

- Billing Maternal Health Services (list of services, who to bill, and maximum established reimbursement rates)
- Maternal Health Services Summary (revised)

Child Health

Child Health

- What Child Health services will be billed to IDPH? (See handout)
  - Initial inform / initial re-inform
  - Inform completion / re-inform completion
  - Care coordination for Title V and Title XIX clients (including oral health care coordination)
  - Home visit for care coordination for Title V and Title XIX clients

Child Health

- Billing for informing / re-informing
  - Initial inform / re-inform
    - Initial inform contact
    - Follow-up attempts to reach the family – ***must*** include phone or face to face attempts
  - Inform / re-inform completion
    - Verbal contact made with the family to explain services available under the EPSDT program and assess family needs

Child Health

- Billing care coordination
  - Links clients to the health care system – medical and dental
  - No minimum number of minutes; Submit claims for all care coordination provided.
  - 15 minute unit: Total all minutes and divide by 15 to determine number of units to be reimbursed.
  - Care coordination for Title V and Title XIX clients will be paid on a fee-for-service basis.

Child Health

- Billing home visit for care coordination
  - Care coordination services provided in a home setting (See guide sheet)
  - Do not include travel time in number of minutes.
  - 15 minute unit: Total all minutes and divide by 15 to determine number of units to be reimbursed.
  - Home visit for care coordination for Title V and Title XIX clients will be paid on a fee-for-service basis.

Child Health

- Care coordination cautions
  - Do not submit claim for medical care coordination provided in conjunction with direct medical services.
  - Do not submit claim for dental care coordination provided in conjunction with direct oral health services.
  - Do not submit claim for care coordination provided as part of an inform / re-inform completion.

Child Health

- Care coordination cautions
  - Do not submit claim for unsuccessful phone attempts to reach family to remind them of periodic screens that are due.
  - Do not submit claim for written communication to family; Must involve verbal or face-to-face contact with family.

Child Health

- NEW! Care coordination caution
  - Federal and state Medicaid guidelines stipulate that a child in a targeted case management (TCM) program is to receive all care coordination services from their assigned case manager.
  - Care coordination services for children in a TCM program are to be provided from their assigned case manager.
  - Child health agencies are to refer these families to the TCM provider.
  - Iowa DHS will provide IDPH identifying information by county of residence for children receiving TCM services.

Child Health

- Service documentation notes for informing/re-informing and care coordination services in CAReS
  - Place of service if not main agency address
  - Who spoke with
  - Issues addressed, input from family, services declined, outcomes, referrals
  - Time in and time out including a.m. and p.m. for care coordination
  - First name, last name, and credentials of service provider if not entering own data in CAReS
- Maintain signature log

Child Health Tools

- Billing Child Health Services (list of services, who to bill, and maximum established reimbursement rates)
- Child Health Services Summary (revised)

Submitting the Claim to IDPH

Submitting the Claim to IDPH

- How do we submit claims to IDPH?
  - Continue to submit monthly claims for grant fund expenditures as you have always done (GAX + monthly expenditure reports).
  - A separate GAX and supporting documentation will be submitted for the fee-for-service outreach/informing and care coordination claims.
  - Both GAX forms are due to IDPH within 45 days following the end of the month in which the services were provided.

Billing Fee-for-Service to IDPH

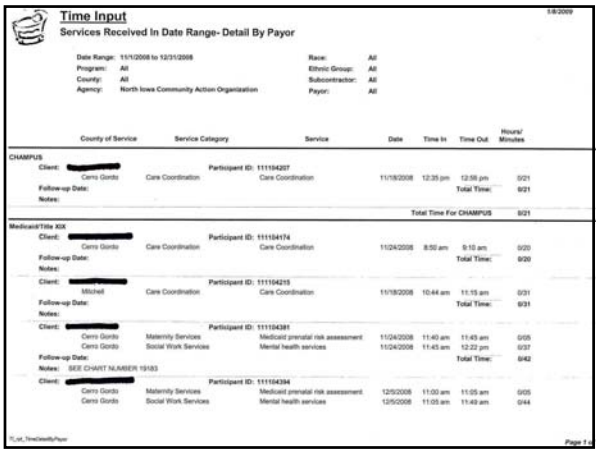
- Submit the following to IDPH
  - GAX
  - Lists of client information by service and funding source
    - Service listings: See slide # 29
    - Client information: See slide #30
    - Funding source for care coordination: Title V or Title XIX
- CMS 1500s will no longer be submitted for informing and care coordination services.

Listing Services on Fee-for-Service GAX

- Maternal Health
  - Outreach (presumptive eligibility)
  - Title V care coordination
  - Title XIX care coordination
  - Title V home visit for care coordination
  - Title XIX home visit for care coordination
- Child Heath
  - Initial inform
  - Re-inform (initial)
  - Inform completion
  - Re-inform completion
  - Title V care coordination
  - Title XIX care coordination
  - Title V home visit for care coordination
  - Title XIX home visit for care coordination

Supporting Documentation

- For each service on GAX, include list of
  - Client first and last names
  - Maternal health clients: WHIS identification number
  - Child health clients: Medicaid and/or child health identification number
  - Birth date
  - Date of service
  - Time in and time out with a.m. and p.m. for care coordination
  - Number of minutes for care coordination
- Title V and Title XIX care coordination supporting documentation will be listed separately.
- Format for providing supporting documentation will be provided by IDPH.



Time Input

Services Received In Date Range- Detail By Payor

Date Range: 11/1/2008 to 12/31/2008 | Race: All
Program: All | Ethnic Group: All
County: All | Subcontractor: All
Agency: North Iowa Community Action Organization | Payor: All

County of Service	Service Category	Service	Date	Time In	Time Out	Hours/ Minutes
CHAMPUS						
Client: [redacted]		Participant ID: 111104207				
Cerro Gordo	Care Coordination	Care Coordination	11/18/2008	12:35 pm	12:56 pm	0/21
Follow-up Date:					Total Time:	0/21
Notes:						
					Total Time For CHAMPUS	0/21
Medicaid/Title XIX						
Client: [redacted]		Participant ID: 111104174				
Cerro Gordo	Care Coordination	Care Coordination	11/24/2008	8:50 am	9:10 am	0/20
Follow-up Date:					Total Time:	0/20
Notes:						
Client: [redacted]		Participant ID: 111104215				
Mitchell	Care Coordination	Care Coordination	11/18/2008	10:44 am	11:15 am	0/31
Follow-up Date:					Total Time:	0/31
Notes:						
Client: [redacted]		Participant ID: 111104381				
Cerro Gordo	Maternity Services	Medicaid prenatal risk assessment	11/24/2008	11:40 am	11:45 am	0/05
Cerro Gordo	Social Work Services	Mental health services	11/24/2008	11:45 am	12:22 pm	0/37
Follow-up Date:					Total Time:	0/42
Notes: SEE CHART NUMBER 19183						
Client: [redacted]		Participant ID: 111104394				
Cerro Gordo	Maternity Services	Medicaid prenatal risk assessment	12/5/2008	11:00 am	11:05 am	0/05
Cerro Gordo	Social Work Services	Mental health services	12/5/2008	11:05 am	11:49 am	0/44

Quality Assurance Monitoring

- Agencies shall assure that documentation of services in CAReS and WHIS meets requirements and supports ***all services billed***.
- Partial claims will not be paid.
  - Incomplete and/or inaccurate documentation or claims information will result in denial of the entire claim.
  - Denied claims must be corrected and resubmitted.

Plan for additional training

- By January 28th, submit questions in writing to Julie Montgomery at jmontgom@idph.state.ia.us.
- February 5th 9:00 – 10:30 a.m.: Conference call to address questions
  - Phone number 1-866-685-1580
  - Conference code 0009990487#
- February 20th 9:30 – 11:30 a.m.: Billing training via ICN
- April 6th: If desired, agencies may schedule technical assistance on the day prior to the 2009 Iowa Public Health Conference, Scheman Conference Center, Ames, IA

Thank you!

Next Upcoming Training Event

Conference call to address questions on February 5, 2009 9:00 – 10:30 a.m.

LPH/IDPH Contracting Issues Workgroup

Formed in May 2008 to address specific issues identified by SE Iowa LPH and IDPH

Introduction

- Local Public Health agencies identified issues with contracts, duplicate program reporting, and duplicate data entry in multiple programs
- IDPH formed workgroup for state and local staff to address issues

Workgroup Meetings

- 3 meetings
- Subcommittees formed to study and address identified areas:
  - Data Sharing
  - Program Reporting
  - Financial

Data Sharing Subcommittee

Issue: Data sharing between IDPH applications and program reports

- Iowa Vital Records System (IVRS)
- Immunization Registry Info System (IRIS)
- Child & Adolescent Reporting System (CAReS)
- Iowa WIC Information Network (I-WIN)
- Lead Program (STELLAR)

Applications

- Do not “talk to each other” or share data
- Subset data entered into each, i.e. name, address, DOB, parent’s name
- Share clients

Progress and Challenges: IVRS

- Capable of sharing data with other applications
- Electronic Birth Registration – can be used to share data with applications capable of accepting data from another source

Progress and Challenges: IRIS

- Re-write to be completed by end of 2009
- Every live birth in Iowa – “place holder” in IRIS from birth registry of IVRS

Progress and Challenges: CAReS

- Cannot receive data from another application without a manual upload process
- Receives client records from DHS - Medicaid

Challenges: CAReS

If IDPH contracts with outside company to rewrite CAReS to accept birth records:

- Cost minimum $300,000
- Two years work by outside contractor
- Client records – potential for creating duplicate record if do not have exact match for name, DOB, address

Progress and Challenges: Lead Program - STELLAR

- CDC Application
- Each agency has own copy of STELLAR (not a web-based data system).
- Does not communicate with any IDPH application, i.e. Iowa Vital Records System (IVRS)

Challenges: Lead/STELLAR

- If re-written, cost several hundred thousand dollars and couple of years to re-write
- STELLAR has some of the same functions as IDSS, but it is also a patient care record and contains property data as does a tax assessor database.
- New web-based lead data system (HHLPSS) to be deployed mid-2009.
  - LPHAs willl enter environmental and case mgt data.
  - IDPH will electronically import blood lead tests, which eliminates duplicate entry of demographic information by local agencies.

Data Sharing: Summary

- To resolve issue – single person identifier is needed that is uniform across state agencies and multiple states.
- Without unique identifier, there will be issues between matching data sets and the number of duplicate records will be unmanageable.

Data Sharing: Recommendations

- New applications should be compatible with IVRS
- New IRIS will accept birth records – all children born in Iowa would already be in IRIS
- Lead – HHLPSS (new web-based system) will resolve issues of duplicate data entry of demographic information by local agencies.
- Education from IDPH to LPHAs on IT (possibly an IT newsletter)

Program Reporting Subcommittee

Issue: duplicate program reporting

- Lead
- Immunization
- MCH

Program Reporting: Lead

- Looked at specific reports required
- Lead Program does not ask for information that must also be reported in other programs
- New web-based data system expected in mid-2009: data entry of blood lead test completed by importing files at IDPH; local agencies will enter case mgt activities

Program Reporting: Immunizations

- On-going reporting requirements
  - Temps, IRIS data, year-end report
- Required for RFP/RFA
  - Vaccine Storage & Handling Plan
  - Objectives
  - Narrative
- Funding: 65% CDC federal, 35% state

Program Reporting: MCH

- On-going reporting requirements
  - CAReS & WHIS data entry
  - Quarterly ***hawk-i*** and dental data report
  - Annual Cost Analysis & Transportation Plan
  - Annual Internal Chart Audit & Biennial External Audit
  - Year End Report
- Required for RFP/RFA
  - Written description of Child And Adolescent Immunization Practices are being met assurance of documentation into IRIS, relationship with other immunization providers (RFP only)
  - Report on how children receive blood lead testing & agency's role in CLPPP
- Funding: blend of Title V Block Grant Funds and Medicaid reimbursement

Program Reporting: Summary

- Immy Contract: children birth through 18 years of age – served by VFC program
- MCH Contract: birth through 21 years of age – Medicaid covers birth through 20 yrs, and Title V covers birth through 21 yrs
- Possible duplicate reporting identified in RFPs for Immy and MCH – both ask for narrative description of immy services provided by contractor; will be addressed for FFY 2011 RFP to identify potential streamlining

Financial Subcommittee

Proposal:

- Annual electronic expenditure workbook to replace hard copy GAX
- Document library to permit access and posting by contractor, program staff, and finance staff
- IDPH to standardize program review processes

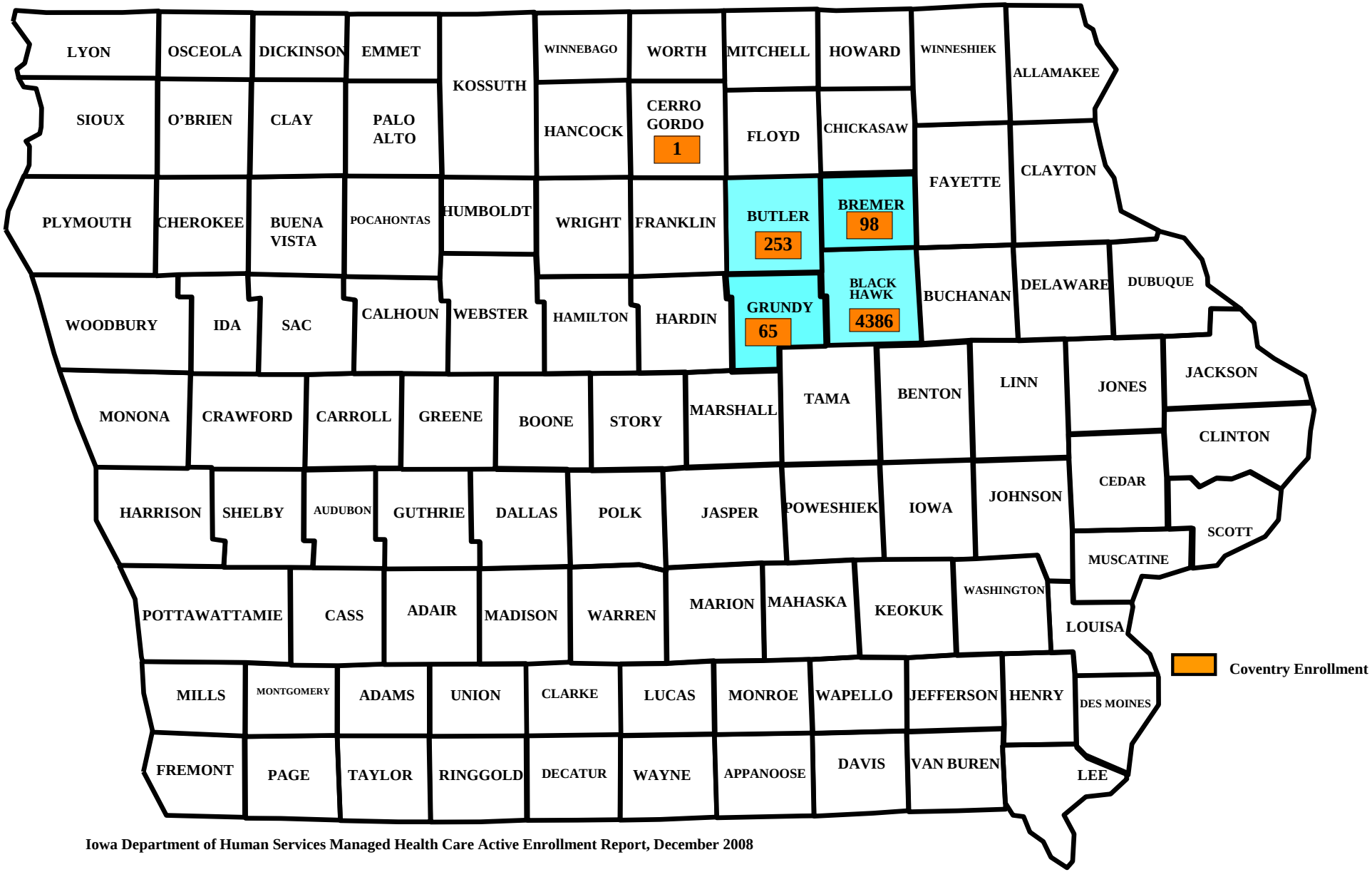
Financial Subcommittee Cont

- Electronic Expenditure Workbook Pilot Project
- Certification statement on each monthly sheet
- Pilot of workbooks for Immy, MCH, and Emergency Preparedness
- Draft protocols for IDPH & Bureau of Finance
- Request for procurement of Document Library – costs and support staff

Future Steps

- Next meeting: April 2009
- Reports from Subcommittees

Medicaid HMO Enrollment
December 2008



Iowa Department of Human Services Managed Health Care Active Enrollment Report, December 2008