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PROGRAM OVERVIEW

MEDICAID ENHANCED SERVICES

Medicaid Enhanced Services are designed to address medically compromising risk factors that interfere with patients' ability to attain or maintain an optimal state of health. These services support and complement primary medical care. While they are each designed to support linkage of patients to a medical home and reinforce medical care, they are also intended to encourage patients to consider and make responsible decisions about their own health care.

BEST PRACTICE GUIDELINES FOR PERINATAL CARE

The High Risk Channeling Project (HRCP), a Freedom of Choice Waiver program that encouraged risk-appropriate care for Medicaid-sponsored pregnant women and infants, expired on August 11, 2001. Because the waiver expired, the Department of Health and Human Services (DHHS) transitioned to recommended best practice guidelines for perinatal care.

DHHS remains committed to the concept(s) of risk-appropriate care and enhancing maternal and child health outcomes. Therefore, the following Medicaid Best Practice guidelines are recommended:

- Early and continuous risk screening for all pregnant women
- Early entry into prenatal care
- Care for all prenatal women by the provider level and specialty best suited to the risk of the patient (*Guidelines for Perinatal Care,* Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997)
- Risk-appropriate care for all infants in a setting that is best suited to the level of risk presented at delivery (*Guidelines for Perinatal Care,* Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997)
- Risk assessment of the infant prior to discharge from the hospital

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PROGRAM OVERVIEW

BEST PRACTICE GUIDELINES FOR PERINATAL CARE (CONT'D.)

- A Postpartum/Infant Home Visit (PP/IHV) for every Medicaid-eligible mother and infant
- Communication and coordination regarding the perinatal plan of care between each provider (*i.e.*, the specialist physician should communicate pertinent information back to the community level physician)
- A medical home for the mother-infant unit before and after delivery to handle long-term health care needs
- Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) referrals when medically indicated

For additional recommendations and guidelines for risk-appropriate ambulatory prenatal care for pregnant women, refer to the book Guidelines for Perinatal Care, which is endorsed by the American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG).

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PROGRAM REQUIREMENTS

DOCUMENTATION REQUIREMENTS

Client Record

There must be a record for each client/patient that includes sufficient documentation of services rendered to justify Medicaid participation. The record should be arranged in a logical manner so that the clinical description, course of treatment, and services can be easily and clearly reviewed and audited. All clinical records must be kept in a confidential and safeguarded manner as outlined in Section 1.

Medical Service Documentation

Documentation of services should comply with guidelines set forth under each service in this section. Adequate documentation reflects:

- What was done for the patient
- Why
- By whom
- For what length of time
- What future actions are planned, if applicable

A reviewer should be able to discern from this information that adequate and appropriate observations were used in assessing needs and planning care.

Notations should be concise, but descriptive and pertinent. Although minimum parameters must be addressed, documentation should reflect individualization of care.

Abbreviations and Symbols

Each provider must maintain a list of approved abbreviations and symbols used in patient/client record documentation.

Legibility

All entries must be in ink or typed, legible, and in chronological order. Entries must be dated and signed with the staff person's name and title.

Error Correction

The client/patient record is a legal document and should be corrected with caution.

Each provider must have a documented error correction

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PROGRAM REQUIREMENTS

Error Correction (Cont'd.)

policy in place. At a minimum, single entry errors should be corrected as follows:

- A single line drawn through the error so that the words remain legible
- The word "error" written above or beside the error
- The correction entered
- Signed, initialed, and dated

Errors should not be erased or totally obliterated.

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PROGRAM SERVICES

PREVENTIVE AND REHABILITATIVE SERVICES FOR PRIMARY CARE ENHANCEMENT

Preventive and Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are interventions that address medical risk factors that interfere with a patient's ability to maintain an optimal state of health. P/RSPCE support primary medical care. The services are directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability.

Since preventive and rehabilitative services are provided to support primary medical care, all patients who receive P/RSPCE must exhibit risk factors (health related or medical) that directly impact their medical status. These risk factors must be clearly documented in the patient's record, and linkage to the patient's medical status must be obvious. It must be reasonable to assume that preventive and rehabilitative services will positively impact the identified risk factors.

Risk factors that affect the medical status or medical care of the individual must be identified to qualify for the service. Once a risk factor is identified, the patient, physician, and P/RSPCE staff will develop a plan of care. Individual and/or group visits consist of services such as dental and medical appointment follow-up, identifying resources to transition patients into an appropriate system of care, and other health resources.

Purpose

P/RSPCE support and complement primary medical care. The service goals are to:

- Prevent disease, disability, and other health conditions or their progression
- Prolong life
- Promote physical and mental health and efficiency
- Reduce physical or mental disability
- Restore an individual to the best possible functional level
- Promote positive health outcomes

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Communication with the Primary Care Physician (PCP)

Involvement of the patient and the primary care physician (PCP) in developing the plan of care is essential to the accomplishment of these goals. In order for the provider to bill Medicaid for service provision, a licensed physician or other appropriate practitioner (*i.e.*, certified nurse practitioner or physician assistant) must approve the plan of care. Communication may be either verbal or written; however, there must be supporting documentation of communication with the PCP. Supporting documentation must include the name of the PCP contacted, the date, and the time.

P/RSPCE providers should maintain and document communication with the PCP throughout all phases of the patient's care in the clinical record.

Medical Necessity Criteria

"Medically necessary" means that a service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Provision of P/RSPCE must be based on an initial assessment and plan of care as defined later in this section. Covered P/RSPCE must either be (1) required for the development and implementation of a comprehensive plan of care by a physician and other appropriate practitioners, or (2) preventive services identified in the comprehensive P/RSPCE plan that are not otherwise covered under the state plan.

P/RSPCE may also be provided to individuals who are "self-referred walk-ins" or who have been referred by various entities (*e.g.*, schools, Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] providers, Department of Social Services, etc.). In these situations, medically necessary P/RSPCE services must be rendered in the same manner as all other referrals.

Monitoring of patients should be kept to a minimum — only patients with acute health issues should be monitored. Patients who have demonstrated overall compliance with health care instruction should require a minimum of contact or be discharged from services. All patients should be encouraged and urged toward self-management.

Making and coordinating referrals to community resources such as the clothing bank, housing authority, legal aid, and/or utility companies are not considered medical in nature. Monitoring of a pregnant woman who has no history of noncompliance and no individual risk factors

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Medical Necessity Criteria (Cont'd.)

would not be medically necessary, and therefore would not be appropriate for this service. Counseling and education regarding family planning are also not appropriate for this service. Developmental, environmental, and psychological risks are billable only when these risks directly relate to the medical need as identified by the attending physician.

Documentation

Documentation requirements include the following:

- P/RSPCE must be documented on electronic or paper forms that conform to documentation requirements specified in this manual.
- If the patient is a member of a PEP, HOP, PCCM, or one of the Medicaid-sponsored HMOs, all P/RSPCE must be provided within managed care guidelines.
- The source of and reason for patient referral (including when the patient is "self-referred") and risk factors must be included in the patient record.
- All P/RSPCE assessments must be completed, and appropriate follow-up begun, within 20 working days of the referral.
- Documentation must reflect that the service provided is based on the assessment/plan of care.

P/RSPCE documentation must include, at a minimum:

- Date, place of service, and the number of units
- Intervention/service provided
- Patient response and participation level
- Indication of whether service included direct contact (*i.e.*, face-to-face or by phone with the beneficiary), when applicable, or if the service included indirect contact (*e.g.*, telephone call to the PCP)
- Review and/or revision of plan of care as indicated by original or ongoing assessment
- Future intervention plans (detailed in the assessment and revised as indicated in the plan of care)
- Expected client outcomes (goals and/or objectives), activities to be accomplished (if applicable), inter-

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PROGRAM SERVICES

Documentation (Cont'd.)

ventions, referrals for additional services, frequency of contacts, and collaboration with other providers (if applicable)

- Discharge documentation including:
  - Reason for closure
  - Signature
  - Date of closure
  - Referrals for other needed services (if applicable)
  - Documentation of verbal or written communication with the medical home

Billing

Documentation time (*e.g.*, time spent writing letters to physicians about the patient, faxing or photocopying information about the patient, setting up the medical record, and making clinical entries about the visit) is considered an integral part of service delivery and should not be billed separately. Only direct, one-on-one contact with the parent and/or caregiver (*e.g.,* for infants or mentally impaired individuals) will be billable. Monitoring of patients should be kept to a minimum; only patients with acute health issues should be monitored.

All P/RSPCE must be billed under the Medicaid number of the patient who is the primary focus of the assessment/ intervention. All P/RSPCE services must have a direct and significant impact on the patient under whose Medicaid number they are billed. Documentation must occur in the medical record of the person to whom services were provided (*e.g.*, mother-baby unit. If the provider is working on problems related to the mother, then documentation must appear in the mother's record. If the provider is working on problems related to the baby, then documentation must appear in the baby's record).

P/RSPCE assessment/service planning and other P/RSPCE interventions may, with support documentation, be billed for/on the same date of service. A Postpartum/Infant Home Visit (PP/IHV) and a P/RSPCE home visit may not be provided by the same provider (*e.g.*, health department or home health agency) on the same day.

Section 3 should be consulted for further information regarding billing.

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Standing Orders

If a patient does not have a PCP, clinic "Standing Orders" may be used for a period not to exceed six months with the understanding that the P/RSPCE provider must actively seek a PCP for all patients. Upon securing a medical home, the patient, the patient's PCP, and the P/RSPCE provider must jointly develop (either verbally or in writing) the plan of care. At the end of the six months, if a PCP has not been located, P/RSPCE must be discontinued and further P/RSPCE services cannot be billed to Medicaid.

See Section 5 for an example of a Standing Order.

Billing Codes

Procedure Code	Description	Frequency	Modifiers
S0315	Disease Management Program; Initial Assessment and Initiation of the Program	Eight units per contract year (15 minutes per unit)	TD = Registered Nurse TE = LPN HN = Person w/ bachelor's HO = Person w/ master's
S9445	Patient Education, Not Otherwise Classified, Non-Physician Provider; Individual, Per Session	As indicated	TS = Follow-up service
S9446	Patient Education, Not Otherwise Classified, Non-Physician Provider; Group, Per Session	As indicated	TS = Follow-up service
S0316	Follow-up/Reassessment	As indicated	TD = Registered Nurse TE = LPN HN = Person w/ bachelor's HO = Person w/ master's HM = Paraprofessional
96153	Health and Behavior Intervention, Each 15 Minutes; Face-to-Face; Group	As indicated	TD = Registered Nurse TE = LPN HN = Person w/ bachelor's HO = Person w/ master's HM = Paraprofessional

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Billing Codes (Cont'd.)

Note: A provider is authorized to bill for a maximum of eight units per contract year for the assessment and plan of care development and then a maximum of 64 units per contract year for service delivery (*i.e.* Patient Education, Follow-up/Reassessment, and Health and Behavior Intervention). In the event of extreme and unusual circumstances, additional units may be requested by a PCP and can be authorized by the DHHS Review Committee. Examples of extreme and unusual circumstances requiring more than 64 units per calendar year are a change of diagnosis or a special needs child with unusual requirements.

Assessment

The assessment will determine immediate and long-term patient needs and whether preventive or rehabilitative interventions are necessary. Assessments may be targeted or comprehensive in scope and may include:

- Interviews with the patient and identified family members
- Other evaluation activities prescribed by relevant professional practice standards

Targeted Assessment

Patients who have previously been assessed and who are identified with specific risk factors (*e.g.*, those referred from a physician's office) may benefit from a targeted assessment and resulting plan of care.

Comprehensive Assessment

Patients who have not previously been assessed (*e.g.*, those patients who are self-referred) and who have unknown risk factors may benefit from a comprehensive assessment and resulting plan of care.

If the assessment indicates the need for treatment/services, a decision must be made concerning whether the services will be preventive (PSPCE) or rehabilitative (RSPCE) in nature or if the patient should be referred for other treatment. The documentation should support the type of service provided (it is permissible to use a check box to check [] preventive or [] rehabilitative). Also, a plan of care must be developed.

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Documentation

Assessments must include, at minimum:

- Date, place of service, and the number of units
- Subjective information (*e.g.*, barriers, needs identified by the patient)
- Objective information (*e.g.*, observed behavior, testing results, medical exam results)
- Indication of whether service included direct contact (*i.e.*, face-to-face or by phone with the beneficiary), when applicable, or if the service included indirect contact (*e.g.*, telephone call to the PCP)
- Patient response and participation level, when applicable
- Medical risk factors
- Signature, title of service provider, and date service was delivered
- Referral source and reason for the referral
- Notation of communication with primary medical care provider
- If appropriate, documentation that P/RSPCE is not indicated (and there will be no follow-up activities)

Plan of Care

A plan of care is based on the findings of an assessment that indicates a need for additional interventions. The plan of care sets forth the goals/objectives along with specific interventions that address needs identified in the assessment.

Once the decision is made to provide services, the patient must sign a release of information to accommodate information sharing and coordination of care with the PCP (medical home) and other providers involved in providing care to the patient. The PCP must approve the plan of care either verbally or in writing within 30 calendar days. ***All records must contain documentation for approval of the plan of care from the PCP for service provision to be Medicaid billable.***

All patients who receive P/RSPCE must have a plan of care that is developed in conjunction with the patient (*e.g.*, documentation should indicate patient understanding of the

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PROGRAM SERVICES

Plan of Care (Cont'd.)

plan of care). The P/RSPCE provider must also communicate (either verbally or in writing) with the medical home regarding the initial plan. The plan must be goal-oriented and address risk factors (health related or medical) identified in the assessment. The plan must include goals/objectives as well as interventions that are designed to address needs in the assessment.

Plan of Care Components

The plan of care for a patient receiving services must include the following components:

- A goal-oriented plan of care must be developed in conjunction with the physician (verbally or in writing) and patient. The plan must address the risk factors identified in the assessment and specify which service(s) are necessary to:
  - Reduce/ameliorate the risk factor(s) (for preventive services)
  - Restore the patient to an optimal state of health (for rehabilitative services)
- The plan of care should denote whether services to be delivered are preventive or rehabilitative (it is permissible to use a check box to check [] preventive or [] rehabilitative).
- If multiple risk factors that directly impact the P/RSPCE plan of care are identified, ongoing communication between all providers of care must be initiated. The P/RSPCE provider's participation in these groups should be only to provide and receive input regarding the P/RSPCE plan of care. This would include participating in inter/intra-agency staffing groups (*e.g.*, Interagency System of Care for Emotionally Disturbed Children [ISCEDC]) for the benefit of the client.

Note: Each patient must have only one plan of care per P/RSPCE provider. If the patient is being followed by more than one professional (*e.g.*, social worker and dietitian), both courses of treatment must be in the same plan of care. The plan of care must document patient risk factors as well as any and all services that the patient receives. If the assessment determines the patient does not have any risk factors, neither PSPCE nor RSPCE can be provided

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Plan of Care Components (Cont'd.)

as a part of a routine protocol.

There may be instances where more than one entity provides P/RSPCE services (*e.g.*, the hospital and the local health department). In these cases, collaboration between entities will be critical to avoid duplication of effort and to ensure that the patient's needs are met.

Documentation

At a minimum, the plan of care must include all of these:

- The identified problem(s)
- Planned interventions
- Expected client outcomes (goals and objectives)
- Referrals for additional services (if applicable)
- Frequency of contacts
- Collaboration with other providers (if applicable)

Goals/Objectives

Goals/objectives are outcomes that the client desires to achieve. They should be broad based, client focused, and measurable. There are both long-range and short-term goals/objectives.

Interventions

Interventions are those actions undertaken in order to achieve a goal/objective. The frequency or duration of the action(s) (*e.g.*, "will monitor for three months") should be noted along with the expected outcomes (*e.g.*, "the provider will…", "the client will…", "the PCP will…").

Appropriate Staff

A physician, registered nurse, licensed master's or bachelor's level social worker, registered dietitian, or other Licensed Practitioner of the Healing Arts (LPHA) must perform the assessment and development of the plan of care. Providers must maintain a list of current credentials for those who render P/RSPCE services.

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PREVENTIVE SERVICES FOR PRIMARY CARE ENHANCEMENT

Description

PSPCE are interventions that are furnished to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Preventive services promote full and appropriate use of primary medical care and promote positive health outcomes.

PSPCE interventions, based on the assessment, consist of:

- Assessment/evaluation of health status, individual's needs, and knowledge level
- Identification of relevant risk factors or needs which justify the medical necessity for PSPCE
- Development of a goal-oriented plan of care (in conjunction with the physician and individual) that addresses risk factors and needs identified in the assessment and specifies the service(s) necessary to reduce/ameliorate the risk factor(s)
- Anticipatory guidance/counseling to limit the development/progression of a disease/condition and to achieve the goals in the medical plan of care

In order to be covered as PSPCE, services or activities must: (1) be included in the PSPCE medical plan of care; (2) be directly related to the care of the patient; and (3) be medically oriented. PSPCE services include the provision of risk-specific, goal-oriented interventions in group or individual settings that address the identified medical problem or need documented in the plan of care. Group sessions that allow direct one-on-one interaction between the counselor and the individual may also be used to provide some components of this service.

Services may be provided in the patient's home, in the clinic, or in other appropriate settings. Documentation for each service must be related to the needs identified in the assessment. PSPCE are designed to be supportive of primary medical care and the service must have direct linkage to the plan of care.

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Description (Cont'd.)

Interventions also include activities to:

- Determine patient responses to structured interventions
- Assess overall patient progress or lack of progress toward achieving the outcomes indicated in the plan of care
- Determine the need for revision of the patient's initial plan of care
- Reassess the interventions provided to: (1) determine overall effectiveness; (2) make and coordinate referrals to community resources, other public programs, or schools; and (3) evaluate resources to transition patients into an appropriate system of care and other health-related resources
- Complete appropriate discharge activities
- Complete referral activities (if applicable)
- Communicate (may be verbal or in writing) patient progress to primary care provider

Preventive services promote full and appropriate use of primary medical care and promote positive health outcomes.

Medical Necessity Criteria

Indications that preventive services are medically necessary include, but are not limited to:

- High risk for developing a disease or experiencing a negative health outcome
- Mental/physical impairments that result in risk of poor adherence to a plan of care or the need for reinforcement to enhance the likelihood of full and appropriate use of primary care
- Need for effective management of a recently diagnosed disease/illness/condition, when such management could prevent further progression of the disease/illness/condition

Appropriate Staff

Providers of PSPCE are physicians or other practitioners of the healing arts licensed by the state and acting within the scope of their practice under state law (*e.g.*, nurse practitioners, registered dietitians, registered nurses, licensed

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Appropriate Staff (Cont'd.)

master's or bachelor's level social workers, licensed practical nurses). Providers must maintain a list of current credentials for those who render PSPCE services.

REHABILITATIVE SERVICES FOR PRIMARY CARE ENHANCEMENT

Description

Rehabilitative Services for Primary Care Enhancement (RSPCE) are provided to reduce physical or mental disability and restore an individual to his or her best possible functional level.

RSPCE interventions, based on the initial assessment, include:

- Monitoring of health status, patient needs, skill level, and knowledge base/readiness
- Counseling regarding identified risk factor(s) to achieve the goals in the medical plan of care

In order to be covered as RSPCE, rehabilitative services must be: (1) included in the RSPCE medical plan of care; (2) recommended by a physician or other LPHA; (3) directly related to the care of the patient; and (4) medically oriented. RSPCE include the provision of risk-specific, goal-oriented, structured interventions in group or individual settings that address the identified medical problem or need documented in the plan of care. Group sessions that allow direct one-to-one interaction between the counselor and the individual beneficiary may also be used to provide some components of this service.

RSPCE may include counseling services to build client and caregiver self-sufficiency through structured, goal-oriented individual interventions. Services may be provided in the patient's home, in the clinic, or in other appropriate settings. Documentation must reflect that each service is of obvious benefit to the individual patient. RSPCE are designed to be supportive of primary medical care and the service must have direct linkage to the plan of care.

Interventions also include, but are not limited to, activities that:

- Determine patient responses to structured interventions

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Description (Cont'd.)

- Assess patient progress or lack of progress toward achieving the outcomes indicated in the plan of care
- Determine the need for revision of the patient's initial plan of care
- Reassess the interventions provided to: (1) determine overall effectiveness; (2) make and coordinate referrals to community resources, other public programs or schools; and (3) evaluate resources to transition patients into an appropriate system of care and other health-related resources
- Complete appropriate discharge activities
- Complete referral activities (if applicable)
- Communicate (may be verbal or in writing) patient progress to the primary care provider

Medical Necessity Criteria

Indications that rehabilitative services are medically necessary include, but are not limited to:

- Failure to attain an optimal level of health within the primary care delivery continuum
- Entry into the primary health care continuum with an advanced degree of disease/condition as evidenced by a clinical evaluation and documentation in the medical plan of care
- A demonstrated pattern of noncompliance with the medical plan of care
- Need for effective management of recently diagnosed disease/illness/condition when such management could prevent further progress of the disease/illness/condition and promote a positive outcome

Appropriate Staff

Providers of RSPCE are physicians, other LPHAs acting within the scope of their practice under state law, master's or bachelor's level staff, and unlicensed health paraprofessionals (persons possessing, at a minimum, a high school diploma or GED with documented special training and/or certification) operating under the supervision of a licensed professional and furnishing services which are within the scope of practice of the licensed professional. Providers must maintain a list of current credentials for staff who

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Appropriate Staff (Cont'd.)

render RSPCE services.

For paraprofessional staff, DHHS adheres to the supervision policy defined for physicians in the *Physicians, Laboratories, and Other Medical Professionals Provider Manual*: "For Medicaid billing purposes, direct supervision means that the supervising physician is accessible when the services being billed are provided; and, the supervising physician is responsible for all services rendered, fees charged, and reimbursements received. The supervising physician must sign the patient's chart, indicating that he or she accepts responsibility for the service rendered." The LPHA or Certified Health Educator must adhere to this definition in supervising paraprofessional staff.

DHHS recognizes the LPHA or Certified Health Educator as being ultimately responsible for the service being rendered. The LPHA must sign each clinical entry by the health paraprofessional.

P/RSPCE AND DENTAL SERVICES

P/RSPCE may be used for dental services. The following process should apply for dental services:

- A risk-specific referral is received (risk-specific means the referring source has already identified the need [*e.g.*, dental education, appointment follow-up, etc.]) or an initial assessment indicates the need for preventive services.
- The LPHA reviews the referral and notes an appropriate intervention to address the identified need, or an LPHA develops a plan of care to address the need identified on the assessment.
- The LPHA performs the required intervention or refers to the appropriate P/RSPCE provider.
- The outcome of the visit is documented.
- If the provider of the service was a paraprofessional, the supervising professional cosigns and dates the entry.
- Additional follow-up/closure is determined.
- The P/RSPCE provider communicates the results of the visit back to the dental provider. (The LPHA would communicate with the dental provider if the service was provided by a paraprofessional.)

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S.C. Medicaid Dental Program Referral Form for Broken Appointments

This form may be used to refer Medicaid beneficiaries who are noncompliant. Appropriate P/RSPCE staff will follow the referral and efforts will be made to encourage beneficiary compliance. The provider should provide as much information as possible to assist in contacting the beneficiary or the beneficiary's parent/guardian.

A copy of the Referral Form for Broken Appointments can be found in Section 5 of this manual.

POSTPARTUM/INFANT HOME VISIT

Purpose

The Postpartum/Infant Home Visit is designed to assess the environmental, psychosocial, nutritional, and medical needs of the infant and mother.

Medical Necessity Criteria

All Medicaid-sponsored postpartum mothers and newborns are eligible for this visit. It is recommended that the Postpartum/Infant Home Visit be made within three days of discharge from the hospital; however, the home visit must be made within 14 working days after delivery. Although the visit is targeted to mother/infant units, in certain circumstances only the mother or only the infant may be visited (*e.g.,* infant is in foster care or only the mother has been discharged from the hospital).

Description

The visit must include:

- Appraisal of the mother's health status (including questions concerning her physical recovery, contraceptive plans, and emotional status)
- Information regarding postpartum recovery and appraisal of the infant including but not limited to physical, nutritional, and elimination assessments
- Appraisal of mother-infant bonding
- Appraisal of the household (safety and health factors)
- Discussion with the mother/caregiver regarding concerns about the care of the infant and her own well-being
- Discussion and appropriate follow-up as desired by

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PROGRAM SERVICES

Description (Cont'd.)

the patient to ensure that the mother has a postpartum appointment, the infant has a two-week EPSDT visit, and referrals to other needed services (*i.e.*, WIC) are made.

One repeat visit may be made to complete essential components of the Postpartum/Infant Home Visit (*e.g.*, the mother was not at home and only the infant and environment assessments were completed). Also, if during the initial visit the nurse determines that a return home visit is needed to follow up on a problem that can only be accomplished via a home visit, the repeat visit may be billed. One repeat visit may be made to follow up on an identified medical need (*e.g.*, the infant/mother had a fever).

Appropriate Staff

A Postpartum/Infant Home Visit must be made in response to a referral from a physician. The visit must be provided by a registered nurse who meets one of the following three criteria:

1. Pediatric experience including a minimum of six months of experience in a hospital or clinic in the last two years
2. Completion of a community/public health course from an accredited School of Nursing
3. All of the following:
   a) Completion of a comprehensive pediatric assessment course followed by a satisfactory demonstration of pediatric assessment skills
   b) In-service review of the postpartum assessment given by a qualified medical doctor or nurse practitioner with experience in this area
   c) A minimum of six months experience in a Community or Public Health field with a documented experience in performing environmental assessments

Documentation

At a minimum, documentation of the visit must include:

- Date of the visit
- Subjective and objective observations regarding the following:

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Documentation (Cont'd.)

- Physical and emotional status of the mother
- Contraceptive plans of the mother
- Physical status of the infant, including feeding and elimination
- Mother-infant bonding
- Household (safety and health factors)

- Action taken regarding the following:
  - Provision of information regarding the Family Planning Waiver
  - Postpartum appointment for the mother
  - EPSDT appointment for the infant
  - Referrals to other needed services (including WIC)
  - Provision of information (contraception, resources, etc.)
  - Coordination with any applicable case management or other supportive programs
- Signature of the person conducting the home visit

The following conditions must also be met:

- The provider must be enrolled as a Postpartum/ Infant Home Visit provider to perform this service. The Division of Care Management should be contacted for enrollment information at (803) 898-4614.
- The visit must be in response to a physician referral.
- The source of the referral must be documented.
- If the Postpartum/Infant Home Visit and a P/RSPCE home visit are provided on the same day, only one service may be billed. EPSDT Outreach may not be billed with the Postpartum/Infant Home Visit for the same date of service.
- The Postpartum/Infant Home Visit provider should coordinate referrals and communicate findings with the provider of P/RSPCE if the infant is receiving P/RSPCE.

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PROGRAM SERVICES

Documentation (Cont'd.)

- Copies of the assessment(s) should be sent to the primary medical care provider(s) of the infant and the mother within one week of the visit. A release of information will be necessary.

PRE-DISCHARGE HOME VISIT

Purpose

The Pre-Discharge Home Visit is designed to assess the condition of the home of an infant who is, or has been, a patient in a Neonatal Intensive Care Unit (NICU) or has had a significant medical problem. The goal is to ensure a safe household conducive to the health of the infant after discharge from the hospital.

Medical Necessity Criteria

The visit must be made in response to a referral by a physician directly involved in the care of the infant while he or she was hospitalized (unless the infant is a member of a Physician's Enhanced Program or a Health Maintenance Organization). This source of referral also applies to infants who have been transported from a Level III hospital back to the county of residence.

Description

The visit consists of an assessment of the home to determine whether there are obvious health hazards to a fragile infant. This assessment includes discussions with the mother, if possible, as well as other adults living in the home.

Appropriate Staff

Visits should be conducted by a registered nurse with demonstrated knowledge and skills in maternal and infant health.

Documentation

- The source of referral must be documented.
- At a minimum, documentation of the visit must include:
  - Date of the visit
  - Referral source
  - Action(s) taken regarding any problems found
  - Signature of the person conducting the home visit

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Documentation (Cont'd.)

- Subjective and objective observations regarding the following:
  - Readiness of the mother or caregiver to provide care
  - Readiness of a household to promote the health and safety of a fragile infant
- The visit must be in response to a physician referral.
- Documentation of the results of the visit should be sent to the medical primary care provider(s) of the infant and mother (if applicable) within one week of the visit. A release of information will be necessary.
- If the Pre-Discharge Home Visit and a P/RSPCE home visit are provided on the same day, only one service may be billed. EPSDT Outreach may not be billed with the Pre-Discharge Home Visit for the same date of service.
- The Pre-Discharge Home Visit provider should coordinate referrals and communicate findings with the provider of P/RSPCE if the infant is receiving P/RSPCE.
- The provider must be enrolled as a provider to perform this service. The Division of Care Management should be contacted for enrollment information at (803) 898-4614.

ENHANCED FAMILY PLANNING SERVICES

Patient Education/Counseling

Purpose

Enhanced Family Planning Services are designed to assist reproductive age individuals (typically 10–55 years of age) in making informed decisions about family planning and voluntary use of appropriate birth control methods, thereby preventing unwanted or unintended pregnancies. The goal is to reinforce the importance of family planning methods.

Medical Necessity Criteria

Use of this service is limited to the following reproductive age Medicaid-eligible individuals:

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Medical Necessity Criteria (Cont'd.)

- Individuals who are noncompliant with family planning
- Individuals who demonstrate difficulty in understanding family planning instructions
- Postpartum women who, during a Postpartum/ Infant Home Visit, are given a new (never used before) contraceptive method, are not currently using a family planning method, request instruction, and have difficulty understanding how to use the new method

Description

Services are face-to-face education/counseling encounters to enhance patients' comprehension of or compliance with their family planning method of choice.

Documentation must clearly demonstrate noncompliance, difficulty in understanding, or that the postpartum woman has never used the contraceptive method dispensed during the Postpartum/Infant Home Visit.

In **all** instances the ultimate purpose of this patient education/counseling is to reinforce the importance of appropriate family planning methods.

A woman who has received a sterilization procedure as a long-term family planning method is not eligible for family planning services.

Pregnant women are not eligible for family planning services.

Levels of Service

Family Planning Education/Counseling may be billed using two levels of service, depending on the intensity of service.

Comprehensive Level

Documentation for S9445-FP (individual) or S9446-FP (group) should be related to family planning and include five or more of the following:

1. Importance of compliance with prescribed family planning methods and follow up visits
2. Identification of family planning problems
3. Treatment plan to resolve identified family planning problems (lifestyle changes, etc.)

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Levels of Service (Cont'd.)

4. The client's response and participation level as it relates to family planning
5. Information on STDs and prevention of STDs as it relates to family planning
6. Information on the importance of family planning as a health priority
7. Discussion of the benefits of abstinence
8. Discussion of the benefits of delaying sexual activity
9. Discussion of the benefits of delaying pregnancy
10. Discussion of the availability of other health care resources related to family planning
11. Discussion of the long- and short-term health risks related to early sexual activity
12. Discussion of adolescent development as relates to human growth, development, and sexuality

Standard Level

Documentation for S9445-FP (individual) or S9446-FP (group) should be related to family planning and include three or more of the topics outlined above.

Appropriate Staff

Physicians, licensed nurses, other Licensed Practitioners of the Healing Arts, and health educators may deliver Patient Education/Counseling services.

Documentation

Documentation for S9445-FP or S9446-FP must be related to family planning and must have supporting documentation of the reason that the service was rendered and issues discussed.

Check-off sheets must be accompanied by a narrative description of the service that clearly demonstrates that the individual is noncompliant with family planning or has difficulty understanding family planning instructions.

Billing

Family Planning Education/Counseling must be billed separately. It may NOT be billed on the same day as an office or postpartum visit. It may NOT be billed on the same day as a Non-Medical Family Planning Education service (procedure code H1010).

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PROGRAM SERVICES

Non-Medical Family Planning Education

Purpose

Non-Medical Family Planning Education is designed to enable reproductive age individuals (typically 10 – 55 years of age) to make informed decisions about family planning and voluntary use of birth control methods, thereby preventing unwanted or unintended pregnancies. The goal is to reinforce the importance of compliance with family planning methods.

Medical Necessity Criteria

Use of this service is limited to the following reproductive age Medicaid-eligible individuals:

- Individuals who are noncompliant with family planning
- Individuals who demonstrate difficulty in understanding family planning instructions
- Postpartum women who, during a Postpartum/ Infant Home Visit, are given a new (never used before) contraceptive method, are not currently using a family planning method, request instruction, and have difficulty understanding how to use the new method

Description

Services are direct individual one-on-one discussions of birth control options/issues. This service may also be used for any patient care contact with a noncompliant patient where family planning issues are discussed and documented.

Documentation must clearly demonstrate noncompliance, difficulty in understanding, or that the postpartum woman has never used the contraceptive method dispensed during the Postpartum/Infant Home Visit.

In **all** instances the ultimate purpose of this patient education is to reinforce the importance of appropriate family planning methods.

A woman who has received a sterilization procedure as a long-term family planning method is not eligible for family planning services.

Pregnant women are not eligible for family planning services.

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Levels of Service

Non-Medical Family Planning Education may be billed using two levels of service, depending on the intensity of service.

Comprehensive Level

Documentation for H1010-FP should be related to family planning and include three or more of the following:

1. Discussion of the options and issues of birth control methods, including abstinence
2. Outlining the benefits and risks of long-term birth control methods
3. Instruction on the proper or appropriate use of birth control methods
4. Response and participation of the client as it relates to family planning
5. Noncompliance where family planning issues are discussed
6. Outlining the long- and short-term health risks related to early sexual activity
7. Discussion of adolescent development as it relates to human growth, development, and sexuality

Standard Level

Documentation for H1010-FP should be related to family planning and include two of the topics outlined above.

Appropriate Staff

Physicians, licensed nurses, other Licensed Practitioners of the Healing Arts, and health educators may deliver Non-Medical Family Planning Education.

Documentation

Documentation for H1010-FP must be related to family planning and must have supporting documentation of the reason that the service was rendered and issues discussed.

Check-off sheets must be accompanied by a narrative description of the service that clearly demonstrates that the individual is noncompliant with family planning or has difficulty understanding family planning instructions.

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Billing

Non-Medical Family Planning Education must be billed separately. It may NOT be billed on the same day as an office or postpartum visit. It may NOT be billed on the same day as an Individual Family Planning Education/Counseling service (procedure code S9445).

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

Purpose

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) are educational and counseling services delivered to adolescents at risk of engaging in sexual behavior at an early age. The goal of these services is to delay or prevent unintended and unwanted pregnancies. MAPPS enhance the ability of adolescents to make responsible decisions about sexual activity, including the importance of effective use of contraception. The result is a lowered incidence of pregnancy and sexually transmitted diseases, and improved overall physical and mental health.

Medical Necessity Criteria

MAPPS include education about the health risks associated with unprotected sexual activity and counseling services related to birth control alternatives.

Eligibility Criteria

- Participant is a Medicaid beneficiary.
- Participant is between the ages of 10 and 19.
- Participant has one or more of the following risk factors:
  - Parent(s) were teen parents.
  - Sibling is pregnant and/or is a teen parent.
  - Participant is a teen parent.
  - Peer pressure to engage in sexual activity is identified as a problem by the adolescent.
  - Participant is sexually active and/or has a history of sexual abuse.

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PROGRAM SERVICES

Service Descriptions

Needs Assessment and Intervention Case Plan

Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol (T1023-FP)

A basic screening assessment must be completed and filed in each participant's record that includes all information contained in the Basic Needs Assessment Form (see Section 5), along with a description of services to be provided. Relevant information should be documented on social, psychological, environmental, and health risk factors that justify the delivery of MAPPS to the participant. The assessment must also identify the capacities and resources of the participant and his or her family that may help address the identified risks. The assessment findings will be used to develop the initial service or case plan. Individual and family member interviews may be used in the completion of the assessment process. All contact for the purpose of gathering information for the assessment must be face-to-face. The assessment must be completed by a licensed or certified health care professional.

A written intervention/case plan must be completed based on the results of the Needs Assessment for that individual adolescent and placed in the record. The Needs Assessment and the Intervention Case Plan must be completed prior to providing Family Planning Counseling and Family Planning Instruction/Education services for new participants. The plan must include family planning goals and objectives based on the assessment, expected time frames for completion of the goals and objectives, the worker's signature, the signature of the participant, the signature of the parent/caregiver, and the date of agreement. The intervention/case plan must be completed by a licensed or certified health care professional and must be updated at least annually (every 12 months) or whenever additional risk factors are identified.

- **Procedure Code:** T1023-FP
- **Unit of Service:** 15 minutes

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PROGRAM SERVICES

Needs Assessment and Intervention Case Plan (Cont'd.)

- **Frequency:** Up to a maximum of eight units per contract year for assessment/case plan of a new participant

Statewide MAPPS rates will be incorporated in contracts on an annual basis.

Services in excess of these guidelines must be submitted in written format for prior approval by a DHHS review committee. The documentation must contain information on the specific individual's risk factors that necessitate additional units of service.

Individual Session

Patient Education, (S9445-FP), Not Otherwise Classified, Non Physician Provider, Individual, Per Session

An individual session is defined as a face-to-face **educational/counseling session** to assist reproductive-age individuals in making informed decisions about family planning and appropriate usage of birth control methods. This procedure code will be measured in 15-minute units and must address a minimum of three documentation points plus the client's response from the Documentation Points list (see Section 5). All documentation must contain the content in the Individual or Group Session Form (see Section 5) along with a narrative description. Documentation of the session must support time billed and points discussed. DHHS will provide reimbursement for a maximum of 16 hours or 64 units of individual sessions per contract year for each participant. Individual sessions may be provided to the participant or the participant and parent. This procedure code should also be used at least every six months to review the assessment/case plan. Providers must take reasonable steps to ensure that communication with the participant is confidential.

Individual sessions may be provided by licensed/ certified staff or by staff directly supervised by licensed/ certified staff. Licensed/certified staff must cosign all documentation provided by unlicensed/non-certified staff. Unlicensed/non-certified staff providing individual sessions must also attend an approved individualized counseling training before providing individual educational/counseling sessions.

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PROGRAM SERVICES

Individual Session (Cont'd.)

- **Procedure Code:** S9445-FP
- **Unit of Service:** 15 minutes
- **Frequency:** Up to a maximum of 64 units per contract year

Services in excess of these guidelines must be submitted to a DHHS review committee for approval prior to delivery of the service. Requests must be in written format specifying individualized risk factors that necessitate additional units of service.

Group Session

Patient Education, (S9446-FP), Not Otherwise Classified, Non-Physician Provider, Group, Per Session

A group session is face-to-face consultation designed to assist reproductive age individuals in making informed decisions regarding family planning and voluntary utilization of appropriate birth control methods, thereby preventing unwanted or unintended pregnancies. Group size will be defined as at least two participants, but no more than 15 participants. Groups larger than 15 are not billable as Medicaid services. A group session will be measured in 15-minute units; a group session must last a minimum of 45 continuous minutes and must address at least five documentation points plus the client's response from the Documentation Points list (see Section 5). All provider forms for documentation must contain the content included in the Individual or Group Session Form (see Section 5) along with a narrative description of the services. Evidence-based curricula must be used. Curricula must be age/reading level appropriate. Students may only attend each curriculum series once.

Group sessions may be provided by licensed/certified staff or by staff directly supervised by licensed/certified staff. Licensed/certified staff must cosign all documentation provided by unlicensed/non-certified staff.

- **Procedure Code:** S9446-FP
- **Unit of Service:** 15 minutes
- **Frequency: A minimum of 3 units per session;** up to a maximum of 64 units per contract year

Statewide MAPPS rates will be incorporated in contracts on an annual basis.

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PROGRAM SERVICES

Group Session (Cont'd.)

Services in excess of these guidelines must be submitted to a DHHS review committee prior to delivery of the service. Requests must be in written format specifying the individualized risk factors that necessitate additional units of service.

Appropriate Staff

Individuals providing MAPPS assessments and intervention case plans must be licensed or certified by appropriate state authorities as health care professionals. DHHS recognizes the following as eligible: Licensed Professional Counselor (LPC), Licensed Marriage and Family Counselor (LMFC), Licensed Psycho-Educational Specialist (LPES), Certified Health Educator, Licensed Practical Nurse (LPN), Registered Nurse (RN), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Independent Social Worker-Clinical Practice (LISW-CP), Licensed Independent Social Worker-Advanced Practice (LISW-AP), Licensed Psychologist, or Licensed Physician Assistant.

Unlicensed or non-certified staff must be **directly** supervised by a licensed or certified health care professional in order to provide individual and/or group educational counseling.

For Medicaid billing purposes, direct supervision means that the supervising licensed or certified health care professional is accessible when the services are being provided; and, the supervising licensed or certified health care professional is responsible for all services rendered, fees charged, and reimbursement received. The supervising licensed or certified health care professional must cosign all documentation provided by unlicensed/non-certified staff, indicating that he or she accepts responsibility for the service rendered.

All staff providing direct services (both professional and paraprofessional) must attend a minimum of 20 hours of family planning training per contract year. New staff providing direct services must receive at least 12 of the 20 hours of family planning training during the first quarter of employment as a MAPPS provider. All non-licensed/non-certified staff providing individual counseling/education

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PROGRAM SERVICES

Appropriate Staff (Cont'd.)

must receive training that is approved by DHHS in individual counseling prior to providing individual sessions. This training may be included in the 20 hours of family planning training required each year.

Documentation

Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project or Treatment Protocol (T1023-FP); Patient Education, Individual, Not Otherwise Classified, Non-Physician Provider, Per Session, (S9445-FP); and Patient Education, Group, Not Otherwise Classified, Non-Physician Provider, Per Session (S9446-FP) must be documented in the beneficiary's record. All documentation must specify group or individual service, time spent providing the service, number of units billed, date of service, and signature of the provider. All documentation of services provided by unlicensed/non-certified staff must be cosigned and dated by the supervisory professional staff.

Documentation of Patient Education, Not Otherwise Classified, Non-Physician Provider, Individual, Per Session (S9445-FP); and Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per Session (S9446-FP) must reflect services specific to the client. This includes individualization of all documented services, including purpose, objective of the session, and the client's response and participation level related to family planning. Documentation must reflect that the service provided meets an objective in the plan of care. All provider forms must include the information in the samples provided in the **Adolescent Pregnancy Prevention Provider Training Manual** or the Basic Needs Assessment Form and Individual or Group Session Form (see Section 5) along with a narrative description of the services. All documentation must support time billed for services.

Providers must continue to use evidence-based curricula when conducting group sessions. Curricula must be age/reading level appropriate. Participants may only attend each curriculum series once.

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FAMILY PLANNING WAIVER

SCDHHS has received approval from the Centers for Medicare and Medicaid Services (CMS) to continue the Family Planning Waiver (FPW) Expansion of Medicaid Benefits through June 30, 2005. The FPW is a statewide program that improves access to family planning services for all women at or below 185% of the Federal Poverty Level (FPL).

FPW Objectives

- Assure that all women who want and need publicly supported family planning services receive such services
- Increase the age at first birth and reduce inadequately spaced subsequent live births among all women eligible for family planning services under the waiver
- Reduce the number of unintended and unwanted pregnancies among women eligible for Medicaid
- Estimate the overall savings in Medicaid spending attributable to providing family planning service to women with family income at or below 185% of poverty
- Promote partnership with community health centers for primary medical homes for waiver participants

Covered Services

Family planning services include family planning examinations, counseling services, contraceptives, related laboratory services, etc., and sterilization with a completed sterilization consent form. Family planning services may be prescribed and rendered by physicians, clinics, pharmacies, or other Medicaid providers. **Medicaid will not cover any services other than those directly related to family planning. Additionally, procedures to address routine side effects or complications associated with the various family planning methods are not covered.**

The following services are not covered under the Family Planning Waiver:

- Procedures provided to a woman who is known to be pregnant
- Services that would usually be for pregnancy prevention but which are rendered for a medical purpose only (*e.g.*, administering Depo-Provera® for endometriosis, administering birth control for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services (Cont'd.)

menopausal symptoms, follow-up on Pap smears)

- Hysterectomies and induced abortions

Pregnancy Testing

Pregnancy testing (when the test result is negative) would be a reimbursable family planning-related service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the particular family planning method properly, or when the patient is having an unusual response to the family planning method.

Eligibility Criteria

Eligibility is determined by DHHS guidelines. Eligibility terminates if a woman moves out of state or has a sterilization procedure.

Women who receive Medicaid coverage through the Optional Coverage for Women and Infants (OCWI) program do not automatically transition into the Family Planning Waiver following the 60-day postpartum period. The eligibility worker must complete an ex parte determination before terminating OCWI coverage to determine whether the beneficiary qualifies for the full range of Medicaid benefits under another category. If the beneficiary does not qualify for a category that provides the full range of Medicaid benefits, then the worker should determine whether the beneficiary qualifies for the Family Planning Waiver.

If a woman becomes certified for regular Medicaid benefits, she will be terminated from the Family Planning Waiver, transferred to the appropriate eligibility category, and receive family planning services in addition to the full range of other Medicaid-covered services.

Note: Non-postpartum women under the age of 16 must have written parental consent to be eligible for the waiver.

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PROGRAM SERVICES

Promotion of Primary Medical Care

In addition to meeting the family planning needs of the participants, the waiver promotes the increased use of primary medical care services. Primary medical care can serve to provide a more holistic and comprehensive approach to ensuring reproductive health. Promotion of primary medical care provisions can result in the continuity of access and utilization of necessary services to improve overall health.

SOUTH CAROLINA PARTNERS FOR HEALTH CARD

During the month of December 2001, DHHS replaced both the monthly paper Medicaid card and the FPW Medicaid card with a permanent plastic South Carolina Partners for Health Card. The blue and yellow card includes the client's name, date of birth, and Medicaid number.

There is a magnetic stripe on the back of the card that may be used in Point of Sale (POS) devices. For service providers who do not have POS devices, the Medicaid Interactive Voice Response System (IVRS) enables them to use a touch-tone phone to verify Medicaid eligibility by dialing a toll-free number. The number, (888) 809-3040, is located on the back of the plastic card.