

Medicaid Update

PRENATAL CARE SPECIAL EDITION

■ **NOTE:** The Department has revised and reissued this Prenatal Care Special Edition which now incorporates an important clarification about presumptive eligibility. [See page 14 for this important announcement.](#)



Important Prenatal Care Legislation Enacted

WHAT PROVIDERS NEED TO KNOW!

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New Prenatal Care Legislation Enacted



This Special Edition of the Medicaid Update focuses on several programmatic changes that will affect the care received by pregnant women who qualify for Medicaid. During 2008-2009, the New York State Department of Health worked with internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. In addition, new legislation (Chapter 484 of 2009), was enacted to address the impact of the new Ambulatory Patient Group (APG) payment methodology on Medicaid reimbursement for prenatal care services; eliminate PCAP designation, certification, and associated rates; and ensure that the model of prenatal care provides all pregnant women who qualify for Medicaid, comprehensive, high quality, prenatal and postpartum care.

The prenatal care standards included in this supplement incorporate new evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. They integrate updated standards and guidance from the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low-income, high-risk pregnant women. The standards provide a comprehensive model of care, including but not limited to: comprehensive prenatal risk assessments; prenatal diagnostic and treatment services; HIV counseling and services; dental care; immunizations; lead poisoning prevention, testing and services; nutritional counseling; screening for genetic disorders; and testing for fetal well-being. These standards will be used to develop measures to evaluate and audit the quality of prenatal and postpartum care provided to all pregnant women who qualify for Medicaid. Important new benefits for pregnant women with Medicaid coverage include: diabetes and asthma self-management training, smoking cessation counseling, and mental health counseling services provided by certain licensed social workers. In addition, all women enrolled in Medicaid are presumed eligible for one medically necessary postpartum home health care visit benefit.

THE NEW LEGISLATION HAS THREE MAJOR COMPONENTS

- requires the Commissioner of Health to develop and periodically update standards for the provision of prenatal care under the Medicaid program;
- updates the income eligibility standards for presumptive eligibility of pregnant women under the Medicaid program; and
- eliminates statutory references to the Prenatal Care Assistance Program (PCAP) and includes reimbursement provisions for prenatal care in Social Services Law (SSL) rather than Public Health Law (PHL). In addition, this legislation requires that all Medicaid enrolled Article 28 prenatal care providers perform presumptive eligibility determinations, and assist with completion of the full Medicaid application and Medicaid managed care plan selection. Furthermore, all prenatal care providers must provide prenatal care services to pregnant women determined presumptively eligible for Medicaid but not yet enrolled.

These comprehensive changes will improve the quality of prenatal/postpartum care provided to pregnant women who receive care under the Medicaid program.

NEW YORK STATE MEDICAID PRENATAL CARE STANDARDS - NOVEMBER 2009

■ A. REQUIREMENTS

1. General Requirements:

a) Prenatal care providers shall create and maintain records and reports that are complete, legible, retrievable and available for review by representatives of the Commissioner of Health upon request. Such records and reports shall include the following:

i) a comprehensive prenatal care record for each pregnant woman which documents the provision of care and services received and which is maintained in a manner consistent with medical confidentiality requirements;

ii) special reports and data submissions as necessary for the Commissioner of Health;

iii) records of internal quality assurance;

iv) all written policies and procedures required by this section; and

v) data submissions in electronic form as requested by the Commissioner of Health in compliance with the most current Department of Health policies for health information exchange in New York State.

b) Prenatal care providers shall comply with all federal, state and local laws and regulations regarding the disclosure of protected medical information when sharing or transferring medical information with other healthcare providers or facilities. Providers shall therefore obtain written informed consent from patients prior to transfer of medical records or information where required by law.

c) Prenatal care providers shall comply with the requirements to obtain informed consent for all services described herein, in accordance with all applicable laws and regulations.

d) Any subcontracts between the prenatal care providers and other agents or agencies providing care and services shall:

i) be available for review and inspection by the Department of Health; and

ii) require that subcontractors provide contracted care and services that meet the minimum standards established in this section and are provided in accordance with generally accepted standards of practice and patient care services.

e) Prenatal care providers shall participate in quality improvement initiatives as requested by the Commissioner of Health.

2. Provider/Staff Requirements:

a) Prenatal care services, including prenatal diagnostic and treatment services, provided to pregnant women and postpartum women shall meet generally accepted standards of care as described by the most current American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) guidelines for perinatal care ¹ and shall be provided by a qualified provider practicing as:

i) a licensed physician practicing in accordance with Article 131 of the New York State Education Law and must be either an obstetrical care physician (MD/DO), Board Certified or Board Eligible in their area of specialty, or have completed an accredited residency program in Family Practice or Obstetrics/Gynecology;

ii) a nurse practitioner practicing in accordance with Article 139 of the New York State Education Law and certified in the specialty of obstetrics/gynecology;

iii) a licensed midwife practicing in accordance with Article 140 of the New York State Education Law; or

iv) a registered physician assistant practicing in accordance with Part 94 of this Title, Article 37 of the NYS PHL and article 131 of the NYS Education Law.

-continued on next page-

b) Prenatal care providers shall promote the delivery of prenatal care services in a culturally sensitive/competent manner to all pregnant women including those with limited English proficiency and diverse cultural and ethnic backgrounds. Interpretation services must be offered to patients whose primary language is not English, in person when practical, or via telephone if a translator is not immediately available.

c) Prenatal care providers must either have admitting privileges at one or more hospitals or shall develop agreements with planned delivery sites including a system for sharing patient information for continuity and follow-up care.

3. Provider/Specialist/Consultation Requirements:

Prenatal care providers shall provide pregnant women timely access and referral to appropriate levels of prenatal care, (basic, specialty, and subspecialty), based on her assessed risk status in order to prevent, recognize and treat conditions associated with maternal and infant mortality and morbidity.²

a) Management of pre-existing medical conditions: Providers shall provide or arrange for the provision of care for the specific needs of a pregnant woman with a pre-existing medical condition, according to current standards of practice.

b) Transfer of care: Practices shall develop criteria requiring transfer of primary responsibility for patient care from a family medicine practice physician, physician assistant, licensed midwife or nurse practitioner to an obstetrician and/or maternal-fetal medicine specialist (high risk obstetrician or perinatologist).

c) Specialty physician consultation/referral: Prenatal care providers shall develop criteria for consultation and referral for care to a maternal-fetal medicine specialist, perinatologist, high risk obstetrician, specialty physician, behavioral health specialist, including licensed social worker or other health care specialist as necessary based on the identification of specific risk factors or medical conditions requiring additional specialty monitoring and management. Prenatal care providers should follow AAP/ACOG's early and on-going pregnancy risk specific recommendations for consultation.³

Referrals for specialty provider consultations should include:

- i) a description of the indication for the consult,*
- ii) the role of the consultant during the initial consult,*
- iii) the role of the consultant during the follow-up care throughout the stages of pregnancy, and*
- iv) the sharing of patient/clinical information between the primary care obstetrical provider and the special care consultant.*⁴

■ B. ACCESS TO CARE

1. Any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day. All prenatal care service providers must provide prenatal care services to recipients determined to be presumptively eligible for medical assistance but not yet enrolled in Medicaid.

2. Prenatal care providers shall assist or refer women for assistance with application for medical assistance and managed care plan selection in accordance with procedures established by the Commissioner.

3. Prenatal care practices must provide or arrange for the provision of 24 hour/7 day week coverage (after hours and weekend/vacation number to call that leads to a person or message that can be returned by a health care professional within one hour). Pregnant women shall have access to unscheduled or emergency visits on a 24-hour basis.⁵

4. Prenatal care providers must develop systems, or arrange for reminder/call backs to patients needing continued or follow-up services, and for visits requiring follow-up for abnormal test results. Prenatal care providers shall contact patients to reschedule missed appointments in a manner that maintains patient confidentiality.

5. Prenatal care providers shall schedule prenatal care visits for an uncomplicated pregnancy consistent with AAP/ACOG recommendations. Pregnant women with medical, obstetrical and/or psychosocial problems may require more frequent visits. The need for increased surveillance is best determined by the prenatal care provider based on the individual needs of the woman, and the nature and severity of her problems.

■ C. PRENATAL RISK ASSESSMENT, SCREENING AND REFERRAL FOR CARE

Prenatal care (PNC) providers shall conduct a comprehensive prenatal care risk assessment for both maternal and fetal risks, at the earliest prenatal care visit, on all pregnant women.

1. The risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors. Prenatal care providers are encouraged to use a standardized written risk assessment tool, such as the ACOG, Hollister or POPRAS form. Using established criteria for determining high risk pregnancies, the prenatal care provider shall determine the woman's risk status based on generally accepted standards of practice.

The risk assessment shall be:

- a) reviewed at each visit;
- b) repeated formally early in the third trimester;
- c) used to form the basis for the development of the care plan and;
- d) documented clearly in the medical record.

2. Based on results of the risk assessment and the individual woman's increased risk for a poor pregnancy outcome, the prenatal care provider shall refer the pregnant woman for follow-up care. Referrals for such care may include but are not limited to: prenatal case management programs provided by managed care plans, other case management programs, home visitation agencies, or community-based programs for prenatal care coordination.

3. In accordance with Public Health Law section 2530-a (2) and (3), prenatal care providers shall complete a standardized New York State Prenatal Care Risk Screening Form, which summarizes the results of the comprehensive risk assessment (as described in C.1.) for each new pregnancy. The completion of this risk screening form once during the pregnancy and reporting of the information shall be with the pregnant woman's informed written consent and shall be in a format to be developed by the Commissioner.

If consent and voluntary participation is obtained, prenatal care providers shall complete the New York State Prenatal Care Risk Screening Form at the earliest prenatal care visit and transmit the information in a confidential manner to be determined by the Commissioner.

■ D. PSYCHOSOCIAL RISK ASSESSMENT, SCREENING, COUNSELING AND REFERRAL FOR CARE

Prenatal care providers shall conduct a psychosocial risk assessment of all pregnant women during the first prenatal care visit. The assessment should be reviewed at each visit and formally repeated early in the third trimester and postpartum to identify important issues that may have developed over time. The assessment shall include a broad range of social, economic, psychological and emotional problems.

Screening should include but not be limited to assessment of barriers to care, unstable housing, communication barriers (i.e. language and /or cultural barriers), nutrition, tobacco use, substance use, depression or other psychiatric illness, safety, domestic abuse, sexual abuse, and stress. Based on the results of this assessment the providers shall identify areas of concern, validate major issues with the patient, provide information, and if indicated, provide treatment or make appropriate referral(s).

The psychosocial risk assessment shall include but not be limited to screening for the following: ⁶

1. **Tobacco Use** - Prenatal care providers shall assess all pregnant women about their past and present use of tobacco and exposure to second hand smoke. All pregnant women should be advised to avoid or minimize time spent in the presence of tobacco smoke.

The patient who smokes should be strongly advised to stop smoking and be provided with tailored counseling to assist in smoking cessation. Patients who smoke shall be offered a referral to an appropriate smoking cessation education and/or treatment program. ⁷

2. Substance Use – Prenatal care providers shall assess all pregnant women about their past and present use of all substances, including drugs, alcohol, or the use of any prescription or nonprescription medications, including herbal supplements. The possible effects of any substances used before or during pregnancy should be discussed. A woman who acknowledges the use of any substances should be counseled about the implications of their use during pregnancy, and strongly encouraged to refrain from use of any substances that may negatively affect her or her fetus. If appropriate the woman should be offered a referral to a treatment program.

3. Domestic Violence – Prenatal care providers shall screen all pregnant women for domestic violence. Descriptions of domestic abuse from the patient should be documented in the patient's medical record, safety of the patient and family shall be ascertained and referrals made to appropriate counseling, legal and social service advocacy programs.

4. Depression – Prenatal care providers shall screen pregnant and postpartum women for depression utilizing an appropriate screening tool, and should have a system in place to ensure that positive screening results are followed by accurate diagnosis, implementation of treatment, and follow-up either within the practice or through referral.

■ E. NUTRITIONAL SCREENING, COUNSELING AND REFERRAL FOR CARE

Prenatal care providers shall provide or arrange for the provision of nutritional and physical activity screening, counseling and referral which includes:

1. Individual nutritional risk assessment including an assessment of pre-pregnancy body mass index (BMI), weight gain to date, if any, and specific nutritional risks at the initial prenatal care visit and continuing reassessments as needed;
2. Documentation of the nutritional assessment, risk status and the plan of care in the patient's medical record;
3. Referral of pregnant women identified as being at nutritional risk for specific nutritional counseling, monitoring and follow-up;

4. Provision of basic nutrition education and counseling for each pregnant woman which includes:

- a) appropriate dietary intake and recommended dietary allowances during normal pregnancy;
- b) recording of height and weight at the initial prenatal visit to allow for the calculation of the BMI and sequential weight monitoring at each visit. Parameters of appropriate weight gain should be made based on the pre-pregnancy BMI categories recommended in the 2009 Institute of Medicine (IOM) guidelines;⁸
- c) a focused approach to nutrition counseling based on AAP/ACOG guidelines which includes exercise and lifestyle changes for all women, but particularly for women with a BMI in the obese (BMI>30) or underweight (BMI<18.5) ⁹ range; and
- d) counseling and education regarding infant feeding choices discussed with the woman during prenatal visits and immediately postpartum. Prenatal care providers should support breastfeeding by counseling the patient regarding the nutritional advantages of human breast milk and should provide her with information regarding the benefits of breast feeding for both the mother and infant.

Exclusive breastfeeding is recommended for the first six months of life and should be continued along with supplemental foods through the second half of the first year of life and for as long as desired thereafter. Breastfeeding is not recommended for HIV positive women and may be medically contraindicated in other situations. Income eligible women considering breastfeeding should be referred to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for breastfeeding education and support.

5. Referral of pregnant women identified as needing to access proper nutrition and assistance in obtaining supplemental food to programs such as the Supplemental Nutritional Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
6. Special considerations for underweight and/or overweight/obese women:

a) Prenatal care providers shall assess and counsel underweight and overweight/obese women regarding the increased risk for pregnancy complications related to their weight and encourage these women to participate in a lifestyle improvement program, including diet, exercise, and behavior modification.

b) Prenatal care providers shall consider screening obese patients for gestational diabetes upon presentation or in the first trimester, and repeat screening later in the pregnancy if results are initially negative.¹⁰

■ F. HEALTH EDUCATION

Prenatal care providers shall provide or arrange for the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care providers should focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and language needs of the patient as well as her gestational history.

Such services shall be provided by professional staff, documented in the medical record and shall include but not be limited to the following:

- > Rights and responsibilities of the pregnant woman;
- > Signs and symptoms of complications of pregnancy;
- > Physical activity, exercise and recommended weight gain during pregnancy;
- > Avoidance of harmful behaviors including the use of alcohol, drugs, non-prescribed medications and nicotine;
- > Sexuality during pregnancy;
- > Occupational and environmental concerns including lead exposure;
- > Risks of HIV infection and risk reduction behaviors;
- > Signs of labor;
- > Labor and delivery process and availability of various delivery options;

- > Relaxation techniques in labor;
- > Obstetrical anesthesia and analgesia;
- > Preparation for parenting including infant development and care, options for feeding and the benefits of breastfeeding;
- > Newborn screening program, including the distribution of newborn screening literature;
- > Family planning and optimum inter-pregnancy interval.

■ G. DEVELOPMENT OF A CARE PLAN AND CARE COORDINATION

Prenatal care providers shall develop a care plan jointly with each pregnant woman which addresses the problems identified as a result of the initial and ongoing risk assessments. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant woman, her family and the appropriate members of the health care team.

1. Care shall be coordinated to:

- a)** Ensure that relevant information is exchanged between the prenatal care provider and other providers, health plan case managers or sites of care including the anticipated delivery site.
- b)** Ensure that the pregnant woman and her family or other designated representative, with her consent, have continued access to information resources and are encouraged to participate in the decisions involving the care and services being provided.
- c)** Encourage and assist the pregnant woman in obtaining necessary medical, dental, nutritional, psychosocial, drug and substance abuse services appropriate to her identified needs.
- d)** Provide the pregnant woman with an opportunity to receive prenatal and postpartum home visitation when medical and/or psychosocial benefits may be derived from the visits.
- e)** Provide or refer the pregnant woman for needed services as identified in the risk assessment.

f) Obtain special tests and services that may be recommended or required by the Commissioner of Health, when necessary to protect maternal and/or fetal health. Pregnant women shall be provided appropriate medical care, counseling and education based on test results.

2. The prenatal care provider shall coordinate labor and delivery services by developing agreements with planned delivery sites which address, at a minimum, the following:

- a) a system for sharing prenatal medical records, including HIV test results;
- b) pre-booking of women for delivery by 36 weeks gestation for low risk pregnancies and by 24 weeks gestation for high risk pregnancies;
- c) scope of services; and
- d) sharing of delivery/birth outcome information.

3. The prenatal care provider shall arrange for postpartum home visitation care as necessary and available when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.

■ H. PRENATAL CARE SERVICES

Prenatal care providers shall provide or make arrangements for the provision of comprehensive prenatal care services in accordance with generally accepted standards of professional practice, as outlined by the AAP and ACOG. ¹¹

1. Prenatal diagnostic and treatment services shall include but not be limited to the following:

- a) Comprehensive assessment – An initial comprehensive assessment including history, review of systems, and physical examination.
- b) Standard and special laboratory tests – Based on AAP/ACOG recommendations, standard and special laboratory tests and procedures should be performed at the recommended gestational age.

c) Follow-up, evaluation of results and referral – Follow-up shall be conducted as indicated based on abnormal findings from the comprehensive assessment, results of preliminary abnormal laboratory test findings and repeat testing of women considered to be at high risk. Prenatal care providers shall discuss the following with the pregnant woman:

- i) findings from the comprehensive assessment,
- ii) results of all laboratory tests,
- iii) recommendations for additional testing,
- iv) treatment options and obtaining informed consent for treatment,
- v) technological support and referrals as necessary.

2. HIV Services

a) Prenatal HIV Counseling and Testing
Prenatal care providers shall provide HIV counseling to all pregnant women as early as possible in the pregnancy without regard to risk. Counseling shall be provided and informed consent obtained prior to HIV testing and shall be consistent with the requirements described in Article 27F of the Public Health Law and NYCRR Title 10 Section 63.3. A repeat third trimester test, preferably at 34 – 36 weeks should be routinely recommended to all pregnant women who tested negative early in prenatal care to identify sero-conversion after an initial negative prenatal HIV test. ¹² The New York State Department of Health Informed Consent to Perform HIV Testing (DOH Form – 2556), allows the pregnant woman to receive counseling for both tests at the initial counseling and to sign for both tests at that time.

The pregnant woman should be counseled about benefits to knowing her HIV status, specifically the significant reduction in risk of mother-to-child HIV transmission with the provision of antiretroviral (ARV) prophylaxis to HIV-positive women during pregnancy, at delivery and to the newborn. The pregnant woman should be informed that if she does not have a prenatal test, she will be HIV-counseled again when she presents for delivery, and that expedited testing will be done on her, with her consent, or on the

newborn, without her consent. She should also be told that all newborns are routinely screened for HIV as part of the Newborn Screening Program, as a final safety net to identify exposed infants. Pregnant women who receive negative test results should be provided with their results and if at continued risk for developing HIV, encouraged to access HIV prevention programs and services appropriate to their risk(s). Pregnant women who receive positive HIV test results should be provided with post-test counseling consistent with Public Health Law section 2781 and Part 63 regulations and will be provided necessary care and/or appropriate referrals for services.¹³

Prenatal care providers should transfer information regarding a prenatal patient's HIV counseling and testing status, including a copy of the result, if one exists, to the delivery setting. Routine consent procedures for the transfer of medical records are sufficient to authorize the transfer of HIV-related information to health care providers.

b) Care of an HIV-Positive Pregnant Woman
Management of antiretroviral (ARV) medications during pregnancy should be done by, or in consultation with, an experienced HIV specialist familiar with state and federal clinical guidelines for the care of HIV-positive pregnant women and the prevention of mother-to-child HIV transmission. Breastfeeding is not recommended for HIV-positive women where there are good alternatives.

3. Dental Care

The prenatal care provider shall conduct an assessment of the woman's oral health care needs at the first prenatal care visit. The assessment shall include but not be limited to interviewing the patient regarding current oral health problems, previous dental problems, and the availability of a dental provider.

Pregnant women identified as having a current oral health problem or not having a dental visit in the past six months should be referred to a dentist as soon as possible, preferably before 20 weeks gestation. The prenatal care provider shall educate the pregnant woman about the importance of oral health and that dental care is safe during pregnancy. Oral health care should be coordinated between the prenatal care provider and the dentist.¹⁴

4. Immunizations

Pregnancy is not an absolute contraindication to any vaccination. Some vaccines are strongly recommended for pregnant women during the prenatal period. Many women will not be up-to-date and each pregnant woman should be evaluated for immunization status. Guides for immunizing during and after pregnancy are available from the Centers for Disease Control and Prevention (CDC)¹⁵ and the New York State Department of Health Bureau of Immunization.¹⁶

a) All pregnant women shall be evaluated for serologic evidence of immunity to rubella at their first prenatal visit, unless known to be immune by documentation of a previous test. Varicella immunity shall also be assessed by either a reliable history of disease, laboratory evidence of previous disease or documented receipt of two doses of vaccine.

b) Influenza vaccine is strongly recommended for all pregnant women due to the increased risk of influenza-related complications among pregnant women. Pregnant women should only receive the trivalent inactivated influenza vaccine (TIV), and not the live attenuated influenza vaccine (LAIV), the nasal spray.

c) The following immunizations are recommended for women at risk for these diseases and who do not have a history of immunity:

i) Hepatitis B - A pregnant woman's risk of acquiring Hepatitis B Virus (HBV) should be assessed along with her risk of acquiring other sexually-transmitted infections. Pregnant women who have been identified as being at risk for HBV infection should be vaccinated. Pregnancy is not a contraindication for HBV vaccination, and limited evidence does not suggest any fetal harm from the HBV vaccine.

ii) Tetanus, Diphtheria/Tetanus, Diphtheria, Pertussis booster (Td/Tdap) - Pregnant women who have not received a Td booster within the last 10 years and require immediate protection against tetanus and diphtheria (ie. wound prophylaxis) should be vaccinated with Td based on the severity of the risk of tetanus and the need to be immunized. Immunization with Td during pregnancy is preferred in the 2nd or 3rd trimester.

iii) Tdap may be administered during pregnancy if the woman requires protection from pertussis. Tdap is not contraindicated during pregnancy; however, data on its safety and effect on newborn immune response to the primary DTaP series is limited.

d) Other pregnancy related immunization issues:

i) New York State Public Health Law 2500-e requires that every pregnant woman be tested for the presence of hepatitis B surface antigen (HBsAg) and that the test results and the date are documented in the prenatal record. It also requires that infants of women who are hepatitis B surface antigen positive or whose test results are unknown receive treatment at birth with hepatitis B vaccine and hepatitis B immunoglobulin (HBIG).

ii) New York State Public Health Law 2112 (effective July 1, 2008) prohibits the administration of vaccines containing more than trace amounts of thimerosal, a mercury-containing preservative, to pregnant women, unless the supply is insufficient. There is no evidence that thimerosal causes harm to the pregnant woman or her fetus.

e) Postpartum Period – The following vaccinations or a history of immunity are recommended for all postpartum women: influenza, MMR (measles, mumps, rubella), Tdap, varicella and human papilloma virus. An adult schedule should be checked for appropriate indications in regard to age, previous history of disease or prior history of vaccination.¹⁷ Women who plan to breastfeed can and should receive vaccinations as no evidence exists of any risk to a mother or her infant if she is vaccinated while breastfeeding. Breastfeeding is not a contraindication to any vaccination, with the exception of vaccinia vaccine.

5. Lead Poisoning Prevention, Testing and Management

As required by NYS Public Health Law and Regulations (NYCRR Subpart 67-1.5), prenatal health care providers shall provide all pregnant women with anticipatory guidance on preventing lead poisoning, information on the major sources of lead and the means to prevent exposure. At the initial prenatal visit, each pregnant woman shall be assessed for exposure to lead by using a risk assessment questionnaire recommended by the State Commissioner of Health.¹⁸

If the pregnant woman responds “yes” to even one of the questions, she is considered to be at risk, and should have a blood lead test and be counseled on how to eliminate lead exposure. Pregnant women found to have a confirmed blood lead level of 10 micrograms per deciliter (mcg/dL) or greater should be provided with risk reduction counseling and follow-up testing in accordance with NYS Department of Health guidelines. In addition, all pregnant women with a confirmed blood lead level of 10 mcg/dL or greater who may have been occupationally exposed to lead should be referred to an occupational health clinic for individual guidance.

All women should receive anticipatory guidance on the prevention of childhood lead poisoning at their postpartum visits. Consultation for medical management of a lead poisoned pregnant woman is available from the Regional Lead Resource Centers (RLRC).¹⁹

Prenatal care providers are required to adhere to the most current New York State Department of Health guidelines for the prevention, identification and management of lead poisoning in pregnancy, as described in *Lead Poisoning Prevention Guidelines for Prenatal Care Providers – NYSDOH & ACOG District II*, June, 2009.²⁰

6. Use of Ultrasound

Prenatal care providers must document the medical indication for performing an ultrasound examination of a pregnant patient based on identified need. Ultrasound for gestational dating is recommended, especially before 20 weeks, if there is a size-date discrepancy or imprecise menstrual dates.²¹

Ultrasonography shall be provided only by physicians or technologists who have undergone training and only when there is a valid medical indication for the examination documented in the woman’s medical record by a qualified prenatal care provider.²² AAP/ACOG guidelines should be followed when recommending an ultrasound exam. Common indications for ultrasound include but are not limited to evaluation for gestational age; fetal number, viability, placenta location, abnormal amniotic fluid volume, fetal growth disturbances, fetal anomalies and aneuploidy screening.²³

7. Screening for Genetic Disorders

Prenatal care providers shall offer all pregnant women additional maternal/fetal screenings to identify fetal abnormalities/genetic problems as follows:

- a)** Birth defects – Prenatal care providers shall offer all pregnant women screening tests to identify birth defects at specific times throughout the prenatal period based on AAP/ACOG recommendations.
- b)** Invasive diagnostic testing for aneuploidy should be available to all women regardless of maternal age. Early amniocentesis (at less than 15 weeks gestation) should not be performed.²⁴
- c)** Pregnant women should be counseled regarding the differences between screening and invasive diagnostic testing for aneuploidy including a discussion of the risks and benefits of the invasive test compared with other available screening tests. Pregnant women who choose not to undergo invasive diagnostic testing for aneuploidy shall be offered aneuploidy screening before 20 weeks gestation regardless of maternal age.²⁵
- d)** Prenatal care providers should offer information on cystic fibrosis screening to all couples and cystic fibrosis carrier screening should be offered to all couples regardless of race or ethnicity.²⁶
- e)** Prenatal genetic screening or diagnosis should be offered to pregnant women based on personal and family history. Genetic screening and counseling criteria should be based on AAP/ACOG recommendations. This includes screening for genetic disorders based on racial and ethnic background, such as hemoglobinopathies (sickle cell, α -thalassemia, β -thalassemia), Tay-Sachs disease, Canavans disease and familial dysautonomia, cystic fibrosis and other genetic disorders based on family history.²⁷

8. Fetal Well-Being

Tests of fetal well-being are indicated in the presence of specific maternal and pregnancy-related conditions and shall be performed based on the judgment of a qualified prenatal care provider according to individual patient need.²⁸ There are several tests used in clinical practice to assess fetal status and each test has advantages, disadvantages as well as risks. The prenatal care provider, based on clinical judgment and recommended AAP/ACOG guidelines should choose the test that best meets the needs of the pregnant woman and her fetus and initiate testing at the appropriate gestational age. The test results and the interpretation shall be discussed with the pregnant woman, documented in the medical record and appropriate referrals initiated as soon as possible.



■ I. POSTPARTUM SERVICES

The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule, (approximately 4 – 6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7–14 days of delivery). The visit should include an interval history and a physical examination to evaluate the patient's current status and her adaptation to the newborn.

1. The visit shall include but not be limited to the following:

- a)** identify whether any medical, dental, psychosocial (including depression), nutritional (including breastfeeding), tobacco/smoking cessation needs, alcohol and drug treatment needs of the mother or infant are being met;
- b)** provide anticipatory guidance on the prevention of childhood lead poisoning;
- c)** refer the mother or other infant caregiver to resources available for meeting identified needs and provide assistance in meeting such needs where appropriate;
- d)** assess family planning/contraceptive needs and provide advice and services or referral when indicated;
- e)** provide appropriate inter-conception counseling including information such as recommended preconception daily intake of folic acid (400 mcg) as per CDC and ACOG guidelines and encourage a preconception visit prior to subsequent pregnancies;
- f)** refer the infant to preventive and special care services appropriate to his/her needs;
- g)** advise the mother/caregiver of the availability of Medicaid eligibility for infants; and
- h)** advise or refer the mother for assistance with an application for on-going medical care assistance for herself, in accordance with her financial status, health assistance program eligibility and the policies and procedures established by the Commissioner of Health and the State of New York.

i) recommend that overweight/obese women continue a nutrition and exercise regimen after pregnancy to encourage weight loss before attempting another pregnancy.²⁹

2. The prenatal care provider shall arrange for postpartum home visitation as necessary when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.

3. Postpartum documentation by the prenatal provider shall include: delivery outcome, maternal physical exam, health status of the mother/infant including medical, nutritional, psychosocial needs with referrals.



■ REFERENCES

- ¹ American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). *Guidelines for Perinatal Care, Sixth Edition, October 2007.*
- ² AAP/ACOG, Chapter 2, pgs. 2 and 8.
- ³ ACOG Guidelines Appendix B and C, pgs. 385 - 388.
- ⁴ Maternal Fetal Medicine Society. *Recommendations to Address Documentation Guidelines for Level of Involvement in Consultation/Co-Management of Obstetric Patients*, pgs. 1 - 3.
- ⁵ AAP/ACOG Guidelines, pg. 87.
- ⁶ ACOG Committee on Healthcare for Underserved Women. Committee Opinion. *Psychosocial Risk Factors: Perinatal Screening and Intervention*, Vol. 108 (2), August 2006; pgs. 469 - 477.
- ⁷ Medicaid currently covers up to six (6) smoking cessation counseling sessions within a 12-month period. Effective January 1, 2010, Medicaid will cover smoking cessation counseling for up to 180 days postpartum.
- ⁸ Institute of Medicine (IOM). *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: The National Academies Press. Posted online May 28, 2009.
- ⁹ Institute of Medicine (IOM). *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: The National Academies Press. Posted online May 28, 2009.
- ¹⁰ ACOG Committee on Obstetric Obesity. Committee Opinion. *Obesity in Pregnancy*, Vol. 106 (3), September 2005; pgs. 671 - 675.
- ¹¹ American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG). *Guidelines for Perinatal Care, Sixth Edition*. October 2007.
- ¹² NYSDOH 2007 Health Alert: *Steps to Further Reduce Mother-to-Child HIV Transmission in New York State* at: <http://www.health.state.ny.us/diseases/aids/testing/healthalert.htm>.
- ¹³ NYSDOH 2005 Guidance for HIV Counseling and Testing and New Laboratory Reporting Requirements, Rev. 2006
- ¹⁴ NYS Oral Health Guidelines August 2006. http://www.health.state.ny.us/prevention/dental/oral_health_care_pregnancy_early_childhood.htm.
- ¹⁵ Centers for Disease Control and Prevention (CDC) Website at: <http://www.cdc.gov/vaccines/pubs/preg-guide.htm>.
- ¹⁶ New York State Department of Health Bureau of Immunization at: <http://www.health.state.ny.us/prevention/immunization/providers/>.
- ¹⁷ New York State Department of Health Adult Immunization Schedule at: <http://www.health.state.ny.us/publications/2391.pdf>.
- ¹⁸ New York State Department of Health, Lead Exposure Risk Assessment Questionnaire available at: http://www.health.state.ny.us/environmental/lead/exposure/childhood/risk_assessment.htm.
- ¹⁹ Regional Lead Resource Centers (RLRC). Contact information for RLRC available at: http://www.health.state.ny.us/environmental/lead/regional_lead_resource_centers.htm.
- ²⁰ New York State Department of Health, *Lead Poisoning Prevention Guidelines for Prenatal Care Provider – NYSDOH & ACOG District II*, June 2009. Access online at: <http://www.health.state.ny.us/environmental/lead/>.
- ²¹ AAP/ACOG, pgs. 110-112.
- ²² AAP/ACOG, pg. 102.
- ²³ ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists, *Ultrasonography in Pregnancy*, Number 101, February 2009.
- ²⁴ ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists, *Invasive Prenatal Testing for Aneuploidy*, Number 88, December 2007.
- ²⁵ ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists. *Screening for Fetal Chromosomal Abnormalities*. Number 77, January 2007.
- ²⁶ ACOG Committee on Genetics. Committee Opinion. *Update on Carrier Screening for Cystic Fibrosis*, Vol. 106 (6), December 2005; pgs. 1465-1468.
- ²⁷ AAP/ACOG. pgs. 84-85.
- ²⁸ AAP/ACOG, pgs. 111-112.
- ²⁹ ACOG Committee Opinion Number 315. September 2005, Vol. 106 (3), pg. 673.

Presumptive Eligibility

■ PRENATAL CARE PROVIDERS AND PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN:

With the enactment of Chapter 484 of the Laws of 2009, all Medicaid enrolled licensed Article 28 providers of prenatal care must perform Presumptive Eligibility (PE) determinations and assist pregnant women in completing the Medicaid application and submitting the completed Medicaid application (DOH 4220) to the appropriate local department of social services for a full Medicaid eligibility determination. The PE determination is performed when the pregnancy is confirmed during the woman's first visit to the provider.*

■ PRENATAL CARE SERVICES INCLUDE:

- > Prenatal Risk Assessments; Prenatal Care Visits;
- > Lab Services; Social Service Screening;
- > Labor & Delivery; Referral for Pediatric Care;
- > Transportation Services for Prenatal Care; Dental Services;
- > Emergency Room Services; Home Care; Pharmaceuticals;
- > Mental Health and related Social Services, including screening and counseling;
- > Health Education for both parents regarding prenatal nutrition and other aspects of prenatal care, alcohol and tobacco use, substance abuse, use of medication, labor and delivery, family planning to prevent future unintended pregnancies, breastfeeding, infant care and parenting;
- > Referrals for Nutrition Services including screening, education, counseling, follow-up and provision of services under Special Supplemental Nutrition Program for Women, Infants and Children and Supplemental Nutritional Assistance Program;
- > Postpartum Care including family planning services, inpatient care and specialty physician and clinic services which are necessary to assure a healthy delivery and recovery.



■ **PRESUMPTIVE ELIGIBILITY:** Presumptive eligibility is a means of immediately providing Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. A trained Article 28 prenatal care provider (or other prenatal care provider approved by the State Department of Health) performs a preliminary assessment of the pregnant woman's and spouse's income, if she is married. Then, based upon guidelines established by the Department, the provider determines if the woman is presumptively eligible for all ambulatory Medicaid services or a limited array of medical services. A pregnant woman does not need to provide documentation of income for the presumptive eligibility determination. **Pregnant women are also not required to document citizenship/immigration status for presumptive eligibility or for ongoing Medicaid eligibility. Citizenship/immigration status is not an eligibility requirement for a pregnant woman throughout her pregnancy and for 2 months after the month in which the pregnancy ends.** Once the PE screening checklist has been completed by the provider, it must be sent to the local department of social services to authorize PE coverage. Medicaid pays providers during the presumptive eligibility period for care provided to pregnant women.

Presumptive Eligibility (continued)

If the pregnant woman and her spouse, if any, have combined income no greater than 100% of the federal poverty level, she is eligible for coverage of all ambulatory Medicaid services. When the income is above 100% but less than or equal to 200% of the federal poverty level, the pregnant woman is eligible for coverage of ambulatory prenatal care Medicaid services only. For the pregnant woman to continue her coverage past the period of presumptive eligibility, she must complete the Medicaid application process, submit required documentation and meet the eligibility requirements for ongoing Medicaid. The prenatal care provider organization shall develop a relationship with the local department of social services and submit the pregnant woman's PE screening checklist and Medicaid application within five (5) business days. Presumptive Medicaid eligibility begins on the date the prenatal care provider determines presumptive eligibility. This is usually the date of the pregnant woman's first visit or the date services were first rendered to her. This is also the date of application for on-going Medicaid. Current provider organizations designated to perform PE may continue to do so.

■ **MANDATED TRAINING FOR PRESUMPTIVE ELIGIBILITY PROVIDERS:** Licensed Article 28 providers of prenatal care services are mandated by the new law to make presumptive eligibility determinations for pregnant women. PE providers shall also provide full Medicaid application assistance and assist pregnant women in choosing a Medicaid managed care health plan. In order to perform PE determinations, the PE screener must complete on-line training, at the Center for Development of Human Services (CDHS) e-learning portal, which is available at <http://www.bsc-cdhs.org/eLearning/>. To ensure compliance with the new law, the trainees must register for training at the e-learning portal. Upon completion of the PE training modules, the individual will be given a certificate of training completion. This certificate must be retained to show proof of meeting the training requirement to screen for PE. The Department will monitor the extent to which Article 28 prenatal care providers have completed on line presumptive eligibility training. The Department encourages prenatal care providers who have not recently performed presumptive eligibility determinations for pregnant women to repeat the training modules.

* The law permits an Article 28 facility that provides prenatal care to pregnant women to apply to the Commissioner of Health for an exemption from this requirement on the basis of undue hardship.

New APG Payment Methodology Replaces PCAP Rate Schedules

■ **STATUTORY AUTHORITY:** Chapter 53 of the Laws of 2008 established a new Medicaid fee for service payment methodology based on Ambulatory Patient Groups (APGs) that would apply to most outpatient services provided by hospitals, clinics and ambulatory surgery centers. The new payment methodology began in hospital outpatient clinics on December 1, 2008, and will be implemented in freestanding D&TC clinics upon federal approval by the Centers for Medicare and Medicaid Services (CMS). While the new APG payment methodology will be phased-in over several years, once it begins in an Article 28 setting, prenatal services will only be reimbursable through the APG payment methodology. Existing threshold clinic rate codes and/or specialty PCAP rate codes will be end-dated and threshold clinic rates and PCAP rate schedules will no longer be applicable. Federally Qualified Health Centers (FQHCs) have the option of participating in APGs. Prenatal services provided by FQHCs that do not participate in APGs will be reimbursed through the FQHC's existing Prospective Payment System (PPS) rate.



The Department's regulations on APGs are available online at:
http://nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_regulations.pdf.

■ **OVERVIEW OF NEW PAYMENT METHODOLOGY:** The APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information Systems, Inc. APGs categorize the amount and type of resources used in various outpatient visits, including visits for prenatal care. Patients within each APG have similar characteristics and resource utilization patterns. APGs are designed to predict the average pattern of resource use of a group of patients in a given APG.

The APG payment methodology pays differential amounts for outpatient services based on the resources required for each patient visit. The APG payment methodology provides greater reimbursement for higher cost services and lower reimbursement for lower cost services. Like the old PCAP rates, the APG payment methodology includes the cost of ancillary lab and radiology services in the overall payment to the prenatal care provider.

Upon implementation of APGs, PCAP rate codes and outdated threshold clinic rates are end-dated and replaced with new APG rate codes and a dynamic new payment system based on the diagnosis of the patient and the prenatal care services provided. The APG payment methodology will improve the clarity and transparency of the payment structure. It will also enable updates in payments to providers that reflect changes in prenatal care standards and the costs of service delivery over time. Under APGs, prenatal care providers will be reimbursed for the services they actually provide and for the ancillary lab and radiology services they order for their patients.

APGs, coupled with new investments in primary care and coverage of new primary care enhancements, will improve access to health care services for Medicaid enrollees, including pregnant women. The new primary care enhancements, which are described later, include coverage of diabetes and asthma self management education, smoking cessation counseling, mental health counseling by licensed social workers, and additional payments for expanded hour access to primary care visits.

■ **PHASE-IN IMPLEMENTATION OF APGS FOR PRENATAL CARE PROVIDERS:** APG reimbursement for prenatal care services provided by hospital outpatient departments and diagnostic and treatment centers is being phased-in. Effective December 1, 2009, the payment for each individual visit will be based on 50% of the full amount that the APG methodology would calculate for the visit (based on coded procedures and diagnoses) and 50% of the provider's average per visit reimbursement for services moving to APGs in calendar year 2007. On January 1, 2011, the APG portion of the blend will increase to 75%; and on January 1, 2012, to 100%.

■ **NEW RATE CODES:** Essentially, the minimum change required to bill and get paid for prenatal care services under APGs is to code claims using one of the new APG rate codes, rather than PCAP rate codes or old threshold clinic rate codes.

Setting	Service	New APG Visit Rate Code*	New APG Episode Rate Code*
Hospital	Outpatient Department	1400	1432
Hospital	OPD-DD/MR/TBI **	1501	1489
Free Standing D&TC	Clinic	1407	1422
Free Standing D&TC	Clinic-DD/MR/TBI**	1435	1425

*Episode rate codes must be used by hospital OPDs after January 1, 2010 and by DTCs, upon activation, except for claims for Medicare/Medicaid dually eligible patients. Claims for dually eligible patients should always be submitted to eMedNy using APG visit rate codes.

-- Rate code 1435, 1489, 1501 and 1425 will be assigned to providers for use in billing services for recipients with mental retardation, developmental disabilities or traumatic brain injury as indicated by recipient exception codes 81 and 95.

For a full list of rate codes subsumed with APG implementation please visit:
http://nyhealth.gov/health_care/medicaid/rates/apg/docs/outpatient_rate_codes.pdf.

■ **IMPORTANCE OF ACCURATE MEDICAL CODING:** To ensure appropriate reimbursement under the new APG payment methodology, all claims **must** include:

- *the new APG rate codes (listed above);*
- *a valid, accurate ICD-9-CM primary diagnosis code*;* and
- *valid CPT and/or HCPCS procedure codes reflecting services provided.*

*The **primary diagnosis code** is the ICD-9 code describing the diagnosis, condition, problem or other reason for the encounter/visit shown in the medical record chiefly responsible for the services provided.

APG reimbursement for an Evaluation and Management (E & M) visit will be determined by the primary ICD-9-CM diagnosis code and the level of the E & M visit CPT code. Diagnosis and procedure coding and billing must be supported by the documentation in the medical record. Secondary diagnoses or additional codes that describe any coexisting conditions should also be coded, as certain significant conditions may be used in place of the primary diagnosis to group the medical visit, and could result in higher payment.

■ **PRENATAL CARE RATE CODE CHANGES:** Hospital outpatient departments (OPD) were converted from PCAP rate codes to the APG reimbursement methodology effective December 2008. Free-standing Diagnostic and Treatment Center (D&TC) providers who have billed the PCAP clinic rates will be converted to the new APG reimbursement methodology. PCAP rate codes 3101, 3102, and 3103 have been end-dated and replaced with APG rate codes 1400 or 1432 for OPDs and will be end-dated and replaced with rate codes 1407 or 1422 for D&TCs upon CMS approval of APG implementation. FQHCs that do not participate in APGs will be reimbursed for prenatal care services provided through their existing PPS rate.

Because the APG methodology is based on service intensity, prenatal care providers must code all procedures performed during the patient encounter on the claim in order to receive full reimbursement. Payment will be based on the APG reimbursement methodology. Ancillary laboratory and radiology services provided or ordered by the prenatal care provider should be coded on the clinic claim and will be included in the APG payment for a significant procedure or medical visit. When the patient receives the ancillary services from a provider other than the prenatal clinic, the prenatal clinic is responsible for paying the individual or entity that provided the ancillary lab or radiology service. All general billing rules that apply to clinic APG billings also apply to prenatal care providers billing under the APG payment methodology.

■ APG BILLING AND PRENATAL CARE BILLING GUIDELINES:

APG billing guidelines, FAQs, implementation materials, training presentations, and new APG billing guidance specifically targeted to prenatal care providers is available online at:

http://www.nyhealth.gov/health_care/medicaid/rates/apg/.

■ WEBINAR TRAINING:

Webinars targeted to prenatal care providers occurred in early February 2010. The Webinars reviewed the new prenatal care standards, presumptive eligibility requirements for Article 28 providers, and APG-related billing questions. A copy of the presentation can be found on the Department's APG website.

PRIMARY CARE ENHANCEMENTS

■ **SMOKING CESSATION COUNSELING:** Medicaid now reimburses office based providers and Article 28 OPDs for smoking cessation counseling for pregnant and postpartum women and children ages 10 through 20. Reimbursement for these services will be available to D&TCs upon APG implementation. This counseling will complement existing Medicaid covered benefits for smoking cessation coverage, which include prescription and nonprescription smoking cessation products.

Reimbursement for smoking cessation counseling (SCC) must meet the following requirements:

- SCC is **ONLY** available to pregnant females, women up to six months postpartum; and children and adolescents ages 10 through 20, who smoke.
- SCC must be provided face-to-face by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife during a medical visit. (No group sessions).
- SCC may be billed by a physician, a registered nurse practitioner, a licensed midwife, or Article 28 OPDs, D&TCs, or FQHCs that bill using APGs.
- Pregnant women will be allowed six (6) counseling sessions during their pregnancy.
- Postpartum women will be allowed six (6) counseling sessions during the 6-month postpartum period.
- Children and adolescents ages 10 through 20 will be allowed up to six (6) counseling sessions in a continuous 12-month period.
- Claims for SCC must include the appropriate SCC CPT procedure code. Only one procedure code per day may be billed. **99406** - Intermediate SCC 3 to 10 minutes; **99407** - Intensive SCC, greater than 10 minutes.
- Also, since SCC must be provided during a medical visit, the appropriate CPT Evaluation and Management (E&M) code, **99201 - 99205, 99211 - 99215**; and/or the appropriate Preventive Medicine Code **99383 - 99386, 99393 - 99396** must be included. EXCEPTION - an E&M code is NOT necessary for practitioners billing for Global Obstetrical Care, which is billed at the end of pregnancy.

Practitioners and clinics will use the appropriate ICD-9 diagnosis code:

- **305.1** - Tobacco use disorder (*Use for children and adolescents ages 10 up to 21*).
- **649.03** - Tobacco use disorder complicating pregnancy, childbirth or the puerperium - antepartum. (*Use for pregnant women who smoke*).
- **649.04** - Tobacco use disorder complicating pregnancy, childbirth or the puerperium - postpartum. (*Use for postpartum women who smoke*).

Please visit: http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-12.htm#smo. for additional information.

■ **MENTAL HEALTH COUNSELING BY LICENSED CLINICAL SOCIAL WORKERS (LCSW) AND LICENSED MASTER SOCIAL WORKERS (LMSW):** Medicaid reimbursement for mental health counseling to pregnant and postpartum women and children and adolescents through age 20 provided by Licensed Clinical Social Workers (LCSWs) and Licensed Master Social Workers (LMSWs) has been authorized by the Legislature and will soon be available to hospital and free-standing clinics upon CMS approval. Reimbursement will cover mental health counseling services provided to pregnant women up to 60 days postpartum (based on the date of delivery or end of pregnancy).

Reimbursement for mental health counseling by a LCSW or LMSW must meet the following requirements:

- *A facility that is offering mental health counseling by LCSWs and LMSWs must have the appropriate certification listed on its operating certificate.*
- *Women must have a primary or secondary diagnosis of pregnancy (ICD-9 codes: 630-677, V22, V23, and V28). Mental health services are also available up to 60 days postpartum with a primary or secondary diagnosis of postpartum depression (ICD-9 codes 648.40 - 648.44).*

The levels of mental health counseling and corresponding rate codes are as follows:

- **4257 - Individual Brief Counseling** (*psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face with the patient*).
- **4258 - Individual Comprehensive Counseling** (*psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 45-50 minutes face-to-face with patient*).
- **4259 - Family Counseling** (*psychotherapy with or without patient*).

Please visit: http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-03.htm#med. for additional information.

■ **DIABETES AND ASTHMA SELF-MANAGEMENT TRAINING:** Diabetes and asthma self management training services (DSMT and ASMT, respectively) are now available for all Medicaid beneficiaries diagnosed with diabetes or asthma when such services are ordered by a physician, registered physician assistant (PA), registered nurse practitioner (RNP), or a licensed midwife (LM). These services are available in physicians' offices and OPDs and in D&TCs upon APG implementation. A Federally Qualified Health Center (FQHC) may bill for this service ONLY if it has elected to be reimbursed under APGs.

Self-management training services are to be provided by a New York State licensed, registered, or certified health care professional, who is also certified as an educator by the National Asthma Educator Certification Board (CAE) or the National Certification Board for Diabetes Educators (CDE). Educators in this program are expected to practice within the scope of practice that is appropriate to their respective discipline, as defined by the Office of the Professions, New York State Education Department. Self-management training services will be billed by physicians, RNPs, LMs, OPDs, D&TCs and Qualified FQHCs who employ (or contract with) certified educators. Physicians and RNPs who are certified educators, themselves, can also bill for these services.

To enhance patient access, offices or clinics that do not directly offer ASMT or DSMT services may refer patients in need of educational services to Medicaid enrolled practitioner offices or clinics that do employ or contract with certified asthma and/or diabetes educators. A referral for ASMT or DSMT services must be written by the referring clinician (physician, PA, RNP or LM).

The following professional entities (who are New York State licensed, registered, or certified, and are Certified Educators in their respective disciplines) may provide Medicaid self-management training services:

ASTHMA

- Registered Nurse
- Registered Nurse Practitioner
- Respiratory Therapist
- Physician (MD, DO)
- Pharmacist
- Physician Assistant

DIABETES

- Registered Nurse
- Registered Nurse Practitioner
- Registered Dietician
- Physician (MD, DO)
- Pharmacist
- Physician Assistant
- Physical Therapist

■ **ASTHMA SELF-MANAGEMENT TRAINING (ASMT)**

- > Beneficiaries, including pregnant women, with newly diagnosed asthma or with asthma and a medically complex condition (such as: an exacerbation of asthma, poor asthma control, diagnosis of a complication, etc.) will be allowed up to 10 hours of ASMT during a continuous 6-month period.
- > Beneficiaries with asthma who are medically stable may receive up to 1 hour of ASMT in a continuous 6-month period.
- > Self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

■ DIABETES SELF-MANAGEMENT TRAINING (DSMT)

- > Beneficiaries, including pregnant women, with newly diagnosed diabetes or with diabetes and a medically complex condition (such as: poor diabetes control [A1c>8], diagnosis of a complication, diagnosis of a co-morbidity, post-surgery, prescription for new equipment such as an insulin pump, etc.) will be allowed up to 10 hours of DSMT during a continuous 6-month period.
- > Beneficiaries with diabetes who are medically stable may receive up to 1 hour of DSMT in a continuous 6-month period.
- > Self-management training services can be provided in individual sessions, or in group sessions of no more than eight patients.

Additional information on CDE and CAE is available for viewing at:

http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-03.htm#cer.

http://nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#dia.

■ ENHANCED PAYMENT FOR EXPANDED 'AFTER HOURS' ACCESS:

A supplemental payment amount is available for prenatal care appointments scheduled to occur on evenings, weekends and holidays as defined by the Department of Health. This payment is effective for patient visits in physician offices and OPDs for services provided. Patient visits in D&TCs will be eligible for this additional reimbursement for services provided upon implementation of APGs. This payment will be added to the otherwise applicable payment amount for each such visit. **NOTE:** A FQHC may bill for this service ONLY if it has elected to be reimbursed under APGs. Clinic reimbursement for expanded hours access will be added to a facility's APG payment for services rendered.

For purposes of receiving the enhanced fee, evenings, weekends, and holidays are defined as follows:

- An evening visit is one which is scheduled for and occurs after 6:00 p.m.
- A weekend visit is one which is scheduled for and occurs on a Saturday or Sunday.
- A holiday visit is one which is scheduled for and occurs on a designated national holiday.

Additional information on 'After Hours' is available for viewing at:

http://nyhealth.gov/health_care/medicaid/program/update/2008/2008-12.htm#inc.

PERINATAL HOME HEALTH CARE VISITS COVERED BY MEDICAID

The Medicaid program also provides payment for medically necessary home health services rendered to eligible persons by providers enrolled in Medicaid. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring. Home health care providers communicate findings, plans and patient needs to the mother or child's physician and/or case manager.

WHICH PROVIDERS ARE ELIGIBLE TO PROVIDE HOME HEALTH CARE SERVICES?

Certified Home Health Agencies (CHHAs) enrolled in Medicaid or Licensed Home Care Agencies under contract with Certified Home Health Agencies enrolled in Medicaid.

WHO IS ELIGIBLE TO RECEIVE THE SERVICE?

Pregnant or postpartum women with full or presumptive Medicaid eligibility.

WHAT ARE THE CONDITIONS REQUIRED FOR A CHHA TO PROVIDE THE SERVICE?

Home health care services, including an initial home visit or postpartum visit, always require a physician's order. The services should be *medically necessary*, ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician. In the absence of an attending physician, or in instances where the attending physician may not be reached or contacted in a timely manner, the County Health Commissioner's (or County Medical Director's) order is acceptable for an initial home health visit.

All women enrolled in Medicaid are *presumed eligible for one medically necessary* postpartum home health care visit which shall include assessment of the health of the woman and newborn, post operative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the treating physician and or case manager of the pregnant woman or infant shall be made as needed. Prior approval may be required for coverage of all home visits for women enrolled in a Medicaid or Family Health Plus health plan. When ordered by the attending physician, prenatal and postpartum home visits other than the initial postpartum visit must meet one of the medical necessity criteria as follows:

- > High medical risk pregnancy as defined by American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or

- > Need for home monitoring or assessment by a nurse for a medical condition complicating pregnancy; or

Pregnant woman otherwise unengaged in prenatal care (no or inconsistent visits); or

- > Need for home assessment for suspected environmental or psychosocial risk including but not limited to intimate partner violence, substance abuse, unsafe housing and nutritional risk.

- > All ongoing prenatal and postpartum cases shall have documentation of:

- *a comprehensive written plan of care developed and based on the comprehensive assessment of the mother and/or infant after a minimum of an initial home visit; and*
- *timely notification to treating providers and case manager concerning significant changes in the woman or infant's condition;*
- *referral and coordination with appropriate health, mental health and social services and other providers; and*
- *review and revision of the plan of care at least monthly or more frequently if the maternal/infant conditions warrant it; and*
- *an appropriate discharge plan.*

WHAT ARE THE LIMITATIONS ON PAYMENT?

- > The same CHHA visit may not be billed for both the infant and the mother.
- > The same CHHA visit may not be billed as a MOMs (health supportive services) visit and a home health visit.



PRENATAL CARE CONTACT INFORMATION

Ambulatory Care Payment Information:

General Policy, Rates Weights, Carve Out Payment Rules or Implementation Issues:
(518) 473-2160 or apg@health.state.ny.us
APG Website: http://nyhealth.gov/health_care/medicaid/rates/apg/index.htm.

Billing, Remittances and Onsite Training: (800) 343-9000

Grouper Software, Pricer Product Support, 3M HIS Sales:
(800) 435-7776 or (800) 367-2447 or <http://www.3mhis.com>.

Local Departments Of Social Services:
http://www.nyhealth.gov/health_care/medicaid/ldss.htm.

Prenatal Care Standards Development:
Office of Health Insurance Programs (518) 486-6865 or fcg01@health.state.ny.us

Prenatal Care and Managed Care:
Division of Managed Care, Office of Health Insurance Programs, (518) 473-1134 or jjd03@health.state.ny.us

Presumptive Eligibility:
Medicaid Coverage and Enrollment, Office of Health Insurance Programs, (518) 474-8887

Presumptive Eligibility On-line Training: <http://www.bsc-cdhs.org/qpt/>

Important Information for Opening, Closing or Relocating a Prenatal Care Clinic

Facilities that are planning a closure, opening or relocation of their prenatal clinic program should contact the Office of Health Systems Management (OHSM) to determine the appropriate approval process. Please note that all facilities providing prenatal services must have prenatal services certified on their operating certificate for all clinic sites offering prenatal care services.

For further information, please contact Susan Berry, Certificate of Need Coordinator, NYSDOH, Division of Certification and Surveillance, Hedley Park Plaza, 433 River Street, Troy, New York 12180 or contact her by phone at (914) 654-7197.