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## 1.0 Description of the Procedure, Product, or Service

Pregnancy Medical Home (PMH) services are defined as managed care services to provide obstetric care to pregnant Medicaid recipients with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care. The PMH seeks to engage the participation of any provider that is eligible to bill NC Medicaid for obstetric services. Case Management services are provided for all pregnant Medicaid recipients who are determined to be high-risk and qualify for services. To allow the PMH to stay abreast of PMH recipient medical needs, DMA's designated vendor shall provide the PMH alerts, including: emergency department (ED) visits, visits to a specialist, missed appointments, and etc.

### 1.1 High-Risk Pregnancy Definition

A high-risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth.

**Note:** Refer to **Subsection 3.2.5** Risk Factors Related to High-Risk Pregnancy

**Note:** The qualified PMH provider shall adhere to documented guidelines in The Division of Medical Assistance (DMA) Clinical Coverage Policy 1E-5 *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).

## 2.0 Eligible Recipients

### 2.1 General Provisions

NC Medicaid (Medicaid) recipients must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

The services included in this Pregnancy Medical Home policy are not covered for NC Health Choice (NCHC) recipients. NCHC recipients, ages 6 through 18 years of age, who become pregnant shall be transitioned to another appropriate Medicaid eligibility category that includes pregnancy coverage, if eligible.

#### 2.1.1 Regular Medicaid

Refer to DMA's Clinical Coverage policy 1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).

#### 2.1.2 Medicaid for Pregnant Women

Refer to DMA's Clinical Coverage policy 1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>). Prior approval for MPW recipients as documented in **Subsection 5.1** in DMA's Clinical Coverage policy 1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>) is effective for the PMH.

### 2.1.3 Undocumented Aliens

Refer to DMA's Clinical Coverage policy 1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>)

### 2.1.4 Presumptive Eligibility

Section 1920(b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined.

The pregnant woman shall apply for Medicaid no later than the last day of the month following the month she is determined presumptively eligible. If the pregnant woman fails to apply for Medicaid within this time period, she is eligible only through the last calendar day of the month following the month she is determined presumptively eligible. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the local department of social services makes a determination on her application.

In the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination, the presumptive eligibility period ends.

**Note:** Presumptive eligibility is limited to one presumptive eligibility period per pregnancy.

### 2.1.5 Retroactive Eligibility

Refer to the *Basic Medicaid and NC Health Choice Billing Guide* Retroactive Eligibility Section at Web site: <http://www.ncdhhs.gov/dma/basicmed/>.

## 2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

### 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid and NC Health Choice Billing Guide:***

<http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

### **2.3 Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Recipients 6 through 18 Years of Age**

**EPSDT does not apply to NCHC recipients.** If a NCHC recipient does not meet the clinical coverage criteria within **Section 3.0** of the clinical coverage policy, the NCHC recipient will be denied services.

Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes will be covered for NCHC recipients.

### **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

#### **3.1 General Criteria**

Procedures, products, and services related to this policy are covered when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

#### **3.2 Specific Criteria**

##### **3.2.1 Antepartum Care**

Antepartum care shall be covered in accordance with DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).

##### **3.2.2 Individual Antepartum Services**

Refer to DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on coverage of Evaluation and Management (E/M) services and individual antepartum care.

##### **3.2.3 Counseling**

Refer to DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on counseling services.

##### **3.2.4 Fetal Surveillance Testing**

Refer to DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on fetal surveillance services.

Refer to DMA's Clinical Coverage Policy #1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on prior approval for obstetric ultrasounds and other imaging services.

### 3.2.5 Risk Factors Related to High-Risk Pregnancy

The PMH model designates certain pregnancy risk factors as “priority” risk factors for the purposes of ensuring the recipients with these risk factors are assessed by a care manager. **See Attachment B** for a list of current risk factors. This list does not represent a comprehensive list of indications for which a recipient would receive case management, nor is it the complete list of the risk screening for which PMH’s are responsible.

### 3.2.6 Care Management

The Pregnancy Medical Home provider shall complete risk screening on all pregnant Medicaid recipients participating in a PMH. The screening must be completed by a physician, nurse practitioner, certified nurse midwife or registered nurse. All pregnant Medicaid recipients determined to be high-risk after screening shall receive case management in proportion to the level of their identified need as determined through assessment by a pregnancy care manager.

#### 3.2.6.1 Pregnancy Care Management Services

- a. Pregnancy care management services must begin with the initial assessment and continue as long as the need exists during the pregnancy.
- b. Pregnancy care management services may begin in the postpartum period if not identified during the antepartum period. Pregnancy care management services shall end on the last day of the month in which the 60th postpartum day occurs.
- c. If the recipient is receiving case management services at the time of the referral, the new pregnancy care manager and the current care manager shall determine who shall be the lead care manager with the recipient during the pregnancy.
- d. Pregnancy care managers shall work in partnership with PMH providers to ensure proper care of the recipient during the pregnancy.
- e. The pregnancy care manager shall refer MPW recipients at the end of their postpartum Medicaid eligibility period to the Family Planning Waiver (FPW) program.
- f. For recipients with full Medicaid, the pregnancy care manager shall ensure that the recipient is referred back to her original provider of care prior to the pregnancy. If she does not have a health care provider, the pregnancy care manager shall assist in connecting the recipient to a primary care provider of her choice.

**Note:** Refer to DMA’s Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on other Medicaid services.

### 3.3 Package Services

Refer to DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on antepartum package, global obstetrics, and postpartum package services.

### 3.4 Referrals

Current Primary Care Provider (PCP) guidelines require Carolina Access (CA) recipients to receive a referral before seeing a specialist. Guidelines for PMH providers are as follows:

- a. Referrals to PMH providers to initiate obstetric care shall only be necessary if the recipient is enrolled in CA.
- b. Prior approval requirements for MPW recipients still apply.
- c. If a PCP and the PMH is the same provider and the recipient becomes pregnant, no referral is necessary.
- d. If the PMH and the PCP are different providers and the recipient is enrolled in CA, the recipient needs a referral from the PCP to be seen by the PMH.
- e. If the recipient is not enrolled in CA, no referral is needed to initiate obstetric care at a PMH.
- f. If the recipient is enrolled with a CA PCP, a referral is required from the PCP to see a specialist.
- g. If the recipient is not enrolled in CA, the recipient does not need a referral to see a specialist.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Non-Covered Criteria

No additional non-covered criteria.

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 5.1 Prior Approval

Prior approval is not required for Medicaid and NCHC recipients.

### 5.2 Ultrasounds

- a. PMH providers are not required to obtain prior approval for any obstetrical ultrasound. See **Attachment D** for a list of exempt ultrasound procedure codes.
- b. The PMH provider shall register all ultrasounds with DMA's designated vendor in order to receive reimbursement.
- c. Certain ultrasound procedures require medical necessity indication, such as a known or suspected fetal anatomic or genetic abnormality, and can only be performed by specific providers. Refer to **Attachment A, H "Reimbursement."**
- d. For all other high tech imaging procedures, the PMH provider shall obtain prior approval before rendering the imaging procedure. Refer to DMA's Clinical Coverage Policy #1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on prior approval for obstetric ultrasounds and other imaging services.

### 5.3 Program Requirements

#### 5.3.1 Pregnancy Risk Screening

- a. The pregnancy risk screening tool must be used to identify pregnant women in need of pregnancy care management services.
- b. Providers shall complete the pregnancy risk screening tool at the recipient's initial visit, and follow-up screening by the end of the 28th week of pregnancy. Providers may rescreen the recipient at any time during the pregnancy if high-risk conditions are suspected.
- c. Medicaid recipients with a priority risk factor present on the pregnancy risk screening tool shall be referred for pregnancy care management assessment. A copy of the pregnancy risk screening tool must be provided to the high-risk case management agency.
- d. Recipients shall be eligible to receive pregnancy care management services at any time during pregnancy or the postpartum period.

**Note:** The Pregnancy Risk Screening Tool is located in **Attachment E**.

## **6.0 Providers Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications**

Individual physicians or physician groups enrolled with Medicaid as one of the following:

- a. General/family practice;
- b. Obstetrics/Gynecology; or
- c. Multi-specialty.
  1. Federally Qualified Health Clinics (FQHC);
  2. Rural Health Clinics (RHC);
  3. Nurse Practitioners;
  4. Nurse Midwives;
  5. Physician Assistants

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### **7.1 Compliance**

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

## 8.0 Policy Implementation/Revision Information

Original Effective Date: March 1, 2011

### Revision Information:

Date	Section Revised	Change
3/1/11	Throughout	Initial promulgation of new policy for Pregnancy Medical Home
3/9/11	Subsection 6.0.b.4	Removed reference to local health departments
3/9/11	Attachment A: H	Removed reference to local health departments
10/15/11	Subsection 3.2.6	Specified "registered" nurse
10/15/11	Attachment A	Deleted Institutional Claim in Attachment A: Claim Type
10/15/11	Attachment E	Updated Risk Screening Tools
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
3/1/12	Subsection 6.1.1	Added Physician Assistants

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid and NCHC managed care programs.

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

Refer to **Section B** of **Attachment A: Claims-Related Information** of DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for covered ICD-9-CM diagnosis code information.

### C. Billing Code(s)

Providers are required to select the most specific billing code that accurately describes the service(s) provided.

The following table contains codes for the billing of the PMH Pregnancy Risk Screening Tool and the PMH Postpartum plan maintenance:

HCPCS Code	Description	Guidelines
S0280	Medical home program, comprehensive care coordination and planning, initial plan	Providers shall bill this code after the pregnancy risk screening tool has been completed
S0281	Medical home program, comprehensive care coordination and planning, maintenance of plan	Providers shall bill this code after the postpartum visit is completed

Refer to **Section C** of **Attachment A: Claims-Related Information** of DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on covered CPT codes.

Refer to **Attachment B: Billing for Obstetrical Services** of DMA's Clinical Coverage Policy #1E-5, *Obstetrics* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on covered Evaluation and Management Services codes.

### D. Modifiers

Providers are required to follow applicable modifier guidelines.

### **E. Billing Units**

Refer to **Section E of Attachment A: Claims-Related Information of DMA's Clinical Coverage Policy #1E-5, *Obstetrics*** (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on billing for multiple births.

### **F. Place of Service**

Inpatient hospital, Outpatient hospital, Office.

### **G. Co-payments**

Co-payments are not required for the Pregnancy Medical Home policy.

### **H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

Any provider who bills global, package or individual pregnancy procedures within their scope of practice is eligible to participate in this program, as long as the provider agrees to the program requirements.

The PMH provider can only bill HCPCS codes S0280 and S0281 one time during the gestational period even if there are multiple births. Once billed, no other provider can bill these codes in the same gestational period.

The PMH practice will be reimbursed for S0280 and S0281 and not the individual physician with the exception of a sole proprietor.

The provider billing S0281 must be the same provider that bills the postpartum visit.

HCPCS code S0281 will not be reimbursed for miscarriage, spontaneous abortion, and terminations.

CPT Procedure codes 76811 and 76812 require medical necessity indication, such as a known or suspected fetal anatomic or genetic abnormality, and can only be performed by specific providers. The PMH may refer a recipient to another provider or may perform these codes in office only if they meet the following:

1. OB ultrasound providers certified with the American Institute of Ultrasound in Medicine (AIUM) or an American College of Radiology (ACR) accredited practice; or
2. Providers with sub-specialty in Maternal Fetal Medicine (Perinatology) or Radiology.

With the exception of FQHC's and RHC's, one of the following procedure codes must be billed before code S0281 will be reimbursed: 59400, 59410, 59430, 59510, or 59515.

Refer to **Section C of Attachment A: Claims-Related Information of DMA's Clinical Coverage Policy #1E-5, *Obstetrics*** (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on obstetrical codes and instructions for **physicians** and **FQHC/RHC** provider billing for PMH.

## Attachment B: Risk Factors Related to High-Risk Pregnancy

Risk factors related to high risk pregnancy include any of the following:

- a. History of preterm birth (less than 37 weeks);
- a. History of low birth weight (less than 2500g);
- b. Multiple gestation;
- c. Fetal complications;
- d. Chronic condition which may complicate pregnancy (e.g., diabetes, hypertension, Human Immunodeficiency Virus (HIV), Systemic Lupus Erythematosus (SLE), sickle cell, asthma, seizure disorder, renal disease, substance abuse diagnosis, mental illness);
- e. Unsafe living environment (e.g., homelessness, inadequate housing, family violence, sexual abuse/coercion, community violence);
- f. Substance use;
- g. Tobacco use;
- h. Missing two or more prenatal appointments without rescheduling; or
- i. Inappropriate hospital utilization (Emergency Department/Labor & Delivery triage visit by pregnant patient with no prenatal care provider, antepartum hospitalization, two or more Emergency Department/Labor and Delivery triage visits by a patient with a prenatal care provider).

**Note:** This list does not represent a comprehensive list of indications for which a recipient would receive case management, nor is it the complete list of the risk screening for which PMHs are responsible.

## Attachment C: Requirements for Pregnancy Medical Home Providers

The Pregnancy Medical Home provider shall agree to all of the following:

- a. Allow DMA or DMA's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
- b. Eliminate elective deliveries prior to 39 weeks gestation if not medically necessary;
- c. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation. 17p will be prescribed when the recipient is deemed an appropriate candidate at the physician's discretion for 17p intramuscular injection and consents to participate after being informed by the provider of the benefits and risks.
- d. Complete a risk screening on each pregnant Medicaid recipient and integrate the plan of care with local pregnancy care management; and
- e. Decrease the primary cesarean delivery rate if the rate is over DMA's designated cesarean rate.

### Attachment D: OB Ultrasound Codes Exempt from Prior Approval (PA) for Pregnancy Medical Home Providers

Procedure Code	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a 76801
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study

### Attachment E: Pregnancy Risk Screening Tool

Risk Screening Form Final June 2011 v1.5

**CCNC Pregnancy Home Risk Screening Form – 1<sup>st</sup> OB visit**

Practice Name: \_\_\_\_\_

First name: \_\_\_\_\_ MI \_\_\_\_\_ Last name: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_ Today's date: \_\_/\_\_/\_\_

EDC: \_\_/\_\_/\_\_ By what criteria:  LMP  1<sup>st</sup> trimester U/S  2<sup>nd</sup> trimester U/S  Other: \_\_\_\_\_

Height: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_ Gravidity: \_\_\_\_\_ Parity: \_\_\_\_\_

Insurance type:  Medicaid  None  Other: \_\_\_\_\_

**CURRENT PREGNANCY (check all that apply)**

- \*Multifetal gestation
- \*Fetal complications:
  - Fetal anomaly
  - Fetal chromosomal abnormality
  - Intrauterine growth restriction (IUGR)
  - Oligohydramnios
  - Polyhydramnios
  - Other: \_\_\_\_\_
- \*Chronic condition which may complicate pregnancy:
  - Diabetes
  - Hypertension
  - Asthma
  - Mental illness
  - HIV
  - Seizure disorder
  - Renal disease
  - Systemic lupus erythematosus
  - Other(s): \_\_\_\_\_
- \*Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
- \*Late entry into prenatal care (>14 weeks)
- Cervical insufficiency
- Gestational diabetes
- Vaginal bleeding in 2<sup>nd</sup> trimester
- Hypertensive disorders of pregnancy (eclampsia, preeclampsia, gestational hypertension, HELLP syndrome)
- Short interpregnancy interval (<12 months between last live birth and current pregnancy)
- Current sexually transmitted infection
- Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
- Communication barriers:
  - Literacy
  - Disability
- Explain: \_\_\_\_\_
  - Non-English speaking
- Primary language: \_\_\_\_\_

**OBSTETRIC HISTORY (check all that apply)**

- \*Preterm birth (<37 completed weeks)  
Gestational age(s) of previous preterm birth(s): \_\_\_\_\_
  - Were any a result of spontaneous preterm labor and/or preterm rupture of the membranes?
  - Is this a singleton pregnancy?

*If yes to both questions, this patient is eligible for 17P treatment.*
- \*Low birth weight (<2500g)
- \*Very low birth weight (<1500g)
- Fetal death >20 weeks
- Neonatal death (within first 28 days of life)
- Second trimester pregnancy loss
- Three or more first trimester pregnancy losses
- Cervical insufficiency
- Gestational diabetes
- Postpartum depression
- Hypertensive disorders of pregnancy
  - Eclampsia
  - Preeclampsia
  - Gestational hypertension
  - HELLP syndrome

- Provider requests pregnancy care management assessment

Reason(s)/Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Items marked with a \* will trigger automatic follow-up by a pregnancy care manager. If you would like a care manager to assess this patient, and none of the \* conditions are marked, check the box above.

Name of person completing form: \_\_\_\_\_ Signature: \_\_\_\_\_

**CCNC Pregnancy Home Risk Screening Form – Follow up**

Practice Name: \_\_\_\_\_

\*\*\*Use this form only if an initial risk screening form was already completed for this patient.\*\*\*

Patient name: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_ Today's date: \_\_/\_\_/\_\_

EDC: \_\_/\_\_/\_\_ By what criteria:  LMP  1<sup>st</sup> trimester U/S  2<sup>nd</sup> trimester U/S  Other: \_\_\_\_\_

Insurance type:  Medicaid  None  Other: \_\_\_\_\_

**CURRENT CONDITIONS (check all that apply)**

- \*Multifetal gestation
  - \*Fetal complications:
    - Fetal anomaly
    - Fetal chromosomal abnormality
    - Intrauterine growth restriction (IUGR)
    - Oligohydramnios
    - Polyhydramnios
    - Other: \_\_\_\_\_
  - \*Chronic condition which may complicate pregnancy:
    - Diabetes
    - Hypertension
    - Asthma
    - Mental illness
    - HIV
    - Seizure disorder
    - Renal disease
    - Systemic lupus erythematosus
    - Other(s): \_\_\_\_\_
  - \*Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
  - \*Missed 2 or more prenatal appointments
  - Cervical insufficiency
  - Gestational diabetes
  - Vaginal bleeding in 2<sup>nd</sup> trimester
  - Hypertensive disorders of pregnancy (eclampsia, preeclampsia, gestational hypertension, HELLP syndrome)
  - Short interpregnancy interval (<12 months between last live birth and date of conception of current pregnancy)
  - Current sexually transmitted infection
  - Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
  - Communication barriers:
    - Literacy
    - Disability
- Explain: \_\_\_\_\_
- Non-English speaking
- Primary language: \_\_\_\_\_

- Provider requests pregnancy care management assessment

Reason(s)/Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Items marked with a \* will trigger automatic follow-up by a pregnancy care manager. If you would like a care manager to assess this patient, and none of the \* conditions are marked, check the box above.

Name of person completing form: \_\_\_\_\_ Signature: \_\_\_\_\_

**CCNC Pregnancy Home Risk Screening Form – Follow up**

Complete this side of the form and give it to the nurse or doctor. Please answer as honestly as possible so we can provide the best care for you and your baby. The care team will keep this information private.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Today's date: \_\_\_\_\_  
Address: \_\_\_\_\_  
County: \_\_\_\_\_ Home phone number: \_\_\_\_\_ Work/other phone number: \_\_\_\_\_  
Cell phone number: \_\_\_\_\_ Social security number: \_\_\_\_\_  
Race:  American-Indian or Alaska Native  Asian  Black/African-American  
 Pacific Islander/Native Hawaiian  White  Other (specify): \_\_\_\_\_  
Ethnicity:  Not Hispanic  Cuban  Mexican American  Puerto Rican  Other Hispanic

1. \*Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?  Yes  No
2. \*Are you in a relationship with a person who threatens or physically hurts you?  Yes  No
3. \*Has anyone forced you to have sexual activities that made you feel uncomfortable?  Yes  No
4. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food?  Yes  No
5. \*Do you have a safe and stable place to live?  Yes  No
6. \*Which statement best describes your smoking status? Check one answer.
  - A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
  - B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
  - C. I stopped smoking AFTER I found out I was pregnant and am not smoking now.
  - D. I smoke now but have cut down some since I found out I was pregnant.
  - E. I smoke about the same amount now as I did before I found out I was pregnant.
7. Did any of your parents have a problem with alcohol or other drug use?  Yes  No
8. Do any of your friends have a problem with alcohol or other drug use?  Yes  No
9. Does your partner have a problem with alcohol or other drug use?  Yes  No
10. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?  Yes  No
11. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?  Not at all  Rarely  Sometimes  Frequently
12. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?  Not at all  Rarely  Sometimes  Frequently

Risk Screening Form Final Spanish June 2011 v1.2

**CCNC Pregnancy Home Risk Screening Form – 1<sup>st</sup> OB visit** Practice Name: \_\_\_\_\_

First name: \_\_\_\_\_ MI \_\_\_\_\_ Last name: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_ Today's date: \_\_/\_\_/\_\_\_\_  
 EDC: \_\_/\_\_/\_\_\_\_ By what criteria:  LMP  1<sup>st</sup> trimester U/S  2<sup>nd</sup> trimester U/S  Other: \_\_\_\_\_  
 Height: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_ Gravidity: \_\_\_\_\_ Parity: \_\_\_\_\_  
 Insurance type:  Medicaid  None  Other: \_\_\_\_\_

**CURRENT PREGNANCY (check all that apply)**

- \*Multifetal gestation
  - \*Fetal complications:
    - Fetal anomaly
    - Fetal chromosomal abnormality
    - Intrauterine growth restriction (IUGR)
    - Oligohydramnios
    - Polyhydramnios
    - Other: \_\_\_\_\_
  - \*Chronic condition which may complicate pregnancy:
    - Diabetes
    - Hypertension
    - Asthma
    - Mental illness
    - HIV
    - Seizure disorder
    - Renal disease
    - Systemic lupus erythematosus
    - Other(s): \_\_\_\_\_
  - \*Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
  - \*Late entry into prenatal care (>14 weeks)
  - Cervical insufficiency
  - Gestational diabetes
  - Vaginal bleeding in 2<sup>nd</sup> trimester
  - Hypertensive disorders of pregnancy (eclampsia, preeclampsia, gestational hypertension, HELLP syndrome)
  - Short interpregnancy interval (<12 months between last live birth and current pregnancy)
  - Current sexually transmitted infection
  - Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
  - Communication barriers:
    - Literacy
    - Disability
- Explain: \_\_\_\_\_  
 Non-English speaking  
 Primary language: \_\_\_\_\_

**OBSTETRIC HISTORY (check all that apply)**

- \*Preterm birth (<37 completed weeks)  
 Gestational age(s) of previous preterm birth(s): \_\_\_\_\_  
 Were any a result of spontaneous preterm labor and/or preterm rupture of the membranes?  
 Is this a singleton pregnancy?  
*If yes to both questions, this patient is eligible for 17P treatment.*
- \*Low birth weight (<2500g)
- \*Very low birth weight (<1500g)
- Fetal death >20 weeks
- Neonatal death (within first 28 days of life)
- Second trimester pregnancy loss
- Three or more first trimester pregnancy losses
- Cervical insufficiency
- Gestational diabetes
- Postpartum depression
- Hypertensive disorders of pregnancy
  - Eclampsia
  - Preeclampsia
  - Gestational hypertension
  - HELLP syndrome

Provider requests pregnancy care management assessment  
 Reason(s)/Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Items marked with a \* will trigger automatic follow-up by a pregnancy care manager. If you would like a care manager to assess this patient, and none of the \* conditions are marked, check the box above.

Name of person completing form: \_\_\_\_\_ Signature: \_\_\_\_\_

Risk Screening Form Final Spanish June 2011 v1.2

**Formulario de Evaluación de Riesgo del Embarazo de CCNC – Primera visita prenatal**

Complete este lado de la forma y entréguesela a la enfermera o el médico. Por favor responda lo más honestamente posible para que podamos proporcionarle el mejor cuidado para usted y su bebé. El equipo de cuidado mantendrá esta información privada.

Nombre: _____	Fecha de nacimiento: _____	Fecha de hoy: _____
Dirección: _____		Condado: _____
Número de teléfono de la casa: _____	Número de teléfono del trabajo/otro: _____	
Teléfono celular: _____	Número de Seguro Social: _____	
Raza: <input type="checkbox"/> Indio Americano/o Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Negro/Africano-Americano		
<input type="checkbox"/> Islas de Pacifico/Nativo de Hawai <input type="checkbox"/> Blanco <input type="checkbox"/> Otro (especifique): _____		
Etnicidad: <input type="checkbox"/> No hispano <input type="checkbox"/> Cubano <input type="checkbox"/> Mexicano Americano <input type="checkbox"/> Puerto Riqueño <input type="checkbox"/> Otro Hispano		

1. Piense en el momento *justo antes* de que quedara embarazada, ¿cómo se sintió al quedar embarazada?  
Marque una respuesta.
  - Hubiera querido quedar embarazada mas pronto
  - No quería quedar embarazada en ese momento, sino después
  - Quería quedar embarazada en ese momento
  - No quería quedar embarazada ni en ese momento ni nunca
  - No sé
2. \* Durante el último año, ¿Usted ha sido golpeada, abofeteada, pateada o maltratada físicamente por alguien?  Si  No
3. \* ¿Está usted en una relación con una persona que la amenaza o la maltrata físicamente?  Si  No
4. \* ¿Alguien la ha forzado a tener actividades sexuales que le han hecho sentir incómoda?  Si  No
5. ¿En los últimos 12 meses estuvo usted alguna vez con hambre pero no comió porque no podía permitirse el lujo de comprar alimentos?  Si  No
6. \*¿Usted tiene un lugar seguro y estable donde vivir?  Si  No
7. \* **Indique su situación actual respecto al habito de fumar** Marque una respuesta.
  - A. Yo **NUNCA** he fumado, o he fumado MENOS DE 100 cigarrillos en toda mi vida.
  - B. Yo dejé de fumar **ANTES** de darme cuenta que estaba embarazada, y no fumo ahora.
  - C. Yo dejé de fumar **DESPUES** de darme cuenta que estaba embarazada, y no fumo ahora
  - D. Yo fumo un poco ahora, pero he reducido la cantidad de cigarrillos que fumo desde que me di cuenta que estaba embarazada
  - E. Yo fumo la misma cantidad que antes de darme cuenta que estaba embarazada
8. ¿Alguno de sus padres tenía problemas con el alcohol o el uso de otras drogas?  Si  No
9. ¿Alguno de sus amigos tiene problemas con el alcohol o el uso de otras drogas?  Si  No
10. ¿Su pareja tiene problemas con el alcohol o el uso de otras drogas?  Si  No
11. En el pasado, ¿Ha tenido usted dificultades en su vida debido al alcohol u otras drogas, incluyendo medicinas que necesitan receta médica?  Si  No
12. Antes que supiera que estaba embarazada, ¿Con qué frecuencia usted tomaba cualquier alcohol, incluyendo cerveza o vino, o utilizaba otras drogas?
  - Nunca Raramente Algunas veces Frecuentemente
13. En el último mes, ¿Con qué frecuencia usted bebió alcohol, incluyendo cerveza o vino, o usó otras drogas?
  - Nunca Raramente Algunas veces Frecuentemente

**CCNC Pregnancy Home Risk Screening Form – Follow up**

Practice Name: \_\_\_\_\_

\*\*\*Use this form only if an initial risk screening form was already completed for this patient.\*\*\*

Patient name: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_ Today's date: \_\_/\_\_/\_\_

EDC: \_\_/\_\_/\_\_ By what criteria:  LMP  1<sup>st</sup> trimester U/S  2<sup>nd</sup> trimester U/S  Other: \_\_\_\_\_

Insurance type:  Medicaid  None  Other: \_\_\_\_\_

**CURRENT CONDITIONS (check all that apply)**

- \*Multifetal gestation
  - \*Fetal complications:
    - Fetal anomaly
    - Fetal chromosomal abnormality
    - Intrauterine growth restriction (IUGR)
    - Oligohydramnios
    - Polyhydramnios
    - Other: \_\_\_\_\_
  - \*Chronic condition which may complicate pregnancy:
    - Diabetes
    - Hypertension
    - Asthma
    - Mental illness
    - HIV
    - Seizure disorder
    - Renal disease
    - Systemic lupus erythematosus
    - Other(s): \_\_\_\_\_
  - \*Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
  - \*Missed 2 or more prenatal appointments
  - Cervical insufficiency
  - Gestational diabetes
  - Vaginal bleeding in 2<sup>nd</sup> trimester
  - Hypertensive disorders of pregnancy (eclampsia, preeclampsia, gestational hypertension, HELLP syndrome)
  - Short interpregnancy interval (<12 months between last live birth and date of conception of current pregnancy)
  - Current sexually transmitted infection
  - Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
  - Communication barriers:
    - Literacy
    - Disability
- Explain: \_\_\_\_\_
- Non-English speaking
- Primary language: \_\_\_\_\_

- Provider requests pregnancy care management assessment

Reason(s)/Comments: \_\_\_\_\_

Items marked with a \* will trigger automatic follow-up by a pregnancy care manager. If you would like a care manager to assess this patient, and none of the \* conditions are marked, check the box above.

Name of person completing form: \_\_\_\_\_ Signature: \_\_\_\_\_

**Formulario de Evaluación de Riesgo del Embarazo de CCNC – visita de seguimiento**

Complete este lado de la forma y entréguesela a la enfermera o el médico. Por favor responda lo más honestamente posible para que podamos proporcionarle el mejor cuidado para usted y su bebé. El equipo de cuidado mantendrá esta información privada.

Nombre: _____	Fecha de nacimiento: _____	Fecha de hoy: _____
Dirección: _____		Condado: _____
Número de teléfono de la casa: _____		Número de teléfono del trabajo/otro: _____
Teléfono celular: _____		Número de Seguro Social: _____
Raza: <input type="checkbox"/> Indio Americano/o Nativo de Alaska	<input type="checkbox"/> Asiático	<input type="checkbox"/> Negro/Africano-Americano
<input type="checkbox"/> Islas de Pacifico/Nativo de Hawai	<input type="checkbox"/> Blanco	<input type="checkbox"/> Otro (especifique): _____
Etnicidad: <input type="checkbox"/> No hispano	<input type="checkbox"/> Cubano	<input type="checkbox"/> Mexicano Americano <input type="checkbox"/> Puerto Riqueño <input type="checkbox"/> Otro Hispano

1. \* Durante el último año, ¿Usted ha sido golpeada, abofeteada, pateada o maltratada físicamente por alguien?  Si  No
2. \* ¿Está usted en una relación con una persona que la amenaza o la maltrata físicamente?  Si  No
3. \* ¿Alguien la ha forzado a tener actividades sexuales que le han hecho sentir incómoda?  Si  No
4. ¿En los últimos 12 meses estuvo usted alguna vez con hambre pero no comió porque no podía permitirse el lujo de comprar alimentos?  Si  No
5. \*¿Usted tiene un lugar seguro y estable donde vivir?  Si  No
6. \* **Indique su situación actual respecto al habito de fumar** Marque una respuesta.
  - A. Yo **NUNCA** he fumado, o he fumado **MENOS DE 100** cigarrillos en toda mi vida.
  - B. Yo dejé de fumar **ANTES** de darme cuenta que estaba embarazada, y no fumo ahora.
  - C. Yo dejé de fumar **DESPUES** de darme cuenta que estaba embarazada, y no fumo ahora
  - D. Yo fumo un poco ahora, pero he reducido la cantidad de cigarrillos que fumo desde que me di cuenta que estaba embarazada
  - E. Yo fumo la misma cantidad que antes de darme cuenta que estaba embarazada
7. ¿Alguno de sus padres tenía problemas con el alcohol o el uso de otras drogas?  Si  No
8. ¿Alguno de sus amigos tiene problemas con el alcohol o el uso de otras drogas?  Si  No
9. ¿Su pareja tiene problemas con el alcohol o el uso de otras drogas?  Si  No
10. En el pasado, ¿Ha tenido usted dificultades en su vida debido al alcohol u otras drogas, incluyendo medicinas que necesitan receta médica?  Si  No
11. Antes que supiera que estaba embarazada, ¿Con qué frecuencia usted tomaba cualquier alcohol, incluyendo cerveza o vino, o utilizaba otras drogas?
  - Nunca  Raramente  Algunas veces  Frecuentemente
12. En el último mes, ¿Con qué frecuencia usted bebió alcohol, incluyendo cerveza o vino, o usó otras drogas?
  - Nunca  Raramente  Algunas veces  Frecuentemente