

Questions and Answers Implementing the Re-designed MIHP

NOTE 1: Please destroy all draft versions of MIHP re-design documents (Medicaid policy, *Operations Guide*, forms, etc.), including all drafts that were handed out at the March 2010 trainings. Make absolutely sure that you are using the current documents, all of which are posted on the MIHP web site.

NOTE 2: This document includes answers to all of the questions submitted in writing to MDCH by the deadline, as well as answers to additional questions that were raised during the coordinator conference call on Aug. 30, 2010. It does not include answers to the questions that were submitted in writing after the deadline. These will be addressed at the September 2010 Coordinator trainings.

Registered Dietitians

1. Judy. If no nutritional risks are identified, can a visit still be made by the nutritionist with the standing order in place? Is it billable?
With a physician order for a dietitian, the RD or nutritionist would document the need for the visit. The need might include poor dietary habits, obesity, under-weight, or requested nutritional education or counseling. The RD may want to use the blank POC, Part 2 form to outline nutritional needs to be addressed such as increased need for calcium, good nutrition, good hydration, or assist with managing weight gain. Any visit by an RD with a physician order in place, and a nutritional need identified, although possibly a minor need, is billable and payable. While in the home addressing nutritional needs, the RD may touch on other domains (e.g., family planning).
2. When the RD sees a client, do we have to put the POC, Part 2 Food sheet in the record, even if the beneficiary scored low-risk on that domain?
Make a note that although the risk didn't show up on the Risk Identifier, you have identified it (e.g., obesity) using professional judgment. Use a blank POC, Part 2 sheet to document the risk, intervention and expected outcome.
3. Judy. What about old charts? Prior to July 1st, the RD had a certain frequency of visits established. Does she carry those out now based on the old POC with the old charts only, and follow the new policy and protocol our agency has established on the new charts only?
You must get a physician's order in order for the RD to see all beneficiaries, including those enrolled prior to July 1, and follow the new policy as described in the answer to Question 1 above. If the RD was seeing the beneficiary prior to July 1, a copy of the physician order must be in the chart to enable the RD to continue to see her after July 1.
4. Judy. Should the RD use the regular progress note?
Yes.
5. RMA. We operate under standing orders for immunizations and other services, and we don't have to keep a copy in each client's file. Why is it necessary to do this for the RD standing order?
It's necessary because it's a Medicaid policy.
6. Does the RD need to have a POC to make a visit?

09-28-10

Final

She needs to provide services based on the POC or she can use the optional blank POC, Part 2 sheet to develop a one to meet the beneficiary's need.

NOTE: MDCH will be sending you a survey on your utilization of RDs and IMH specialists – watch for it in a few weeks.

Generic Questions on Forms

1. Joni. Were any changes made to any of the forms after 6-1-10? I had already saved and printed them for our use when they were posted on the web site. I just need to know if I need to reprint any of them.
Yes, changes were made to the forms. The forms posted on the web site – effective 07/01/10 – are the correct forms. Please destroy the documents you received at the March trainings.
2. Joni. When the question and answers were compiled from the spring Coordinators meetings, it was indicated that “detailed instructions” would be available for each of the new forms. Can you please refer me to where I can find these instructions? I have looked in several places but I am having a hard time locating them.
There are instructions on the web site for select forms. There are general instructions for POC, Part 2 across all domains. There have been some technical difficulties with the web site, including problems with provider agency pop-up blockers. Let Joni know if the links don't work.
3. Joni. Didn't you say that there would be sample forms?
We decided to write instructions instead.
4. Suggestion: We need to see sample forms – these questions don't really specify what is expected for each item and there is going to be a great deal of variation as to how professionals are completing them.
At the Coordinator training in September, we're going to go through the forms in detail and state exactly what reviewers will be looking for.
5. Ingrid. Why do we have to write the Medicaid number on the *Risk Identifier* and progress note? We're constantly writing progress notes and have to write it on both sides – it's unnecessary, repetitive, and inefficient.
We need it on the Risk Identifier for data tracking purposes, but we will look at the progress note.
6. RMA. Could we get unprotected/unlocked access to the MIHP forms so that our agency can upload into our electronic health records system?
We're in the process of developing a protocol for this. The agency must agree not to change the forms in any way, and understand that they will be responsible for making all changes when the forms are modified in the future. If you want to request the unprotected/unlocked forms, ask your MIHP consultant for the form, which must be completed by an authorized agency representative. Note that the Authorization and Consent to Release Protected Health Information will not be included in the unprotected/unlocked forms.
7. I have a suggestion – the consultants should request to review some charts so they can see how much documentation is being required. It's taking a great deal of time and paper, which is expensive.
This is a good idea. We'll visit some programs for this purpose.

Generic Questions on Risk Identifiers

09-28-10

Final

1. Ingrid. Where do we document the location of medical care provider?
Currently there is not a specific box or space on the Maternal Risk Identifier to put this information. This information can be added to the comment section of the Maternal Risk Identifier or you may add it to your own form. We are taking this information under advisement for the next revision of the Risk Identifier.
2. Ingrid. When should I enter a Maternal Risk Identifier?
You should enter information on the Maternal Risk Identifier into the Michigan Department of Community Health's (MDCH) electronic database after the Risk Identifier has been completed. Do not enter the names of beneficiaries into the state system as a placeholder or prior to completing a screen.
3. Ingrid.
 - When we make a mistake (e.g., enter the wrong EDC), we can't change it.
 - If we did a screener and then found out we documented the wrong information accidentally in the screener, is there a way to change it? We found this on a few charts and just hand wrote the changes on the domains and changed the risk levels accordingly.
If you completed the Risk Identifier and got the scoring printout, you can't change the data. If you want to make a change in the data, contact your MIHP consultant and they will delete the first Risk Identifier.
4. Began entering the Maternal Risk Identifier today – got interrupted and did not save and exit screen. When I came back to it was unable to complete - screener said it was in database and couldn't enter unless 2nd pregnancy. What should I do now?
We will send a coordinator email with the step-by-step process for handling this.
5. If the beneficiary is being seen by another MIHP provider, how do we know if the Risk Identifier was really done?
You can find out if another provider did the Maternal Risk Identifier by checking the data base. See the Protocol for Checking Beneficiary's Status and Entering Maternal Risk Identifiers, FW: 09.10 - #32 Coordinator Email. You could also call the other provider.
6. Ingrid. I have several older, incomplete risk screens that I would like deleted from the database so I can complete them.
Contact your MIHP state consultant and she will delete them for you.
7. Ingrid. Are we supposed to be entering the Infant Risk Identifier online, as we do with the Maternal Risk Identifier?
No, the electronic version is not available, and we have been told by the Department of Information Technology that it won't be ready for about a year. So please continue using the paper copy and file them in the beneficiary's record.
8. Joni. DCH sent us an email about billing for the Risk Identifier, even if the beneficiary declines services. We appreciate being able to bill for this, but it creates an internal problem because it looks like she's in the program, but there's no Discharge Summary, etc.
All Medicaid-eligible women get the Maternal Risk Identifier and POC, Part 1, even if they decline services. If a woman declines services, be sure to document this in the record, along with the Infant Risk Identifier and POC, Part 1, and tell her that you will be contacting her again near her due date to see if she needs anything. There are a variety of ways to internally track these women. One provider keeps a file (with EDCs) of women who decline services to know when to

09-28-10

Final

contact them again. At the September Coordinator trainings, you will have an opportunity to discuss tracking strategies with each other.

9. Joni. What if risk is identified and professional staff feels that risk is not enough to generate a POC. Can a brief narrative suffice?

If a risk is identified, you must complete a POC, Part 2. Pull the corresponding POC, Part 2 domain sheet and file it in the record. If the beneficiary does not wish to address this risk, document this in a progress note

10. The comments boxes on the screeners aren't long enough, even if we abbreviate, so you can't see all of our comments.

We will take this under consideration when we are able to revise the Maternal Risk Identifier.

Generic Questions on POC

1. Ingrid.

- How do I capture risks not on the *Maternal Risk Identifier*?
- Some of the Plan of Care Part II interventions are not on the *Maternal Risk Identifier*. What is the mechanism to capture that information?

You gather information about other risks from the questions on the Supplemental Maternal Risk Identifier and from any other supplemental forms that would like to use, along with professional observation.

2. Joni.

- Some of the girls have no risk factors identified on screener so we assume we do not need to add any domain sheets to the chart? We should provide basic info off POC, Part I?
- What if the beneficiary scores no risk in all domains – we only do POC Part 1, right?
- If we open a client to MIHP who has no risk factors based on the electronic risk screening and subsequent risk stratification, is it necessary to include any “Part 2” documents in their POC or will it suffice to follow that applicable intervention steps from Part1 and finish by attaching Part 3 for sign-off/review purposes?

The POC, Part 1 should be completed with all beneficiaries, along with the Risk Identifier and Authorization and Consent. If no risks are identified in the domains, it is not necessary to pull those domain sheets to create a POC, Part2. You should contact women who have no risk factors again prior to delivery to schedule a visit. At that visit, identify any new risk factors. If new risk factors are identified, pull and complete the appropriate POC, Part 2 sheets and the POC, Part 3 sheet. If the professional feels that there is a reason to provide services to the beneficiary, the blank POC must be filled out to document this need.

3. Judy.

- Why does the POC, Part 1 have to be signed by both the SW and RN since it primarily documents providing educational material to the woman and determining further services? We do not have the SW available in WIC where this is customarily done and I can see it getting missed especially if the woman does not agree to the home visits.
- On the Infant Packet - POC, Part 1, do both the RN and SW sign, and only the one who did the assessment?

Yes, they both have to sign it per Medicaid policy. The signing of the form indicates agreement.

4. RMA.

09-28-10

Final

- Five days is not enough to get the required signatures on the POC, especially when staff work at multiple sites. We feel like we're playing a paper game - staff are forced to sign when they haven't even had time to review the POC. We need 30 days.
- If the RN goes over the Maternal or Infant packet (POC, Part I), how soon after does the SW have to sign this form also?
- Our nurse and social worker have been signing on case conference day, which doesn't always occur within 5 days.

Currently, the requirement for getting signatures is five business days for both POC, Part 1 and POC, Part 2. We don't require the nurse and social worker to sign the POC on the same day. However, we have heard your concerns and will meet internally to discuss the possibility of increasing the number of days.

5. Joni. Is POC, Part 1 given to the client? If so, do we keep a copy of it in our charts?

Do we always use this, even if we are using POC, Part 2 domains?

You may give the POC, Part 1 to the beneficiary, if this would be of benefit to her and you have the resources to do so, but it is not required. You must have a copy in the chart, signed by the nurse and social worker. All beneficiaries get POC, Part 1, whether or not they get POC, Part 2.

6. Joni. If a beneficiary scores low risk on all POC Part 2 domains, can we just use Part 1?

*You can just use Part 1 only if the beneficiary has **no** risks. The only domains that have a low-risk level option are the family planning and chronic disease domains. The other domains have only moderate risk, high-risk, and emergency-level options. You cannot assign a low-risk level in domains that only have moderate and high-risk level options. Whenever a risk is identified (including a low risk), you must complete the POC, Part 2. If the risk is identified in one of the existing domains, you must use the corresponding POC, Part 2 sheet. If the risk is identified outside of the existing domains, you must use the POC, Part 2 blank sheet to address it.*

7. Did you say that we can't use moderate interventions with a client who is low-risk in a particular domain?

If a client scores low-risk on the Risk Identifier, but your professional judgment is that she is at moderate risk, you can document this in a progress note and use the moderate risk interventions.

8. Joni. On the individual domain sheet, are we able to write in other risk information based on professional judgment?

Yes, if you would like to. You could write in the second column (Risk Information) on the POC, Part 2 sheet.

9. Joni.

- If we use "clinical judgment" in identifying POC, Part 2 domains to work on with clients, how much individualized documentation should there be on each page/domain?
- When we have a patient who states she just stopped smoking it comes out on the screener as no risk. We have been using our own professional judgment and changing them to moderate risk because we know they may still be smoking and telling us they quit. What type of documentation do you need on the POC to describe our changes in risk levels we feel are wrong after assessment is done that show up on the grid?

If you use professional judgment to identify a risk in one of the 10 domains, use the checkbox on the domain sheet. If you identify a risk outside of the 10 domains, document it using a blank POC sheet. Adequately describe the risk, intervention and outcome.

10. Joni.

09-28-10

Final

- Can risks, interventions and expected outcomes be added, even if not identified initially?
- If we identify a risk in a new domain after the original POC was developed, do we need to revise the POC and get the signatures again?

If you identify additional risks after the initial POC, Part 2 is completed, you do need to revise the POC and get the signatures again. Add the appropriate POC, Part 2 domain sheet, or, if you identify a risk outside of the 10 domains, use a blank POC sheet. The signature sheet (POC, Part 3) has multiple signature lines be used whenever a domain is added. Signatures are not necessary whenever there is a change in risk level.

11. Joni. If risk factors change while we are providing services (moderate risks become high risks, for example), should we modify the POC? Or, is documentation on the Progress Note sufficient?

It's sufficient to document a change in risk level in the progress note. However, if a new risk is identified, you must modify the POC by adding the new domain.

12. Joni.

- When mom was smoking in maternal portion of program then stops and it is re-addressed in infant portion of program, what date do you put on the Infant portion? I assume we do not need to go back through the maternal chart, we just put the date that it was readdressed in the Infant assessment.
- When we enroll an infant, can we “carry over” the Maternal POC pages that we were using during the maternal case? Or, do we have to start new Maternal POC pages for the appropriate risk factors?

If the risks identified in the Maternal Considerations component of the Infant Risk Identifier are the same as the risks that were identified prenatally, you must use new (clean copies) of the appropriate POC, Part 2 sheets. We talked back and forth with the field about whether it's best to make a copy or pull a clean sheet and ultimately determined that it made the most sense to pull a clean POC, Part 2 sheet, as you may have already documented achievement prenatally in a domain that needs to be addressed again postpartum. If a new maternal risk is identified, you must add the appropriate POC, Part 2 domain sheet, along with POC, Part 3.

13. Joni. How do you keep it all (the assessment data) in your head when you develop the POC, Part 2?

You have to look at the Risk Identifier responses, the supplemental tools responses, your own notes from interviewing the beneficiary, and your own notes from professional observations as you develop the POC, Part 2.

14. Joni. Are the forms we have control over creating a problem because we could be adding risks that might not be data-entered? How do we know these risks get addressed? If it's on a supplemental form, it might get missed.

You can add this information in the comment section of the Maternal Risk Identifier or on summary documents. The professional visit notes indicate what is discussed. If it is an added domain, it is treated like any other domain.

15. Joni. On the Maternal POC, Part 1, do we need to "answer" the last four items before the signature line?

No, these are tasks to complete. Your signature verifies that you have completed all of them.

16. Staff can end up writing the beneficiary's name on POC pages 17 or 18 times. Can we just use initials?

The beneficiary's name is on each POC page, in case the chart comes apart.

09-28-10

Final

17. What do we use for POC, Part 2 when we need to provide breastfeeding support? Is it a separate POC page? Also, where do we document this in a progress note – under “Maternal, Food?”
Use the Food domain POC page for pregnant women and the “Feeding and Nutrition” domain POC page for infants. To document breastfeeding support on the progress note, add an “other” checkbox under “Domain/Risk Addressed.” When we revise the form, we’ll add an “other” checkbox.
18. Can the State add breastfeeding as its own domain?
No, but you can include it under “Food” or as an “other” domain and write your own POC for it.
19. When we’re documenting a POC, Part 2 outcome, do we just check the box and give the date, or do you also want documentation on a progress note? If there won’t be a progress note, can the staff who checked the box initial it, so that the Coordinator knows who it was?
You don’t have to document it on a progress note, and you can certainly have your staff initial it.
20. If the POC, Part 2 is client-driven, do we have to incorporate Part 2 domains if she does not wish to address them?
Yes. If the Risk Identifier identifies a risk, pull the corresponding domain sheet and include it in the POC, Part 2. If the client does not want to address the risk, document this in a progress note. There won’t be expected outcomes in this situation.

Maternal Forms

Maternal Risk Identifier

1. Ingrid. Where is the location of prenatal care recorded?
Question # 3 on the Risk Identifier asks where the beneficiary goes for prenatal care, however, it does not ask the specific location. You could add this information in the comment section of the Risk Identifier, on a progress note, or on your own form.
2. Ingrid. There are no questions on the *Risk Identifier* that address transportation needs, yet it is a choice for the POC. If we are to base our POC on the algorithm scoring, this will not come up as a choice since this issue is not addressed.
There is a transportation question on the Maternal Risk Identifier and there are transportation questions on the Supplemental Maternal Risk Identifier. The POC is not exclusively based on algorithm scoring. It is also based on professional judgment, using information obtained through beneficiary interviews and professional observation.
3. Ingrid. The algorithm scoring still does not appear to be correct. For example, one of our clients does not drink alcohol and this was indicated as such on the *Identifier*, yet she scores as a Moderate Risk in this category. Also for this same client, the answer to the question “Has anyone criticized you about your drinking?” the answer comes up as “3 or more”. This is not a correct choice. Was this just an isolated incident for this client, or is this happening to anyone else?
We will test this.
4. RMA. We’re getting beneficiaries who don’t score out moderate or high on the *Risk Identifier*, but who are clearly at high risk based on professional judgment (e.g., 15 y/o with SA history who denies current use or an older woman with a chronic disease). Are there still problems with the algorithm?
This will continue to be the case. The Risk Identifier asks a limited set of questions based on an extensive review of the literature to determine which risks were clearly shown to affect birth

outcomes. Use your professional judgment, along with the Risk Identifier results, to determine risks. Remember that all beneficiaries are eligible for MIHP as a benefit of Medicaid health insurance, even if they only get the Risk Identifier, POC Part 1, and a follow-up contact near the time of delivery. Women with a chronic disease who are under treatment are not considered high risk for MIHP purposes, because we are not providing skilled nursing care.

5. Joni. Why doesn't a history of domestic violence score out and result in a POC?
History of domestic violence does score out on POC, Part 2 as moderate.
6. Ingrid. Why doesn't the Maternal Risk Identifier ask about WIC?
All beneficiaries are asked about WIC in the POC, Part 1. Also, the progress note prompts the professional to ask about WIC at each visit (a required activity as indicated by an asterisk).
7. RMA.
 - If there's no food in the house, the beneficiary still scores "no risk" in the food domain on the Maternal Risk Identifier – how can that be?
 - Why isn't obesity on the Maternal Risk Identifier? It's addressed as a risk on the Supplemental Risk Identifier and on the Plan of Care Part 2 – Food. It's a major issue and we all know it's a risk. It doesn't make sense that it's not on the Risk Identifier. Talk to Barbara Luke, MSU OB-GYN, if you don't believe obesity is a risk factor.
*When the MIHP re-design literature review was conducted several years ago, the goal was to identify every risk that was **clearly** linked to poor birth outcomes **and** for which there were interventions that had proven successful (or were at least very promising) in reducing that risk. Only risks that met both of these criteria were included in the Risk Identifier, as the intent of the re-design was to move toward making MIHP an evidence-based model. MIHP providers are encouraged to use professional judgment to identify and address other risks, as long as the risks identified by the Risk Identifier are given priority. The Risk Identifier is not being revised at the current time, but additional risks will be considered when it is revised.*
8. Joni. The Maternal Risk Identifier doesn't ask info on where dad lives – if he resides with the mom.
You can collect additional information and use additional forms as you see fit. We have a group working on an optional form to gather this type of info.
9. Ingrid. We're entering comments based on our professional judgment on the electronic Risk Identifier. Is someone reviewing our comments to see what different providers are entering so that frequently identified risks can be added when the Risk Identifier is revised?
We're looking at these comments so it's important for you to keep documenting risks based on your professional judgment. We will consider your suggestion in the future.
10. Joni. Why don't the Maternal Risk Identifier and POC follow each other and why is there so much jumping around when trying to fill in the POC? There is a lack of continuity and flow which is time consuming and can be confusing.
The POC does follow the order in the Risk Identifier and the forms have been developed in the same order and using the same language as in the Risk Identifier.
11. Joni. Why are there no questions on the Maternal Risk Identifier related to preconception (interconception?) health or 2nd hand smoke?
Risk Identifier questions are limited – no interconception section was developed. You may collect additional information using your own forms.

09-28-10

Final

12. Joni. The Maternal Risk Identifier doesn't address teen pregnancy and does not capture the need for family planning nor what birth control the client is planning to use after birth.
Risk Identifier questions are limited – you may collect additional information using your own forms. The progress note prompts the professional to ask about family planning at every visit.
13. Joni. Why doesn't the Maternal Risk Identifier capture any nutritional needs of the client? It also does not adequately address history of child abuse.
Risk Identifier questions are limited – you may collect additional information using your own forms. We are in the process of developing a Maternal Nutritional Supplemental form.
14. Joni. The Risk Identifier does not identify the parent whom the client counts on for support.
Risk Identifier questions are limited – you may collect additional information using your own forms.
15. Deb. Why are there no questions regarding literacy and language barriers?
When the Risk Identifier was developed, it was determined that it was not feasible to test literacy as part of the Risk Identification process. It is assumed that providers can readily identify language barriers. You may note suspected literacy or language barriers in the comment section of the Risk Identifier, on a progress note, or on your own form. On the Prenatal Communication and Infant Care Communications forms, there are checkboxes for “concerned about comprehension” and “language barrier.”
16. We're seeing that “pregnancy history” is scoring high for no reason. What causes this – we assumed this was only the case when there was a problem pregnancy.
It would also score high if the beneficiary is not in prenatal care (even if she has an appointment scheduled) or if she didn't want to get pregnant now or in future.
17. Deb. It is felt there are many repeat questions asked throughout.
This is understandable, as some of the questions are quite similar, but each question does have a specific purpose.

MIHP Prenatal Communication

1. Joni. Where does the doctor's address go on the Initial Prenatal Communication form?
We do not have a space for the Dr's address on the form. You may add this information yourself. We will take this back to the MIHP-Medical Provider Communications Committee.
2. Joni. Since we are required to mail the communication form to patient's provider, is it possible to add a space on the *Risk Identifier* to ask "who is your doctor"?
No, the Risk Identifier is not being modified at this time. You may add this information in the comment section of the Risk Identifier, on a progress note, or on your own form.
3. Ingrid.
 - Originally you said we have to tell the medical care provider if a woman declines services. Is this right?
 - If the woman declines services, do we have to mail the Prenatal and Infant Care Communications to her MD, even if the MD wasn't the referral source?
No, this is only true if the medical care provider was the one who made the referral. We'll clarify this on the Communications forms when we revise them.

09-28-10

Final

4. If the client declines services after the Risk Identifier is administered, and then she declines again when we contact just before and then after the baby is born, do we have to mail the Communication form to the medical provider each time?

If the client is not accepting services, you don't need to send the form to the medical care provider, unless he/she was referral source, and then you only need to do it once.

5. Joni.

- What do we use to accompany the Prenatal and Infant Communication reports if clients are not enrolled at all? (Options are 'does not qualify', 'declined', or 'cannot locate').
- Do all MIHP providers need to have a letter that is the same throughout the state that will notify the doctor that the client has refused services? We could add the prenatal communication paperwork that addresses the needs we assessed, if the client signs the Auth to Release Info forms.

We will be taking these questions back to the MIHP-Medical Provider Communications Committee in the fall and may end up revising the Prenatal and Infant Communications Forms. We realize that the section on "receiving services, declined services, cannot be located, etc." doesn't apply unless the medical provider actually made the referral.

6. Joni. We don't see Interconception Health (which is listed in POC, Part I Maternal Packet sheet (M002) listed on the Prenatal Communication Sheet (M022) which is sent to the Doctor?

Interconception health incorporates all of the other domains. For example, if a chronic disease risk was identified, it would be addressed in the chronic disease domain. If a family planning risk was identified, it would be addressed in the family planning domain. Beyond discussing it in POC, Part 1, interconception health is usually addressed after the birth of the baby.

7. Deb. Do we send the original to the doctor or keep it in the chart?

Send the original to the doctor and put a copy in the chart marked "copy".

Maternal POC Part 2 – Family Planning

1. RMA. Why is it necessary to ask at each visit regarding the beneficiary's family planning method when she has clearly stated that she is having a tubal ligation?

It's necessary because the beneficiary may have changed her mind or begun to have doubts or questions. At each visit, ask the beneficiary how her plans for using her selected family planning method are progressing and answer any questions she may have. If she has changed her mind about having the tubal, provide education about other family planning methods. It's important to ask follow-up questions about a beneficiary's family planning method of choice at subsequent visits. Refer to FDA Comprehensive Birth Control Guide in the Maternal Packet and pull questions from there. Be sure to check the "family planning discussed this visit" box on the progress note. (NOTE: We were recently notified that the FDA Guides have run out and won't be re-printed until Oct. 1.)

2. Joni. The form has a checkbox that says "Plan First! application completed," but the application can't be submitted until 60 days postpartum.

The idea is to get her to complete the application before she has the baby, so it's ready to go when her Medicaid ends. This will allow her to access Plan First! services ASAP.

3. We do Plan First! applications online. Do we have to use paper?

If you review the family planning brochure with a beneficiary and help her with an online application, document this in a progress note. The goal is to help her switch over to "Plan First!" as soon as possible after her Medicaid coverage ends.

09-28-10

Final

4. If the beneficiary applies for Plan First!, she is ineligible for other Medicaid programs – it's not advantageous for every beneficiary to apply for Plan First!
If the beneficiary will be keeping her Medicaid coverage, just note in the record that she will continue to get family planning services under Medicaid.

Professional Visit Progress Note

1. Joni.
 - My staff may need more than 2 domains addressed on a visit. Can the State allow us to have access to each page of the progress note individually? This way we can fill in 2 problem areas and then have 2 more available without having to use page 2. This means we only need one page 2 for a visit, but may need two page 1's if we have four domains to address.
 - If we're documenting 3 domains (so we need to use two progress note forms), do we have to fill out the second page twice?
No, just staple the pages together. We've had requests to add more domain sections to the form and may revise the form to allow for this.
2. Joni.
 - We need more than one and a half lines of narrative; that is all the current form allows you to type in the space.
 - Progress notes need more space to document on.
There is an error on page 2 of the progress note – "Other visit information" only allows for 1½ lines of narrative, instead of five lines, so we will change this. The other narrative sections allow for five lines, which was intentional, as we would like narrative documentation to be concise.
3. RMA.
 - At the top beneath "Education Packet Reviewed" it asks for "Section(s)". What is this in reference to? The Education packet or POC? What should be filled into this spot?
 - My staff is confused about "sections" on the progress note. Does this refer to POC, Part 1? Do you need to say which numbers under the domain that you are addressing?
It refers to the Education Packet and the topic that was discussed. No, you do not need to say which numbers under the domain that you are addressing.
4. Joni. Under each "Domain/Risk Addressed" in the section on "Interventions Provided" it asks for "Partial (#s)". What is this in reference to? The POC?
Yes, it refers to the specific, numbered steps under each intervention in POC, Part 2. If you provided numbers 1, 2, and 3, as listed in the intervention column on POC, Part 2, you would just write in those numbers rather than write out the interventions.
5. Joni. If we're documenting Maternal Considerations, do we write it under infant care?
Maternal Considerations on the progress note is a fill-in-the-blank item, but the blank doesn't show up on a hard copy. Check the Maternal Considerations box and after the colon, write in what they are.
6. Joni. Regarding the Professional Visit Progress Note: Can you use the Infant check boxes if you are discussing these items with a mom postpartum and infant hasn't been "added" to program yet under the infant component?
No, infant boxes may only be checked once the Infant Risk Identifier is completed. Discussion around the infant prior to this should be documented in the "other visit information" section of the progress note.

09-28-10

Final

7. Joni. Can we continue to use the old Professional Visit Progress Note for charts open before July 1, 2010, or do we have to switch to new Progress Note? It is very difficult to complete Progress Note based on old POC.
You don't have to switch to the new progress note for old cases unless you want to. It's your choice. For clients enrolled prior to July 1, you could have all old notes, all new notes, or a combination of the two.
8. If we're documenting in an old chart using the new progress note, do we just indicate the intervention level we think it is or write "in process?"
You can make a decision on this based on what's clearest for you.
9. Judy. Regarding the Professional Visit Progress Note: On the back, the note indicates it is required to discuss family planning this visit. What if the client has made a decision regarding family planning option? Do we still need to discuss it and check the "yes" box? Same with immunizations, if you know the pregnant mom is up to date, do you have to continue to ask and check box for each subsequent visit?
Yes, you still need to discuss family planning and immunizations at every visit and check the "yes" boxes per Medicaid policy.
10. If we add a risk to the POC, Part 2 (e.g., obesity), how does that correlate to the progress note? Checking the Food domain interventions box doesn't seem right.
In this case, you would check "other." However, there is no "other" box on the form. We will add it. In the meantime, just add an "other" box when you need to use it.
11. RMA. We have a standing order for all clients – do we always check "yes" on the progress note, even if we're not using the RD?
No, it's checked only if it's an RD visit. Don't put a copy of the standing order in the chart unless RD services are needed.

Maternal Summary

1. Ingrid. Where do I note a pregnancy loss/stillbirth/fetal death/miscarriage/ectopic pregnancy on the Maternal Summary form?
You could add pregnancy loss/stillbirth/fetal death/miscarriage/ectopic pregnancy information to the comment section of the Maternal Summary form. We will look into revising the Maternal Summary form to include this information with the next revision of the form.

Infant Forms

Infant Forms Checklist

1. Ingrid.
 - On the Forms Checklist, what should the infant's referral date be if mom was enrolled in MIHP for this pregnancy and infant is now enrolling in MIHP? We would not technically have received a referral, except from ourselves.
 - Regarding the Forms Checklist for Maternal and Infant: What do you want to see for the "date reviewed" and "referral source"? What if the referral source is our own program-like when we "refer" infant of MIHP mom to Infant part of the program.
Write "internal" for referral source and use the date you closed the mom.

09-28-10

Final

2. What is the reference to 6 weeks? Don't we get 60 days to serve the mom after she delivers?
You are able to serve the mom until her Medicaid is terminated.
3. You said that the date that the staff fills out the Risk Identifier is the date of the referral. What if you get the referral when the beneficiary is still in the hospital? Shouldn't that be the referral date?
We'll talk about this at the Sept. training. We have a list of questions we'll be asking you to discuss with each other during lunch.

Infant Risk Identifier

1. Ingrid. The *Infant Risk Identifier* has no place to indicate visit location, nor a summary or comments section. Is this intentional?
Write the visit location on the last page of the Infant Risk Identifier. The comments section was unintentionally omitted – it will be added before the Identifier becomes electronic.
2. Ingrid. The Infant Component of the *Risk Identifier* does not ask any questions about infant's medications. Is that something that should be added?
You may document additional information using your own forms or a progress note.
3. Ingrid. What if baby does not live with mother? How should the Maternal Component of the *Risk Identifier* be filled out? Should this be skipped altogether, or filled out as appropriate for the current caregiver, i.e., father or other relative?
Complete it as best you can. We will be discussing this internally.
4. Ingrid. Do you foresee an opportunity to get the Infant Risk Identifier pre-populated (like WIC does), so we don't have to repeat all of the questions we asked on the Maternal Risk Identifier?
We have already started working on this. We can pre-populate DOB, MA ID#, etc., but the fields have to match exactly.
5. Ingrid. *Infant Risk Identifier* question 5.5: If mom is breastfeeding it would be "NO" for this answer and the algorithm would go to 5.6, which is actually N/A since infant is breastfed but that would generate a risk. How do you answer 5.6 for breastfeeding infant who never had a bottle? Then question 5.7 also becomes questionable.
We're looking into this to make sure the skip pattern is correct. Until we make a determination, write "NA" if that's the correct answer. Note your comments anywhere on the form, since there is no comment box at this time.
6. RMA. It's taking 2½ hours to complete the Infant Risk Identifier and the Supplemental Nutrition Assessment, the POC, set up the next visit, etc. It's beginning to feel like a visit to do paperwork, not to provide service.
We do understand that it's hard to make the initial visit fiscally feasible, but it should not take 2½ hours. If you are educating the beneficiary as you are administering the Risk Identifier, it may take longer than if you were simply administering the Risk Identifier. It may be best to schedule another visit within a few days to do the educational piece - once you begin having a connection with the beneficiary you can say "we'll talk more about this next time." The only POC you address at the initial visit is the POC, Part and the Supplemental Nutrition Assessment is optional. We would like to talk about this further about this aside from this call.
7. Ingrid. Why does the screening ask whether the father of the baby is a drug user, however there is no intervention for this on the care plan?

09-28-10

Final

Drug -exposed infant interventions are being developed and will include drug use by other household members.

8. Ingrid. Why is there no question asking what the infant's father's name and date of birth is?
You may add these questions using your own form. We may be adding this to the form.
9. Ingrid. Where do we mark SAB (spontaneous abortion?) - in the interconception portion or prenatal care portion and why?
We're not sure which form you're talking about here. Please clarify.
10. Ingrid. Why are there so many repeat questions regarding breastfeeding on the infant component of the screening?
There are no repeat questions on the Infant Risk Identifier. There's only one question that appears on both the Infant Risk Identifier and the Supplemental Nutrition Assessment. The Supplemental Risk Assessment can be done at any time during infant services, so the question may be repeated weeks or months after it is first asked as part of the Infant Risk Identifier. Breastfeeding is promoted as an MDCH priority.
11. Ingrid. On the maternal component of the infant screening, the question is asked "First Time Parent?" If no - "How many?" Is this asking how many total children the mother has had? We would like clarification on this question.
Yes, it is asking for the total number of children the mother has had.
12. RMA. What date for infant do the staff put down if still has Maternal visits left, i.e., if put date of when MSS visits done, then it looks like the nurse did not see the baby in the first 2 months of life.
Complete maternal visits and then administer the Infant Risk Identifier. The date you administer the Infant Risk Identifier is the date you begin infant services for billing purposes. However, you can use a progress note to document infant interventions provided before the Risk Identifier is administered. Use the "Other Visit Information" section", even if the "Domain/Risk Addressed" areas are left blank. This would be a blended visit.
13. Ingrid. In Section 3.4 of the Infant Risk Identifier, there needs to be a "none" option.
This has been communicated to the team working on the electronic Infant Risk Identifier. Until the electronic version is available, you may write in "none" if that's the appropriate response.
14. In the maternal part of the Infant Risk Identifier, can changes be made to the smoking section? Many beneficiaries quit while pregnant, but "still quit" is not an option.
You're right. We'll talk with MSU about this.
15. Pages 8-11 of the Infant Risk Identifier are the Bright Futures questions on general infant development. Can we just use the one page that corresponds to the infant's age to avoid all the extra copying?
You only need to copy the page corresponding to the infant's age and the signature page (pg. 11). We will put a signature line on each separate page – will think about doing this on the hard copy now.
16. The infant component of the Infant Risk Identifier doesn't have a gray area to fill it in electronically – we upload it from the web site.
We'll see what we can do about this.
17. The Infant Risk Identifier doesn't ask for infant's sex or race.

09-28-10

Final

We'll working on the electronic version now and will ask MSU about this. Please capture this information in writing for the time being.

Infant POC, Part 2

1. Do we put the mom's name or the baby's name at the top of the POC, Part 1?
Use the baby's name, even for the Maternal Considerations domain.
2. Do we need to put a Maternal Considerations page in the Infant POC, Part 2, even if no maternal risks were identified?
Yes, if no risks were identified, pull the Maternal Considerations page, check "No risks identified," and stick it in the record. There should be a Maternal Considerations page in every infant record.

Infant Care Communication

1. The Infant Care Communication form has a space for EDC. Is that an error?
Yes, we will address this when the form is revised.

Supplemental Nutrition Assessment

1. Ingrid. Is the Supplemental Nutrition Assessment mandatory or optional?
The Supplemental Nutrition Assessment is optional to use.
2. Ingrid. Is the optional/supplemental infant and maternal nutritional form meant to be used by the RD? Can the RN or MSW use this form?
Any discipline can use and sign this optional form at any time.

Infant Summary

1. Deb. Why is the *Infant Summary for Data Collection* mandatory? The data doesn't even get entered – the form just goes in the chart and no one sees it again.
The data on this form will ultimately be part of the MIHP evaluation. We have submitted a service request to the Department of Information Technology to convert the Summary into an electronic document. Even though Summary data is not being entered in the MDCH data base right now, you need to complete it because it captures risk info at the end of service which can be used by your program for internal quality assurance purposes.
2. Do we send the Infant Summary for Data Collection to the MD?
You have the option to send or not send the Summary to the infant's doctor. Some members of the Communications committee felt that it's inappropriate to send mom's info to the infant's doctor, but others thought it was very appropriate. The name of the form will probably be changed to Maternal Considerations Data Summary.
3. The Summary has a "refused assistance" check-off box for the risk domains, but what if it wasn't a risk for the beneficiary?

09-28-10

Final

In the second column, you indicate if it was a no, low, moderate, high or unknown risk. If it wasn't a risk for a particular beneficiary, the "refused assistance" box wouldn't be applicable.

Edinburgh Postnatal Depression Scale

1. Joni. On the MIHP maternal part of the Infant Risk Identifier, when you do the Edinburgh Postnatal Depression Scale (EPDS), why aren't the score numbers given on the screener?

The scoring numbers are provided on the EPDS in the maternal component of the Infant Risk Identifier (see page 8 of 11).

Developmental Screening

1. Deb. Do we adjust for age on premature infant for Bright Futures?

Yes.

2. Deb. Even if a child has a delay identified in the Bright Futures, is an Ages and Stages to be completed at that visit?

*Generally speaking, the Infant Risk Identifier (which includes developmental screening questions from Bright Futures) and the ASQ are **not** administered in the same visit. The Infant Risk Identifier is billed as an assessment visit and the ASQ is billed as a professional visit – only under unusual circumstances can two visits be billed on the same day.*

The age of the infant is another important consideration. The infant must be at least one month old before it's appropriate to administer the ASQ-3 and at least three months old before it's appropriate to administer the ASQ: SE. So even if the Bright Futures questions trigger a concern, the ASQ-3 and ASQ: SE should not be administered until the infant is old enough.

More specifically, the timing of follow-up developmental screening using the ASQ tools depends on the primary caregiver's responses to the Bright Futures questions, as detailed below:

Positive Bright Futures Screen (concern is triggered):

- a. *If the infant is less than two months old and at least one Bright Futures "not yet" box is checked, administer the ASQ-3 within two weeks. (Again, the infant must be at least one month old before it's appropriate to administer the ASQ-3.)*
- b. *If the infant is two months or older and at least two "not yet" boxes are checked, administer the ASQ-3 within two weeks. If the infant is at least three months old, also use the ASQ: SE. (Again, the infant must be at least three months old before it's appropriate to administer the ASQ: SE.)*

Negative Bright Futures Screen (no concern is triggered):

If the infant screens negative on Bright Futures, administer the ASQ-3 and the ASQ: SE at the next visit or as soon as the infant is old enough. (Again, the infant must be at least one month old before it's appropriate to administer the ASQ-3 and at least three months old before it's appropriate to administer the ASQ: SE.)

Remember that you may refer an infant to Early On for a comprehensive developmental evaluation, based solely on your professional opinion, when the infant is too young for the ASQ-3

or ASQ: SE to be administered, or when you or the parent suspect there is a developmental concern that is not reflected in the infant's ASQ scores.

3. Deb.

- What is the interval for ASQ-3 and ASQ: SE? Is it at every monthly visit or at the intervals?
- What are the guidelines for administering the ASQ-3 and ASQ: SE? Do we just administer them all?

It's important to distinguish between questionnaire intervals and administration intervals:

*Questionnaire intervals are the different versions of the questionnaire based on the child's age in months. The ASQ-3 has 21 questionnaire intervals (2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months). The ASQ: SE has 8 questionnaire intervals (6, 12, 18, 24, 30, 36, 48, and 60 months). The ASQ-3 and ASQ: SE Age Administration Charts at www.michigan.gov/mihp indicate which questionnaire to use with a child who falls outside of these specific intervals (for example, which ASQ-3 questionnaire interval to use with an infant who is 5 months or 11 months old). Also, when selecting the ASQ-3 questionnaire that matches the child's age, it is necessary to adjust age for prematurity if a child was born more than 3 weeks before his or her due date and is chronologically under 2 years of age. The Age Administration Charts explain how to do this. It is not necessary to adjust for prematurity with the ASQ: SE. This is because of the longer time-frame covered by each ASQ: SE interval and the less significant relationship between social-emotional development and prematurity. Administration intervals are the points at which the ASQ-3 and ASQ: SE are repeated. This is a decision that is made by the particular program (e.g., Early Head Start, Healthy Start, MIHP, etc.) that is using the ASQ tools, depending on its structure and goals. For example, a parent support program that provides weekly or bi-weekly visits over several years, may decide to repeat the ASQ-3 and ASQ: SE at every questionnaire interval, using the tools for screening and parent education purposes. However, a parent support program that visits parents much less frequently over a shorter period of time, may decide to repeat the tools one or two times during the course of service, using them primarily for screening purposes. We consulted with Jane Squires, who developed the ASQ-3 and ASQ: SE, about administration intervals for MIHP. She suggested that **MIHP repeat the tools every 4 months (for children under 3 years of age) or every 6 months (for children over 3 years of age). If there is concern, then the tools can be repeated every 2 months.***

Please review the ASQ-3 and ASQ: SE video on the MIHP web site.

4. How does the mom need to be involved in the completing the ASQ-3 and ASQ: SE?

*ASQ questionnaires were developed to be **completed by parents** and scored by professionals, paraprofessionals or clerical staff. The parent tries activities with the child and/or answers quick questions about the child's abilities. It takes about 15 minutes for a parent to complete the questionnaire. Having parents complete the ASQ is not only cost effective, but also enhances the accuracy of screening - regardless of socioeconomic status, location, or well-being - by tapping into parents' in-depth knowledge about their children. You can mail or give the ASQ to a parent and ask her to complete it before your next visit. Or, you can help a parent complete the ASQ during a visit if she is unable to read or has other difficulties completing it independently. (There is also a new online completion option, but programs must purchase a subscription to this service.) It's important to review the ASQ-3 and ASQ: SE video on the MIHP web site and to become familiar with the User's Guide for each tool.*

09-28-10

Final

5. If the child is in Early On, do we still keep doing the ASQ screenings?
No, the child will get an in-depth developmental evaluation and follow-up services through Early On.

Maternal and Infant Packets

1. Joni.
 - Where are the informational packets which are supposed to be given to the clients?
 - Are we going to get the whole educational packets for the moms mailed to us or will we need to order these?
See responses to Questions 2 through 4 below.
2. Joni. When will we be getting the maternal booklets?
We apologize for how long it's taking to get the maternal packets – we hope they will be delivered within a few weeks. We will send you a coordinator email as soon as we hear that they are on their way. We don't believe we will have the funds to replace them when this shipment runs out. We intend to develop our own maternal booklet in-house, after we develop our own infant booklet. Let us know if you have succinct documents we can look at as we develop these booklets.
3. RMA. The Infant Packets that were received by the agencies are the 2002 version. Should the agencies use them until they have access to the 2008 version?
The 2008 version is not available in print. It is posted on the MIHP web site. Use the 2002 version until further notice, but replace the safe sleep page because it's obsolete. We will be sending you an updated, 2-page safe sleep replacement insert which gives the "do's and don'ts" and is very visual. As an alternative, you could use the Safe Sleep brochure.
4. Joni. LHDs are having problems getting some of the other brochures for the maternal packet - what should we do? It's too expensive to copy them.
We reduced the number of brochures you need to include – please see the list on the web site. The brochures that are currently listed there are all available and ready to order from the publisher. We've had significant challenges with the maternal and infant packets, which is why we want to do our own. We heard you say it's too expensive to copy them, so we are only using materials you can order. If they are not available, we will not hold you accountable for distributing them. Be sure to destroy the list of brochures you received at the March trainings.
5. Joni.
 - Are we supposed to provide clients with the entire Infant Packet at enrollment, or can we hand them out on a month-by-month basis?
 - We've worked for years to get staff not to give a client a bunch of brochures at one time – they hit the trash before the client's out the door. Now we give clients the option: "Your blood pressure is high – here are some booklets – feel free to take them if you want them." Handing out a stack of brochures is wasteful and goes against adult learning principles. Clients are only interested in focusing on their current concerns.
The packets are given out at the first contact in case there are no additional contacts with the beneficiary. We reduced the number of brochures in the packets, based on your comments at the March trainings - please see the web site for the revised list. One provider purchases colorful files so beneficiaries can keep the brochures all in one place: Beneficiaries seem to like this and it helps us because we can ask, "Did you get a blue or green file from another social worker?" It's also a way to get back in the door, because we can say, "We'll be back to go over these other folders with you."

09-28-10

Final

Another provider gives out a blue maternal folder and a yellow infant folder. The folders include the educational packets, transportation vouchers, emergency plans, etc. – everything in one place. Plus, staff always carry a master copy of all materials with them in case a woman loses a brochure – they can still review it together, but the staff retains the booklet.

6. Joni. Is the secondhand smoke brochure with Engler's name on it the most recent version?
Yes. We're getting the maternal packets without the Governor Granholm's name because we're in a transition/election year.
7. Joni. Has the State considered serving as a clearinghouse for the packet materials?
Yes, but we don't have the storage capacity or funds to mail the materials on an ongoing basis.

Beneficiary Chart

1. Joni.
 - If the client is admitted (Risk Identifier, Information packets given and risks assessed and info presented r/t those risks), but she refuses to have visits and we put her in the queue to be contacted one month prior to EDC, can we set up the chart as contact only without all the POC, Part 2 paperwork attached until the time she requests to be seen?
 - Our concern is that if she decides she wants visits at a later date, we will need to re-evaluate the needs that are current. We would bill for the admission at the 1st Risk Identifier/Info meeting and thereafter it would be a revisit, but it seems a waste of time to set up a chart for current needs that may be different once we see them again. There is also the possibility that they will refuse at the second contact also.
 - If they refuse at the initial meeting, do we need to do the team conference and keep them on our active list?
 - What documentation has to be completed for the assessment - I am thinking the Risk Identifier, consent POC Part 1? What if the woman declines further participation?
You may choose to start a file or create another record-keeping system for beneficiaries who decline services after the Risk Identifier is administered. You don't need to have a team conference for these beneficiaries. If the beneficiary decides she wants services later in her pregnancy, you would need to see if her current risks are the same as those identified at the time that the Maternal Risk Identifier was administered.
2. Joni.
 - If a mom is enrolled on MIHP and wants to continue the program with her infant, can we use one chart for both participants or still continue to have one chart/record for mom and then start new chart/record for infant?
 - We're trying to decide if we should have one chart or keep separate maternal and infant charts. Also, there's the maternal POC and Maternal Summary issue. At the time you do the Summary, you update the POC to address whatever's hanging out there, and you send the Summary to the medical care provider. Then you do the Infant Risk Identifier, asking the some questions and putting in the same POCs you had as in prenatal. You really weren't done with a domain, but have to update it at the end of pregnancy. How are other providers dealing with this?
MDCH does not dictate what type of filing system you need to use – you can use family, individual or combination of records. You will have an opportunity to discuss this with other providers at the September trainings.

Transportation

09-28-10

Final

1. Judy. If the client is seen in WIC, admission takes place, they refuse home visits, but wish to have transportation assistance, can we do that without having visits?
Yes. Nowhere does it say there must be visits, but it should be well documented so the reviewers will understand why there are no visits. Documentation should also indicate that the mother was asked many different dates about visits. The documentation should indicate why the MHP did not provide transportation when the mother was put into a MHP.
2. We give beneficiaries a token to get here and another token when they leave. If they show up, we can bill Medicaid, but if they don't show up, who do we bill?
Please send this question to us in writing and we'll take it to Judy.

Documenting Referrals

1. Joni. What information goes to a referral source if, for example, it is a community-based organization?
Document and report disposition of the referral (i.e., initiation of services, inability to locate, or refusal of services) to the referring source. (Section 5.3 Operations and Certification Requirements, MIHP Chapter, Medicaid Provider Manual)

Reimbursement

1. Judy. Who do I contact in Provider Enrollment regarding approval so I can start my billing?
You enroll through CHAMPS. Start with the Provider Inquiry Help Line at 1-800-292-2550. Talk with whoever answers the phone. They should get you to the correct person
2. Judy. It used to be that we could request the beneficiary's physician to authorize additional infant visits beyond the assessment and initial 9 visits. Now, our medical director can authorize these additional visits. Before, we had to bill the additional visits with a "22" modifier, and in the comments area give the reason for the additional visits. Is this still the proper procedure?
The second 9 visits can be billed the same way the initial 9 visits are billed. The documentation for the visits should be in the visit notes. It does not need to go on the claim form.
3. Judy. Infant assessment done in the office prior to July 1, 2010 was billed using H2000. Is this correct?
Yes.
4. Judy. We billed an office assessment for Infant portion (ISS) as we could not find the mother and she was in the office so we chose to do an assessment. When our biller billed the H1000 code, it was rejected due to beneficiary's age.
This problem has been corrected. You can claim adjust this service.
5. Judy. On page 25 of the *MIHP Operations Guide*, the billing codes we use to bill for services do not include the office visit codes for an FQHC (which is listed on our Memo of Agreement with Medicaid) as a code 50.
Correct. MIHP is only payable in the 4 listed places of service: 4, 11, 12, and 15. You will still get the wrap around with these places of service.
8. Judy. Clarify CBE billing: The "draft" policy states "An outpatient hospital clinic that provides this service may bill Medicaid directly for FFS beneficiaries." The "final" policy states "shall bill Medicaid directly for FFS beneficiaries."

09-28-10

Final

The final policy (Section 3.1) states: If the MIHP provider contracts with an outpatient hospital or community based organization for childbirth education, the contract must indicate which provider is to bill and receive payment.

9. Judy. It is my understanding that Childbirth Education Classes are listed as an MIHP service in the Medicaid manual. We are not offering these classes free to the public and we are billing Commercial insurances, Medicaid, and the patient if they have no insurance or their insurance denies for not a benefit. As of 10/01/2008 we bill Medicaid only for MIHP services and not the Health Plan. Is this also the policy for Child Birth Classes? I want to make sure we are to bill Medicaid and not the Health Plan.

All MIHP services, including Child Birth Education (CBE), should be billed direct fee-for-service, so you are correct. If you contract with a hospital to provide CBE, you must bill Medicaid per the contract.

10. Judy. We are getting rejections with the explanation that the beneficiary has other insurance. Do we have to bill the other insurance company when we know that MIHP is not a covered benefit?

Report the primary insurance at both the header and line level of the claim. At the line level of the claim, report CAS code 96 and the total charge for the line. If you are filling out an electronic version online, it is translated by your billing agent into 837 electronic claim format. You may have to ask your billing agent how to enter CAS codes through your software. We hope you are not actually filling out a paper CMS-1500 form. Your billing agent should understand this response. If you continue to have a problem with this, contact Judy Tubbs at tubbsj@michigan.gov.

MIHP-MHP Care Coordination Agreement

1. Ingrid. Does the Care Coordination Agreement have to have an end date on it?
The Care Coordination Agreement does not have to have an end date. The agreement is effective until the state terminates its agreement with the health plan.
2. Ingrid. Can the Health Plan rubber stamp their name on the signature page of the Care Coordination Agreement?
Yes, as long as the person using the stamp initials it.

MIHP Data

1. Judy. Do you have any data on the average number of maternal visits that are done by MIHP programs?
We are working on this data. Data from 6 months of paid claims data for three random agencies showed: 1.2 visits per beneficiary, 2.9 visits per beneficiary, and 4.5 visits per beneficiary. These numbers were obtained by dividing the total number of times PC 99402 was paid by the total number of screens (H1000, and H2000) paid. Hopefully these numbers are low, but there is room for improvement. These numbers do not distinguish between mother and infant. There are agencies averaging 8.7.
2. Ingrid. Can I get MIHP data?
We are currently working on the pulling the Maternal Risk Identifiers data from the CHAMPS system. We hoped to have data reports for the first two quarters of this fiscal year to you by the September Coordinator meeting. However, we are running into some technical difficulties. We have to identify providers by their NPIs and some of you have multiple NPIs, which makes it quite difficult. We want to give you clean data, and will have it for you as soon as we possibly can.

Other

1. Ingrid.

- Is there a new form that is being used for audits? If there is, we'd like to use it to do our own chart reviews before the audit this fall.
- If we have the MIHP Review coming up in November, will we be held accountable for the last certification tool or the new certification tool that is still to be fine tuned?

Yes, there will be a new certification review tool, but we're not sure when it will be finalized. We'll get it out to providers before we begin to use it. At this point, use the current tool to prepare for your review. If you have a review scheduled for fall, most likely reviewers will use the old tool and look at old forms. We ask for your patience with this – development of the new tool is a huge task.

2. Judy.

- For infant cases, must the mother be present or can the visit be with a grandmother or aunt?
- If mom works full-time, do we provide services to the day care provider?

Infant visits should be with the infant and the primary caregiver, who may be the mother, father, grandmother, aunt or other person. Primary caregiver is defined as the person who is responsible for the well-being of the infant. This means that if the mom is the primary caregiver, you need to provide services to accommodate her work schedule.

3. Deb. If a beneficiary wants to participate in our program, but does not want certain information shared with her doctor, can she still be enrolled in MIHP?

Yes.

4. What if the beneficiary refuses to sign the Authorization and Consent to Release Protected Health Information form because it states that she is agreeing to allow MIHP to share info with her doctor?

The beneficiary needs to sign both beneficiary signature lines on the form. However, you can add to the sentence "I agree to allow health information disclosure" with a phrase such as "except to Dr. _____." We are in the process of reviewing the Authorization and Consent form.

5. Judy. Is it correct to assume that we're only required to follow the MIHP Medicaid policy, not the additional requirements in the *MIHP Operations Guide*?

No, that's not correct. Providers are required to follow the requirements in the policy and in the Guide. The MIHP Operations Guide is part of the MIHP policy so must also be followed! Every statement that says "must" in the Guide must be followed. (Section 5.3 Operations and Certification Requirements, MIHP Chapter, Medicaid Provider Manual)

6. When will CEUs be available for the Motivation Interviewing online training?

The paperwork was submitted and the CEUs should have been approved by now – we'll check. We've been waiting for three presenters to send in their bio forms, but decided to write the bios for them for their signatures.

7. On page 36 of the Operations Guide, it states that MHPs are contractually required to refer their pregnant members. Does that mean that they give us a lists of names or is it enough for them to just say that they asked the client if she was interested in MIHP?

"Referred" means to refer a specific MHP member. It is not sufficient for the MHP to hand their members a list of MIHP providers and say "contact one of these providers yourself." If an MHP in your service area is just handing out a list, contact your MIHP consultant.

09-28-10

Final

8. Please clarify how we are supposed to serve twins, triplets, etc.

You only open one case and bill under one Medicaid ID number. You get one signed Authorization and Consent, complete one Risk Identifier, and develop one POC. All infants get assessed. In progress note, you would say "baby 2 had concerns." When the electronic Infant Risk Identifier is set to go, there will be a focused decision on whether all multiple birth infants will have the Risk Identifier and services.

9. Ingrid. Since MIHP is now a benefit of Medicaid health insurance, does DHS distribute MIHP flyers or brochures to women who apply for Medicaid?

We don't know if DHS provides information about MIHP as part of the Medicaid application process, but you may wish to discuss this with your local DHS office. We do know that once a woman's Medicaid application is approved, a Michigan Enrolls (Maximus) counselor contacts her to explain that she needs to select a Medicaid Health Plan (MHP) and does provide her with MIHP information at that time.