

## Q & A

### MIHP Regional Trainings – September, 2010

#### Registered Dietitians

1. Can a RD be a care coordinator?  
*No.*
2. Does RD need to sign POC 3 if she adds any new domain?  
*Yes.*
3. RD should be able to use WIC POC – just print from MIWIC and put in MIHP.
4. Can the RD use the “WIC Plan of Care” when seeing an MIHP client, instead of using the “Additional Domain, Plan of Care Part 2”?  
*Yes.*
5. Can RD close charts – send summary/D/c to MD?  
*Yes.*

#### Generic Questions on Forms

1. When a form change is made could you please notify MIHP coordinators so we can stay up to date without reviewing all the forms?  
*Yes. You will receive a Coordinator email message stating that a revised form has been posted on the MIHP web site. Forms will be revised no more frequently than quarterly.*
2. Documentation concerns – unable to document on notes, care plans, etc., sufficiently. Staff has concerns if a court case ever occurred not enough info in record to support “If it was documented it wasn’t done.”  
*By checking the box, you are stating that you took a specific action.*
3. Can you still use old/pre-July 1 forms with clients opened prior to July 1 even after January 1, 2011 – after our 6-month grace period?  
*Yes. If the case was opened prior to July 1, you can still use the old forms after January 1, 2011.*
4. For electronic medical records, do we need a signature or is a typed name of staff acceptable?  
*Electronic signatures that are password protected are acceptable. If you have this capability, you may use it.*
5. Is it okay to have letters on electronic letterhead? Text is not changed but document prints out with letterhead icons. Do we need to maintain the document titles?  
*Yes, it is okay to use electronic letterhead and yes, you must maintain the document titles.*

## Generic Questions on Risk Identifiers

1. What will be the time frame for the state to delete incomplete screens? Time from date of incomplete screen of completion? Recommendations:  
14 + 1-3 days for moms  
7 + 1-3 days for infants  
The plus 1-2 days is for time for office staff to enter info in system.  
*We will delete screens with only a name and date that were entered prior to the last three months.*
2. Maternal Risk Identifier or Infant Risk Identifiers is done but client declines MIHP services. Must the agency follow-up with another contact?  
*If the woman declines MIHP services, ask her if you may contact her again when the baby is due. If a woman is no risk or low risk, you do need to contact her again when the baby is due.*
3. Note: Education level on Risk Identifier is inaccurate in real-time years completed!  
*The grade-level categories are research-based and will not be changed.*
4. The risk screener doesn't give us an option for educational level below junior high school. Many immigrant clients have little education and the risk screener doesn't capture this risk factor. Will this be changed?  
*No. Please see response to previous question.*
5. I will check on Spanish material "Screen" that was supplied to us from someone.  
*We will look into this.*
6. Clarify what non-screened means and how a non-screened client gets services. E.g., in MIHP but screening never billed and not in MIHP and still gets services? If not in MIHP, how does the client get services? From the HMO?  
*The data presented at the training was from 2008. At that time, beneficiaries were not consistently being screened and providers were not consistently billing for screens.*
7. Are we supposed to screen everyone even though they say no?  
*No.*

## Generic Questions on POC

1. What is the purpose of getting both the RN & SW signatures if client does not want services?  
*The signatures verify that POC, Part 1 was carried out.*
2. Outcomes don't reflect all interventions. Can we add more outcomes, for example:
  - a. FDG and nutrition for baby
  - b. Info received and discussed about WIC, referral for WIC
  - c. If mom is on WIC and not breastfeeding, there are no outcomes for baby*Correct, outcomes don't reflect all interventions. You may add outcomes, but may not change the forms.*

3. Please let us staple all the POC, Part 2s together without putting a name on each sheet. Sometimes we have signed their names 20x and our names almost as many times.

*If you staple the pages together, you don't need to write the name on every page.*

4. Our agency has a Green Team that is appalled at the amount of papers in our charts. Is there a way to have the care plan pages that are topic specific laminated for use in the field and find a different way to document what interventions used/goals met? A short ck list that refers back to the program protocols/standards on these care plans?

*You may take a laminated POC, Part 2 out to the field with the beneficiary's Risk Identifier score sheet to know what domains you need to address, but you must have the full chart available for review.*

5. Outcomes aren't specific to interventions.

*Correct, there is not a direct link between every intervention and outcome, but the outcomes are what's expected if you provide the intervention.*

## **Maternal Forms**

### Checklist

1. Please fix the dates on the checklist form.

*Dates should be written in the following format: MM DD 20XX for the sake of consistency.*

### Authorization

1. Authorization to consent form – please allow this form to have the capability to be signed electronically by the beneficiary.

*If your agency has the capability and wishes to do this, please talk with your MIHP consultant about it.*

2. Are you going to rewrite consent to “cover” the confidentiality aspect of providing mom’s information (i.e. depression, substance abuse, etc.) to pediatrician.

*It is our intent that the consent will allow the beneficiary to state that her information may or may not be released to particular entities.*

3. Does the MIHP consent cover the transfer of the record to another MIHP? Or do we need a separate signed release of information signed?

*A separate signed request from the beneficiary is recommended for transfer from one MIHP provider to another. When a request for transfer of a MIHP client is received, the transferring agency has 14 working days to transfer all appropriate documentation to the new MIHP agency. When the case is transferred, the MIHP agency that completed the Maternal Risk Identifier should copy that document, along with any other pertinent clinical information and forward it to the new MIHP providing home visits to the beneficiary. The agency that originally entered the Maternal Risk Identifier into the state data base (SSO) will continue to be noted as the agency that completed that specific document in SSO. Assignment of one MIHP agency's name to the completed Maternal Risk Identifier does not prohibit the new MIHP from serving the beneficiary and billing for visits. For MDCH requirements, please see the*

*Medicaid Provider Manual, Section 2.13, Transfer of Care/Records.*  
[http://www.michigan.gov/documents/mdch/MSA-10-18MIHP\\_322767\\_7.pdf](http://www.michigan.gov/documents/mdch/MSA-10-18MIHP_322767_7.pdf)

### Maternal Risk Identifier

1. Can you make the Maternal Risk Identifier form available in Microsoft Word instead of pdf? This would be beneficial to those of us who are electronic.  
*It's a protected Word document now. Please contact your MIHP consultant if you have an issue regarding electronic forms.*
2. On the prenatal assessment, there is no place to indicate "where on the body" in regards to D.V. This is on the infant assessment - will this be added?  
*This question already is included on both the Maternal and Infant Risk Identifiers.*
3. Can you send us a list of clients with no MA#, so we can see if we can put MA# in for them before they are eliminated?  
*We will only eliminate Maternal Risk Identifiers that have a name and date only.*

### Professional Visit Progress Note

1. On the progress note in additional visit information, can we have lines to write on? It makes the narrative look neater and easier to read.  
*No, we don't have the technical ability to provide lines. We can only provide an open space.*
2. On the visit notes - will the typing fields be increased?
3. We need more room on progress note section to describe interventions beyond 1 line and ½. ASAP. Thanks.  
*We have expanded the space for all narrative sections on the progress note. However, you don't need to use the entire space. Limited narrative is recommended.*
4. Both domains on visit note can be left blank if client refuses to address risks?  
*Yes, but make sure adequate information is provided in other sections of the form to document what was done at that visit.*
5. Progress notes: Not all info needs to be filled out? Use note to meet needs, not use note to gather info.  
*Make sure the progress note adequately reflects what took place during the visit, so reviewers can see how the time was spent.*
6. Can you have "achieved" checked for same domain on more than one visit?  
*On the POC, Part 2, check "achieved" on the first date that the expected outcome is achieved. Effective Jan. 1, 2011, we will remove the "achieved" box on the progress note.*
7. Prof. Visit Note – Section – What info should be written here? Does this need to be filled out at each visit? Is it required?
8. Could you please clarify in writing: Education packets reviewed this visit, Section(s)?  
*We will be changing the word "section" to "topic." It is only required when you discuss the education packet.*

9. Standing Order in place for RD (that RN & SW do not fill this box in)?

*The “Standing Order in place for RD services” box is checked for RD visits only.*

10. Progress Note Change: Education packet narrative this visit to add \_\_\_ yes \_\_\_ no.

*We will add “not applicable” after the “maternal” and “infant” boxes.*

11. Can “no changes” be added to section on back of visit note which currently has \_\_\_ yes \_\_\_ no?

12. On progress note: Add N/A \_\_\_ to Medical Provider visit kept since last visit. This is because we may be doing weekly visits and a medical provider visit may have not been needed between those weekly visits.

*We will look at adding an “NA” checkbox to the “Yes” and “No” checkboxes.*

13. Progress note revision: add a check box for \_\_\_ Non billable visit and \_\_\_ Phone call only, so we have a consistent way to document these visits across professionals and providers.

*You may add these checkboxes to your progress note non-electronically.*

14. POC 1 & Level of intervention checked on progress note.

*We don’t understand this question.*

15. Asking about mom’s immunizations at each visit when she is up to date on immunizations seems worthless.

*We will add an “NA” checkbox to the “Yes” and “No” checkboxes, but it may only be checked if there is documentation that the beneficiary’s immunizations are currently up to date.*

## **Infant Forms**

### Infant Risk Identifier

1. For the Infant Risk Identifier – infant component, I noticed many missing \* next to high risk indicator. Can you take a look at this?

*Do not pay attention to the asterisks. At some point, they will be removed from both Risk Identifiers.*

2. Is a risk identifier for infant required 1<sup>st</sup> visit after birth?

3. RE: enrollment of infant at birth (Infant Risk Identifier). After delivery you still have maternal visits left and want to use them up – what about doing the infant risk identifier – when?

*If mom was enrolled prenatally, you may use any or all remaining maternal visits before doing the Infant Risk Identifier and enrolling the infant. If mom was not enrolled prenatally, or services for mom had been completed, yes – do the Infant Risk Identifier at first visit after birth.*

### Infant Discharge Summary

1. Would it provide clearer info on Infant Discharge Summary if CSHCS was: \_\_\_ Yes \_\_\_ No \_\_\_N/A?

2. On Infant Summary, it says: CSHCS \_\_\_ Yes \_\_\_No. Suggest adding N/A.

*We will make this addition.*

3. What about the meetings that were done before July 1 w/o level of risk – how do you do the new discharge summary?

*You may use the old form, if the case was opened before July 1, or you may use the new form, as best you can. It is your choice.*

## **Developmental Screening**

1. We would like more guidance on how often Ages & Stages should be completed on a healthy, normal infant with no delays – 2, 4, 6, 8, 10, 12 months or 4, 8, 12 months. How should we document this?

*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](http://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.*

2. Do we need to put copies of the completed ASQ-SE and ASQ-3 in the infant's chart or would the summary page suffice?
3. Would recommend that ASQ parent questionnaire is in chart so all home visitors know where issues were (specific questions) and may be addressed.

*At a minimum, the scoring sheet must be in the chart. However, it is recommended that completed questionnaire is also in the chart, so all home visitors can easily see the specific developmental questions or issues that need to be addressed. If the parent requests a copy, make one for her.*

4. Please clarify what part of POC should be activated and how to document on Professional Visit Note when following "Low" risk infant for ASQ screenings.

*You would use POC, Part 1 to set up ASQ appointments. When you do an ASQ, document it on the progress note under “other visit information.” You don’t check off a domain.*

5. Couldn't MDCH provide MIHP agencies with ASQ and ASQ: SE and updates?

*No, we're sorry, but we can't.*

6. Can document if Early Head Start/Early On involved & doing ASQs – MIHP providers can document this and not do their own ASQs.

*If Early Head Start, Healthy Start, etc., is doing ASQ-3 and ASQ: SE screenings for an infant, the MIHP provider needn't duplicate them. If the infant is involved with Early On, he or she will get an in-depth developmental evaluation, which is much more comprehensive than ASQ screening, and will receive follow-up services, so there is no need for the MIHP provider to do ASQ screenings. Be sure to document that developmental screening is being provided by another entity or that the infant is involved with Early On.*

### **Maternal and Infant Packets**

1. How can we obtain more maternal and infant packets? (Allegan Co Health Dept., 686-4515)
2. We are still not able to get the pamphlets that are required.
3. Maternal Packet: Many handouts are not available from website (to send) and when printed off the websites, they're not readable (e.g., *Plan 1<sup>st</sup>* brochure, *Depression During Pregnancy, Smoking Around Children, Quit Smoking For You & Baby, Information about Domestic Violence*).
4. Depression booklet cannot be ordered must be downloaded and printed off – our agency cannot afford this.
5. HRSA PPD booklet cannot be ordered at all through the website – must download English version or they have Spanish books available to order.
6. LHDs cannot assume the costs of copying MIHP materials – care plans (greatly increased # of pages with new care plans) and maternal packets – it is TOO expensive for us.
7. From a health literacy perspective, copies and black & white are not visually appealing and many people will not even look at them so we're wasting our resources.
8. Packets are not available to order as of 9/20/10. Printed off the web are unsightly, unreadable, and cost prohibitive for LHD.
9. Bay County Health Dept. cannot afford to print copies of the required forms, education packets for infant and maternal clients, and the ASQ-3 and ASQ-SE forms to deliver the MIHP. We cannot sustain our present level of expense to deliver this program without MDCH providing the Infant and Maternal Packets materials in particular.

*We're very well aware of this issue and will discuss it with the MIHP Administrative Team.*

*We're working on it as fast as we can and will have an answer for you soon.*

10. Is there a plan for Spanish Maternal and Infant Packet materials? (All)

11. Could we have Chinese resources?

*Not at the present time.*

12. Tomorrow's Child has Spanish and Arabic versions available to order!

13. Can we use alternative Spanish pamphlets?

*You may order brochures from sources other than MDCH, but they can't replace MDCH-required brochures. In other words, you may give out brochures in other languages that were produced by sources other than MDCH, but you also must give the MDCH English version brochures to all MIHP beneficiaries.*

14. Pregnancy booklets, pg. 25 – Sleeping items – Pads? – Blankets?

*You may use the safe sleep insert in the maternal packet.*

### **Maternal-Infant Visits**

1. How many visits/day do you think someone should do? You said doing 9 visits a day is not feasible. Which in an 8-hour day I don't see the issue.

*This is an agency issue. The number of visits/day is based on staff availability and other agency variations, but the need to maintain quality services is a major consideration.*

2. Potentially, could we have 2 cases open at the same time?

3. Recommended the infant be “enrolled” for 1<sup>st</sup> visit, then finish up mom's visits and then go back to infant visits.

*The current procedure is to have only one case open at a time, but we are taking this question to the MIHP Administrative Team.*

4. Whose POC, Part 2 do we follow?

*You follow the POC that was developed for the beneficiary whose Medicaid ID number you will use to bill for services.*

5. Please clarify in writing how to handle infant referral replies when you keep mother open to billed MIHP services for 60 days.

*Reply that you are providing services for this family.*

### **Communications with Medical Care Providers**

1. Do clinic-based programs need to use communication w/ MD form? When we are all one – MIHP is in the same chart.

2. For clinic-based programs, what about the Provider Communication form? We have not used this in the past as we have hand and continue to have close, ongoing communication with Dr. Can we continue to not use it?

3. Clinic based program – coordination of care to medical provider - what's needed?

4. We have an office-based model. In the past, we have not used the provider communication letter (because we all share the same medical record and communicate freely on a day-today-basis). Should we continue to not use a letter with the new system?

5. For a clinic where MIHP & Dr. are in the same clinic, what is the required documentation needed to show Dr. regarding visits? Do they need every visit progress note? Can we show a protocol since we use the same charts for our MIHP clients as providers/prenatal does?

6. “Medical Provider Maternal Discharge Summary, Cover Letter, Form C.”

*You do need to communicate with the physician using the MIHP forms, unless there is documentation in the chart that the physician does not wish to receive these communications.*

7. Please add to communication form to physician: You do not need to sign or return form or copy of letter. You may return if you have additional information.

*We will take this under consideration.*

8. Can we fax the Risk Identifier and letter to the Primary Care Providers?

*Yes, but only if you are sending them from a secure fax to a secure fax, in keeping with HIPAA requirements.*

9. Do we need to send a “POC, Parts 2 & 3 update” to OB – if he/she were the one who DX GDM, but MIHP added a domain?

*No, but you would need to document this in the record.*

### **MIHP-MHP Communications**

1. Is it a state requirement that all MHPs give the agencies a list of potential MIHP members?

*No.*

2. What is the required referral process for the MHP?

*There is no required referral process. Most of the MHPs have made arrangements or plans with the MIHP provider(s) as to how they would communicate.*

3. Can we mandate providers notify MHPs of pregnancy?

*No.*

4. To promote early intervention of pregnant women on Medicaid: Since: MDCH mandates “all women” on MCD be enrolled into a MHP. MDCH mandates all women on MCD be referred to a MIHP provider. **Give consideration: to mandating MCD OB providers to, Notification of all MCD Pregnant Women to their MHP (in area).** The earliest notification of pg to MHP: \*Can initiate referral to MIHP provider ASAP when ID pg., but already on MHP. \*Notification of pg. form from provider - can ID high risk pg. earlier intervention by MHP. MIHP provider that to wait until monthly ID by state route/communications/intervention. MHP notification of MDC pg. women by OB provider: will assist HP’s who are a key player in the mandatory referral process to MIHP providers.

*No.*

### **Reimbursement**

#### Multiple Births

1. Status with twins/triplets – increase time, increase ASQs, screen each infant? Paid each screen? At this time bill – screen one only and service all infants in home.

*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.*

2. What about increasing the number of visits allowed for twins/triplets?

*You already have 18 visits – the standard 9 visits and an additional 9 visits with a physician’s order.*

3. In the instance of triplets, are there special considerations for billing?

*Not as yet, but this is being discussed.*

4. If we have twins or triplets, can all infants have transportation to individual appointments billed to the enrolled infant's Medicaid #?

*Yes.*

### Pregnant Mom with Infant

1. Can we see and bill for mom who is pregnant and her infant at the same time? Billing for both maternal visits when seeing mom and billing visits for infant when seeing infant - at what point do we have to bill blended vs. separate visits for each?
2. Maternal Risk Identifier with pregnant women who are currently being served with baby in MIHP – can screen be done and are we paid for it? Can we do Maternal Risk Identifier only and continue with infant? Do we have to choose one (mom or baby) to continue service (otherwise blended)?

*Per the Medicaid Provider Manual, "MIHP serves the maternal/infant dyad." However, only the mother **or** the infant may be enrolled in MIHP and Medicaid billed for their MIHP services. The mother and infant cannot be enrolled in MIHP at the same time. MIHP services may be provided to both the mother and infant at the same time (a blended visit), but the documentation and billing can only be done under either the mother's ID or the infant's ID. If you have an open case on one beneficiary (mom or infant) and you choose to do a Risk Identifier on the other, you must close the open case first.*

3. If an infant is enrolled and mother becomes pregnant, should we screen her (not provide ongoing visits) to activate blended transportation?
4. If baby is enrolled and mom becomes pregnant, and the risk assessment is completed, and visits continue via blend visits, can you bill travel for both?

*Transportation services may be billed under **either** the mother's ID or the infant's ID, whichever has an open MIHP case. Transportation cannot be billed under both mother and infant at the same time. Transportation for a pregnant mother whose infant is enrolled in MIHP may be available through her MHP. If you have an open case on one beneficiary (mom or infant) and you choose to do a Risk Identifier on the other, you must close the open case first.*

### Other

1. For infant in NICU, and mom enrolled, infant to be in NICU longer than 60 days, transportation is still available. What documentation do you need? What about transportation for father or grandparent visits when mom is not available?

*To provide transportation for the mom when the infant is in NICU longer than 60 days, document it in the progress note and on the transportation log. Whether or not transportation may be provided for the father or grandmother to visit the infant if the mom is not available, depends on the situation. Please contact your consultant to discuss a particular situation.*

2. Are there any Medicaid benefits that apply to a spouse, fiancé, significant other (i.e., transportation reimbursement to travel long distance to see mom and infant during extended hospitalization)?

*No.*

3. What are some QA processes which can be implemented to assure correct billing info is provided to the biller from the MIHP staff?

*The agency needs to devise forms and a process to ensure that the MIHP staff is giving the correct information to the biller. The process will vary from agency to agency.*

4. Not all MHPs pay for all methods of birth control (i.e., IUD). This is a huge inconsistency for a program encouraging family planning. Why is this acceptable?  
*All MHPs must cover all methods of birth control, but may require prior authorization for some methods.*
5. CSHCS children are straight Medicaid – will Medicaid pay for the additional ISS visits?  
*Not all children in CSHCS have Medicaid. Those who do have Medicaid, get the same MIHP services as any other enrolled beneficiary.*
6. Can you outline the steps of billing that Judy went over so we can pass on to our billers who will understand exactly what was said?  
*When this document is completed, it will be posted on the MIHP web site.*
7. Does MIHP need a letter from private insurance companies that states “does not cover MIHP” before billing Medicaid? What are the steps needed to bill if client has private insurance?  
*No, you do not need a letter. If the beneficiary has Medicaid, you bill FFS using the CAS 96 at header and line levels.*
8. What does CAS mean in relation to CAS 96?  
*CAS is the billing code used if a beneficiary has insurance in addition to Medicaid.*
9. If your Medicaid billing claim is incorrect, is there a new law stating that you need to have this paid back within 60 days of finding it?  
*No, please refer to the billing chapter (3) in the Medicaid Provider Manual.*
10. I have heard from two other agencies that they were “cited” for doing a billable MIHP visit with a grandmother. In reading the policy, it seems that if the MIHP infant lives in grandmother’s home (along with mother), the Grandmother is, indeed, a caretaker of infant. Please clarify when/if MIHP visits maybe done with a Grandmother.  
*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.*
11. Will money ever be specifically allocated for MIHP administration? Ever increasing programmatic requirements \*Quality assurance) means more admin time – visit moneys do not provide enough to cover employees and overhead costs. If a program received no outside support (i.e. county appropriations or hospital support) how can they survive solely on home/office visit reimbursement?  
*There are currently no plans for this.*
12. Medicaid Question – MIHP’s run through a FQHC or a health department receive wrap around money which helps them to sustain their programs. Can this wrap around money be made available to all MIHPs? Many MIHPs are struggling to remain cost effective and face program termination if reimbursement is not changed.

*No, MIHP is FFS so providers are reimbursed for services rendered.*

13. May we continue to bill after a miscarriage or fetal loss if mom needs support?

*Yes, you may continue to bill until 9 visits are used, or her Medicaid coverage ends.*

14. Can one county MIHP service provider bill for an office visit provided in another county? MIHP client was screened at office in one county – sent to county she lives in – was lost to service by other county – now becomes GDM + referred to see RD in high risk OB (8/10) care. Needs to be continued to be seen for services by RD. Have discussed transferring MIHP back to county that screened her. Can we bill for visit done by R.D. in other county?

*You can bill for RD services rendered by your staff only. MIHP doesn't have restrictions on crossing county lines to provide services.*

15. Can we get data on home births from Vital Statistics?

*Contact Vital Statistics and make a formal request.*

16. What about increasing the number of visits allowed for the pregnant mom?

*If you believe that a particular pregnant beneficiary needs additional prenatal visits, contact your MIHP consultant.*

## **MIHP Data**

1. Data needs - would like # of Medicaid births per co. compared to MIHP enrollment per county (% of pregnant women and % of infants with Medicaid compared to % of pregnant women and % of infants on MIHP).
2. Would like reports per county on % of Medicaid women eligible, screened and enrolled and this same data for infants.
3. Evaluation data – good to know # of MA pregnant women/births and # of women enrolled in MIHP by county.
4. Provide #MA enrolled in a county with quarterly data.
5. All data obtained and reported by state – also available by county.
6. Data analysis – delivery stats - data pulled by paid claim which is tied to facility location, not residence of recipient. What happens for counties without delivering hospitals? How will the stats be determined for MIHP agencies in these areas?
7. When data is presented, can we have written descriptions of how data was analyzed and what's included?

*We will discuss this with the MIHP Evaluation Workgroup.*

8. Ingrid, please send the slides with data that were not included in packet.

*The videotape of the Sept. training has been posted on the MIHP web site with the PowerPoint slides.*

## **Previous Q & A Documents**

1. Is the Q&A from March 2010 still accurate?

*Please refer to the more recent documents - we will review the March 2010 Q&A document to see which responses need to be changed.*

11-04-10

2. Are the questions from the 8/23/2010 teleconference call answered somewhere if we weren't able to listen to the teleconference call?

*This Q&A document (dated 09-28-10) has been posted on the MIHP web site.*

3. Were any changes made regarding forms, concerns, etc., after the last conference call? Never received any communications back from the questions & concerns that were voiced.

*We are in the process of making the changes to the forms. The Q&A document (dated 09-28-10) has been posted on the MIHP web site.*

### **Quality Assurance – Provider**

1. What guidelines do we need to put in place in designing a client survey?

*There are many templates on the web; we'll also ask the MIHP Evaluation WG about this.*

2. For quality assurance how many charts do you recommend to do for the chart review; you recommend this monthly or quarterly; how about a percentage of the case load for the chart review instead of a set number? The same question for review of charts for billing.

*This is an agency decision, but we recommend that that reviews take place at least on a quarterly basis. The agency must determine the percentage of cases to be reviewed.*

### **MIHP Provider Training and Technical Assistance**

1. Agencies are not fiscally able to cover conference costs, mileage, etc. If the trainings are required, why don't they have CEU's from the state? If a certificate is provided, CEUs should be provided. All nurses need CEUs and agencies are not helping with this. Therefore, MIHP CEUs would be helpful.

*We will consider this in the future.*

2. Make sure CE's are for SW too.

*We will consider this.*

3. Will we get retroactive CEUs if we completed the Motivational Interviewing online training prior to CEU availability?

*If you view it again, you would get CEUs.*

4. My question is regarding the mandatory training for motivational interviewing. Many of my staff have recently attended a training on motivational interviewing (one different from the one posted on the MIHP website). Does this fulfill your requirement for motivational training? If so, what documentation is needed?

5. We have motivational interviewing training available to use for free through Touchstone – Apogee in Grand Rapids. It is approved for SW and RN CEUs. Could this be a substitute for the online M.I. training? It is more in-depth, longer and the in-person training is more effective.

*Yes, but you need to have documentation of the training (the sign-in sheet) on file.*

6. Can the Motivational Interviewing training be completed at a staff mtg? Our agency doesn't allow webcasts 6K of the impact on the speed of our system.

*Yes, you can do it at a staff meeting, but you must document who participated on a sign-in sheet.*

11-04-10

7. Suggest that when you go over forms in a training, either tell us to bring a packet or give out the forms to go over. Overhead projector screen is far away and forms are not readable.

*We will do this in the future.*

8. Coordinators Email: could they be kept in a folder on MIHP website?

*State of Michigan websites are in the process of migration (moving from one software to another). Once migration is complete, we should be able to do this.*

9. Wouldn't the internal MIHP manual be the *Operations Guide*?

*No, the internal manual is for use by the State consultants and certification reviewers – it's internal to MDCH.*

10. When we email Providers Consultant regarding a problem, should we cc a copy to Judy or someone in the MIHP?

*No, the consultants will forward messages to the Medicaid Policy Division, as needed.*

## **Other**

1. What about the rules regarding "enticement" of client into your program?

*The general rule is to conduct outreach in an ethical manner – do not use false advertising or promise more than you can actually deliver. If you believe another provider is not meeting this expectation, contact your MIHP consultant.*

2. Can the owner of the agency be considered as one of the disciplinary Team being employed?

*Yes.*

3. MIHP policy says that if the MIHP agency also does Home Care, the infant must be followed by MIHP. If a baby comes home with apnea monitor, feeding tubes etc., is MIHP the appropriate service?

*If the baby requires skilled nursing care, it should be provided by skilled nursing personnel in home health. However, the baby concurrently may receive MIHP services from the same provider or from a different MIHP provider. Home health well-baby checkups are no longer being provided.*

4. Baby in NICU, mom was never enrolled in MIHP but needs services due to a move, etc., hospital is requesting MIHP for family. What can we do?

*Refer the mom to other community resources while the infant is still in the hospital. You may enroll the infant in MIHP after he/she is discharged from the hospital.*

5. What about MOMS clients who have preterm deliveries, so continued need for services exists? Medical needs covered by hospital, but not emotional/coping needs/concerns.

*Refer the mom to other community resources. You may enroll the infant in MIHP after he/she is discharged from the hospital.*

6. Identified for possible/future MIHP services: HIV+ Mother for ID in hospital. +Drug/ETOH in hospital before release.

*MIHP cannot provide services in the hospital.*

11-04-10

7. If you are concerned about program identity, why not mandate all programs refer to themselves as MIHP – (then program name)? This could help prevent duplicate services too.  
*Providers can use their own program names, as long as they identify themselves as MIHP providers.*