Operations Guide

Maternal Infant Health Program
Division of Maternal and Infant Health
Bureau of Health and Wellness
Public Health Administration
Michigan Department of Health and Human Services

Operations Guide: Cycle 9
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Index of Acronyms and Definitions

CPS	Children's Protective Services
HIPAA	Health Insurance Portability and Accountability Act
IBCLC®	International Board-Certified Lactation Consultant
Home Visitor	Any staff who conducts billable MIHP home visits
MCIR	Michigan Care Improvement Registry
MDHHS	Michigan Department of Health and Human Services
MDHHS MIHP	MDHHS staff associated with MIHP
MHP	Medicaid Health Plan
MOMS	Maternity Outpatient Medical Services Program
PHI	Protected Health Information
POC	Plan of Care
Program Coordinator	Person identified as the central representative of the program
Provider	Entity authorized by Medicaid and MDHHS to provide MIHP services
RD	Registered Dietitian
RN	Registered Nurse
Social Worker	Licensed Social Worker (LBSW, LLBSW, LMSW and LLMSW)

MIHP Operations Guide: Cycle 9

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Section 0 – Quality Assessment & Compliance Certification Requirements

This section details the Quality Assessment and Compliance Certification review process.

Timeline

- All Providers will be scheduled for the Quality Improvement Assessment between June 1, 2022, and May 31, 2023. This assessment is solely for the purpose of understanding agency practices.
- All Providers will receive at least one Cycle 9 Compliance Certification Review between June 1, 2023, and May 31, 2024. The Compliance Certification Review assures and measures compliance with policies and standards documented in the Medicaid Provider Manual, MIHP Operations Guide, and MIHP forms.
- Providers requiring a compliance review before June 1, 2023**,** will be reviewed using the Cycle 8 Certification specifications and tool.

Quality Improvement Assessment

The Quality Improvement Assessment aims to measure and support the use of best practices in home visiting. The goal of the assessment is threefold:

1. To allow providers to become familiar with best practices – as outlined in tools such as the Michigan Home Visiting Quality Assessment System (MHVQAS) – and identify opportunities for improvement.
2. To allow MDHHS to understand program-wide quality and identify opportunities for additional support.
3. To allow MDHHS to understand the strengths of MIHP within the continuum of home visiting models.

Quality Assessment Process

- MDHHS MIHP will contact provider to schedule the Program Coordinator interview and Quality Assessment results meeting.
- MDHHS MIHP will send Quality Assessment Scheduling Letter.
- Provider will submit all requested information/documents by the date listed on the Quality Assessment Scheduling Letter.
- MDHHS MIHP will communicate with the provider to:
    - Share beneficiary chart selection or request EMR login information.
    - Confirm date/time of Program Coordinator interview.
- Provider will submit charts or EMR login information.
- Provider home visitors will complete a survey.
- MDHHS MIHP will review documentation, charts, and survey responses.
- MDHHS MIHP will conduct an interview with the Program Coordinator, which will last approximately one and a half (1.5) hours.
- MDHHS MIHP will provide the Program Coordinator with written details and analysis regarding their assessment.
- MDHHS MIHP will meet with the Program Coordinator for approximately one (1) hour to discuss findings.

Protocol Approval Process

- Provider must submit protocols in accordance with the protocol specification requirements.
- MDHHS MIHP will provide feedback regarding compliance with protocol specifications.
- Provider will submit any necessary edits.
- MDHHS MIHP will approve protocols to be implemented by providers.

Compliance Certification Review

- Prior to Certification Review
  - MDHHS MIHP will contact Program Coordinator to schedule review.
  - MDHHS MIHP will inform Program Coordinator on format (virtual or onsite).
  - MDHHS MIHP will send scheduling letter that includes required pre-review documents and due date.
  - Provider must provide all requested documents by 5:00pm on the date listed in the scheduling letter.
- Beneficiary Charts
  - Open and closed charts are selected randomly based on:
    - Date of Enrollment
      - Beneficiaries enrolled after the last review or within the eighteen months prior to review.
    - Number of paid claims for professional visits
  - Provider is required to produce one complete chart for each beneficiary. Only documents in the identified chart will be reviewed.
  - All requested charts must be provided by 5:00pm on the date listed on the scheduling letter.
- During Certification Review
  - Introductions and agenda
  - Agency observation.
  - Agency document review.
  - Beneficiary chart review.

Certification Categories

- Provisional Certification (new providers only)
  - MDHHS MIHP grants new providers Provisional Certification upon completion of the new provider training requirements and virtual or onsite provisional certification review.
  - A follow up certification review will occur approximately nine months after Provisional Certification status is granted.
  - MDHHS MIHP will schedule and conduct periodic consultation visits after the provider receives Provisional Certification status.
- Full Certification
  - Existing provider receives at least 85% on the certification review.
  - Next certification review will occur in next cycle.
- Conditional Certification
  - Existing or new provider receives at least 70% on the certification review.
  - Next certification review will occur approximately nine months after Conditional

Certification status is granted.
  - Providers will be reviewed on the Cycle 9 requirements.
  - MDHHS MIHP consultation is required for providers who receive Conditional Certification.

After Certification Review

- MDHHS MIHP will send the Certification Report Letter within 45 calendar days after the certification review is completed.
- Based on the outcome of the certification review, a Corrective Action Plan (CAP) may be required.
  - Provider must submit a CAP to address any critical indicators (those weighted a 3, 4, or 5) that were found to be not met.
  - Provider must submit a CAP using the *Corrective Action Plan Submittal Form* to MIHP@Michigan.gov within 21 calendar days of receiving the Certification Report Letter to receive full credit on the next certification review.
  - MDHHS MIHP will review the CAP and will approve or return for revisions within 14 calendar days of receipt.
  - Provider will submit CAP revisions within five business days.
  - CAP must be approved within three submissions to receive full credit on the next certification review.

Decertification

- MDHHS MIHP will decertify an existing provider that receives Conditional Certification status for two successive reviews.
- MDHHS MIHP will decertify an existing provider that receives less than 70% on their certification review.
- MDHHS MIHP may authorize an emergency decertification if there is a pattern of activity that threatens the health, well-being, or safety of a beneficiary.
  - MDHHS MIHP may make an unannounced site visit, based on one or more of the following:
    - A whistleblower reports or MDHHS MIHP suspects possible fraud/abuse.
    - A beneficiary or other entity lodges a complaint of a serious nature regarding unethical behavior or quality of services.
    - There are unusual or questionable findings in a certification review, during a consultation visit or through other communication.
  - Provider may be decertified based on the information acquired during this visit.

Voluntary Inactive Status, Temporary Suspension of Services, and Voluntary Closure

- Provider with Full Certification status may request to move into inactive status for a minimum of six months and a maximum of 12 months.
- Provider must notify MDHHS MIHP within five business days if services will be suspended for any reason and for any length of time.
- Provider may request to voluntarily terminate at any time.

- The Voluntary Closure Protocol form must be completed and submitted to MDHHS MIHP within 10 business days of notice to close or suspend services.
- Agency owners and MIHP Program Coordinators are expected to adhere to the information provided in the Voluntary Closure Protocol.
- Agency owners and MIHP Program Coordinators not submitting and adhering to the Voluntary Closure Protocol will not be considered for reapplication as a MIHP provider.

Section 1 – Personnel & Training

This section details policies relevant to personnel, training, and agency communication. The purpose of this section is to ensure beneficiaries receive services from qualified and trained home visitors.

Personnel Roster

- Provider must use the Personnel Roster to identify all staff.
- Personnel Roster must be updated and submitted to MDHHS MIHP within 10 business days of any personnel change.
- Personnel Roster must correspond with MILogin, identifying all personnel who have access to the database.
- Each MIHP staff member authorized to use the MILogin system must use their unique MILogin username and password.

Home Visitor Credential and Experience Requirements

- Provider must continuously ensure home visitors meet the qualifications defined by the Medicaid Provider Manual, and proof of qualifications must be maintained in the staff file.
  - Verification of licensure through the Michigan Department of Licensing and Regulatory Affairs (LARA) must be maintained in each home visitor's personnel file at the onset of employment.
- At a minimum, the MIHP staff must include the MIHP Program Coordinator, one registered nurse (RN), and one licensed social worker (LLBSW, LLMSW, LBSW, or LMSW).
  - Program Coordinator may also serve as a nurse, social worker, RD, IBCLC®, or Infant Mental Health Specialist.
- Other staff who can provide billable services include an RD, an Infant Mental Health Specialist and an IBCLC® who is also a nurse or social worker.

Note: Internships do not count toward the one year of post-licensure experience required.

- Waiver of Professional Experience Requirement
  - Provider may request experience requirement be waived for any of the following professional staff who meets all other requirements in Medicaid policy:
    - Registered Nurse
    - Licensed Social Worker
    - Registered Dietitian
    - Infant Mental Health Specialist
- MDHHS MIHP Waiver Approval Letter must be maintained in the staff file.

Note: For details regarding waivers, please review the Staff Waiver Process Companion Guide.

Confidentiality

- Staff must sign a confidentiality statement upon hire.

Training

- All staff must have completed course certificates on file for the following trainings:
  - Overview of Maternal Infant Health Program Training
  - Introduction to Health Equity
  - Systemic Racism
- Home Visitors must complete all MIHP Required Trainings.
  - *Notice of New Professional Staff Training Completion form* must be completed and maintained in staff files for all professional and/or back-up staff.
  - *Amended* or *Full Staff Training Matrix* must be completed and maintained in staff file for all waiver staff.
- Program Coordinator or their designee must attend all MDHHS MIHP Coordinator meetings.
- All documentation must be maintained in staff files.
- All required trainings and other waiver staff requirements must be completed prior to conducting home visits independently.

Internal Communication

- Program Coordinator is responsible for disseminating all communication to agency staff, including:
  - Bi-Weekly Update newsletters
  - Coordinator meeting program updates and content
  - MIHP alerts
  - MDHHS MIHP correspondence
  - Great Start Collaborative correspondence

Section 2 – Facility, Technology & Protected Health Information (PHI)

This section details policies relevant to the facilities, technology, and methods for handling protected health information. The purpose of this section is to verify that beneficiaries can identify and contact providers, facilities are ADA compliant, and beneficiary programand protected health information is documented and protected appropriately.

ID Badges

- Home Visitors must carry identification (ID) badges with them when conducting home visits.
  - The ID badge must include:
    - Picture of the staff person
    - Staff person name
    - Agency name

Provider Phones

- Provider must have a business phone listed in the MIHP Directory with a message that includes after-hours emergency information, including directions to call 911 or go to the nearest emergency room.

Provider Facility

- Requirements for facilities in which beneficiaries are seen:

- Adequate privacy for beneficiary counseling and education.
- Adequate privacy whenever beneficiary information is discussed with others.
- A space to accommodate MDHHS MIHP in a smoke-free, pet-free area with a table or desk, chairs and working restroom.
- Entrances, restrooms, passageways, and other public areas are readily accessible and usable by individuals with disabilities, including individuals who use wheelchairs.
- Aisles, passageways, and service rooms that are free of hazards, kept clean and orderly and will assure staff and beneficiary safety and safe passage.
- No objects protruding from walls.
- Handrails installed in stairways having four or more risers.
- Floors, platform stair treads, and landings that are maintained and free from broken, worn, splintered or loose pieces that would create a tripping or falling hazard.
- Two or more exits that permit prompt escape in case of fire or other emergencies.
- Functioning fire alarm system.
- Well-lit and well-ventilated exits, hallways, restrooms, and offices/meeting rooms.
- Fire extinguishers located where they are readily seen and accessible along normal paths of travel, maintained in a fully charged and operable condition, and kept at a designated place and ready to use.
- Requirements for facilities in which beneficiaries are not seen**:**
- A space to accommodate MDHHS MIHP in a smoke-free, pet-free area with a table or desk, chairs and working restroom.

Protected Health Information (PHI)

- Storage
  - All PHI must be kept in a triple-locked system unless a record or document is actively in use.
- Travel
  - Provider must carry only the minimum identifiable information necessary to perform their job duties.
  - When removing records from the office, provider must maintain at least a double- locking system. Records should be returned to the office by close of business. When this is not feasible, records must maintain at least a double-lock.
    - Paper records must remain locked inside of a box or bag.
    - Electronic records must remain password protected.
    - Records must be kept in a locked vehicle, trunk, room, or building.
- Communication
  - Staff communicating PHI electronically must do so in compliance with Health Insurance Portability and Accountability Act (HIPAA) by using fax, an email encryption software or a secure EMR system.
- Retention
  - Provider must retain records, including any applicable physician orders, for at least seven years from the last date of service, unless a longer retention period is otherwise required under federal or state laws or regulations, regardless of change of ownership or termination of participation in Medicaid or MIHP.
  - Records must remain at least triple-locked.

- Records must be destroyed appropriately after the end of the retention period.

- Accessibility
  - Provider must permit MDHHS MIHP access to all information concerning services reimbursed by Medicaid. This access does not require authorization from the beneficiary because the purpose of disclosure is permitted under the HIPAA rule.
  - Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination as a Medicaid provider.
  - Records may only be released to other individuals or organizations if they have a consent signed by the beneficiary authorizing release of the records, or if the disclosure is for a permitted purpose under all applicable confidentiality laws.
  - Any information released is limited to the intent of the "need to know" standard (i.e., limited to the information needed to accomplish the purpose of the person to whom the record is being released).

Section 3 – Quality Assurance

This section details policies relevant to internal provider quality assurance and mechanismsfor beneficiary to file a grievance. The purpose of this section is to institute a system for identifying opportunities for improvement that lead to process changes and responding to beneficiary feedback to improve services.

Quality Assurance

- Care Coordinator must monitor records in accordance with the Medicaid Provider Manual, Section 2.6.
- Chart audits
  - Must be conducted at least quarterly.
  - Must be documented; documentation must be on site for review.
  - Must be signed and dated.
- Billing audits
  - Must be conducted at least quarterly.
  - Must be documented; documentation must be on site for review.
  - Must be signed and dated.
- Chart and billing audits must be conducted in accordance with the provider protocol.
- Documentation must be maintained in accordance with provider protocol.
- Critical indicators (those weighted 3, 4, or 5) must show the following improvement since the previous review, based on percentage documented on data sheet of certification tool:
  - 6 or more not met Cycle 8 indicators were received
    - Improvement must be demonstrated in 4 or more Cycle 9 indicators.
  - 4-5 not met Cycle 8 indicators were received
    - Improvement must be demonstrated in 3 or more Cycle 9 indicators.
  - 1-3 not met Cycle 8 indicators were received
    - Improvement must be demonstrated in 1 or more Cycle 9 indicators.

Grievances

- Provider must document a process for handling beneficiary grievances.

Section 4 – Contracts & Community Engagement

This section details requirements for contracts, community engagement and relationship building with specific entities.

Contracts

- Contracts and letters of agreement with external entities providing billable beneficiary services must be current and include:
  - Time period of the agreement
  - Titles of positions providing services
  - Where the billing responsibility lies
  - Language that meets HIPAA standards

Arrangements for Beneficiary Services

- Provider must arrange for backup staffing for nursing and social work services.
  - Backup staff personnel must meet the minimum required standards in Medicaid policy. Arrangements must include at least one of the following:
    - Collaboration with another MIHP provider.
    - Individual professional provider.
    - Arrangements with a community agency.
    - Use of internal staff.
  - Arrangement must be in writing with verification that the external agency or individual agrees to the arrangements.
  - Backup staff must complete the following trainings before independently conducting visits:
    - Overview of the Maternal Infant Health Program Training Course
    - Introduction to Health Equity
    - Systemic Racism
    - Prenatal Basics for Home Visitors
    - Child Development: Secrets of Baby Behavior
  - Provider must notify MDHHS MIHP within five business days via email when they are void or know they will be void of a nurse or social worker for six consecutive weeks.
  - Provider must notify MDHHS MIHP within five business days via email when a backup staff has been in place for 12 consecutive weeks.
- Provider must arrange for beneficiaries to be seen by supplementary disciplines, including an RD, Infant Mental Health Specialist, and IBCLC®.
  - Provider must identify the entity by name.
  - Provider must document process for referring beneficiaries in agency protocol.
- Provider must arrange for interpretation services, including limited English proficient, deaf, and hard of hearing, and visually impaired beneficiaries.
  - Provider must identify how they will arrange for services under each circumstance, including at least one of the following:
    - Provider staff with the skills to meet beneficiary needs
    - Verbal or written agreement with an identified community organization to provide interpreter services or otherwise assist the provider

        - Assistive technology devices for interpretation
        - Verbal or written agreement with another MIHP provider for the purpose of transferring beneficiaries
    - Agency's protocol must reference the federal Limited English Proficiency (LEP) mandate (Executive Order 13166, August 11, 2000).

Note:

- Use of family or friends over the age of 18 is permitted when requested by the beneficiary, however this cannot be a provider's sole interpretation service plan.
- Provider must identify verified sources, such as those provided by their agency, an agency of the State of Michigan, a community services referral agency, or an intermediate school district. Providers are responsible for paying for the cost of services that are provided on a fee basis.
- Use of interpretation software is permissible, provided the developer has certified that the software is HIPAA compliant, and documentation of such certification is made available upon the request of MDHHS MIHP.
- Under the "reasonable accommodation" provision of the Americans with Disabilities Act (ADA) of 1990, MIHP agency staff may read documents to blind or visually impaired beneficiaries or otherwise make use of assistive technology. Similarly, agency staff may provide written materials to deaf/hard of hearing or hearing impaired beneficiaries or may communicate with beneficiaries via writing.
- Agencies must make their services available to all eligible beneficiaries residing in the county or counties listed on the agency directory.
- Agencies that are not able to enroll beneficiaries due to capacity issues must refer to another MIHP or appropriate service provider.
- Agencies at capacity must notify the MDHHS MIHP team withing five business days of reaching capacity.

Resources

- Provider must be able to demonstrate linkage with the Great Start Collaborative in each county in their service area.
- Provider must demonstrate knowledge of community resources in each county in their service area.

Early On

- Provider must identify local entity coordinating *Early On* services and establish a referral protocol.

Children's Protective Services (CPS)

- The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and other covered entities to report cases of suspected child abuse or neglect to CPS.
- Provider must establish protocol that complies with the reporting requirements mandatedby the Michigan Child Protection Law (Act No. 238, Public Acts of 1975), which must include:
    - Time frame for reporting.
    - Reporting method identified by provider.

  - Time frame to file a written report, if using phone method for reporting.
  - Person in charge to be notified that a report has been made.
- Provider must demonstrate efforts to coordinate with CPS, including establishing protocol that defines how provider will:
  - Make referrals to CPS.
  - Initiate follow-up contact with CPS.
  - Attempt to participate in multidisciplinary team meetings involving infant beneficiaries.

Section 5 – Outreach & Enrollment

This section details policies for connecting with and enrolling beneficiaries. The purpose ofthis section is to ensure beneficiaries receive streamlined care across providers and are enrolled according to program requirements.

Outreach

- Provider must conduct outreach and document outreach activities in each county in their service area.
- Documentation must be maintained in one location.

Accommodations

- Provider must accommodate beneficiary/caregiver schedules or refer the family to another MIHP.

Referrals to MIHP

- Provider must respond to all referrals for maternal beneficiaries within 14 calendar days after the referral is received.
  - Provider must respond to all referrals for infant beneficiaries using the following timelines:
    - Infants referred prior to discharge from hospital
      - Two business days after discharged
    - Infants referred after discharge from hospital
      - Seven calendar days after the referral is received
  - Referral date must be documented on the appropriate form checklist.
    - *Maternal Forms Checklist*
    - *Infant Forms Checklist*
  - When contact with beneficiary is not made within the required timeline, provider must document attempts on the *Contact Log*.

Assessment Visit

- Consent Forms
  - Home Visitor must review content and obtain beneficiary/caregiver signature on the appropriate *Consent to Participate* Form before administering the Risk Identifier.
    - *Maternal Consent to Participate*
    - *Infant Consent to Participate*
  - Home Visitor must review content and obtain beneficiary/caregiver signature on the appropriate *Consent to Release PHI*.
    - *Maternal Consent to Release PHI*

            - *Infant Consent to Release PHI*

- Risk Identifier
    - Home Visitor and beneficiary/caregiver complete the appropriate Risk Identifier.
    - Risk Identifier must be completed, and a Scoresheet received prior to additional MIHP services unless an emergency is documented on the *Professional Visit Progress Note* (*PVPN*) or *Contact Log*.
    - Risk Identifier must be entered into MILogin and Scoresheet obtained prior to billing for the visit.
    - Specifications regarding Assessment Visits for an infant:
        - Home Visitor must complete at least 90% of Infant Risk Identifier visits in the home or a community setting.
        - Home Visitor must document reasoning for an Infant Assessment Visit being completed on the same date as a maternal postpartum visit.
    - If beneficiary/caregiver declined services after the Risk Identifier, home visitor must:
        - Complete *Plan of Care, Part 1*
        - Provide beneficiary/caregiver with the Education Packet, text4baby flyer, or list of approved phone applications
        - Provider may choose whether to complete the *Discharge Summary* at this time. If not completed, provider should maintain contact with the beneficiary to determine future interest in participation. Contact should be documented on the *Contact Log*.
- Plan of Care, Part 1 (*POC 1*)
    - Home Visitor must complete activities associated with the appropriate *POC 1*.
        - *Maternal POC 1* or *Infant POC 1*
- Welcome Packet/Assessment Visit Documents
    - Home Visitor must give beneficiary/caregiver a provider specific Welcome Packet.
    - Components of the Welcome Packet must include at least the following:
        - Education tools, at least one of the following:
            - Education Packet
            - text4baby flyer
            - List of approved phone applications
        - Provider contact information
        - Lead Fact Sheet
        - Healthy Michigan Plan
        - *Your Rights and Responsibilities as an MIHP Participant* [MDHHS 5707]
        - Information on filing a grievance with the provider

Note: Providers must be able to access and provide the Education Packet to families who do not have adequate access to technology or request a physical document.

- Emergency Needs/Referrals
    - Home Visitor must address any emergent needs and referrals the beneficiary/caregiver has identified during the assessment visit.
    - Content addressed during the Assessment Visit must be documented on the *Contact Log* and/or *POC 1*.

Note: Domain(s) and/or intervention(s) addressed during the Assessment Visit do not need to be repeated during a professional visit.

- All documentation as to why a requirement did not occur must be from the beneficiary's perspective.

Policy Exceptions

- Provider may request exceptions in the following instances:
  - Enrollment of an infant over 12 months of age
  - Continuation of services beyond 18 months
  - Risk Identifier scores no risk, but professional judgment indicates a need forservices.
- Provider must send request for approval to MDHHS MIHP team, which will review and recommend exception requests to the Medicaid Health Plan.
- Provider must refrain from providing services until approval has been received.
- Approval documentation must be kept in the beneficiary's chart.

Plan of Care, Part 2 (*POC 2*)

- All *POC 2* domains identified on the Risk Identifier Scoresheet or by professional judgment must be added to the beneficiary's chart; these may include:
  - Maternal *POC 2*
    - Abuse Violence
    - Alcohol
    - Breastfeeding*
    - Family Planning
    - Food/Nutrition
    - Housing
    - Medical Considerations
    - Pregnancy Health
    - Social Support
    - Stress/Depression
    - Substance Misuse
    - Tobacco
    - Transportation
  - Infant *POC 2*
    - Infant Breastfeeding*
    - General Infant Development
    - Infant Feeding
    - Infant Health Care
    - Infant Safety
    - Family and Social Support
    - Substance Exposed Infant*
    - Transportation*

*Indicates *POC 2* that can only be identified through professional judgment, these domains do not have a score on the Risk Identifier.

- Provider must check the appropriate Intervention Level based on the Risk Identifier or professional judgment.
- In the case of unknown risk, the highest intervention level should be assigned for an individual domain.

Note: Birth Health may score as a result of the Risk Identifier but does not have a plan of care. It is a one-time assessment of the infant's health at birth. However, services may still be offered for the beneficiary based on the professional judgment of the provider.

- *POC 2* Intervention Level Adjustments
  - Home Visitors may decide to adjust the Intervention Level on a given *POC 2* on or after the first professional visit.
  - If this occurs, Home Visitor must:
    - Check the new Intervention Level
    - Document the date of the change on the *POC 2*
- *POC 2* Additions
  - Home Visitors may add *POC 2* when professional judgment indicates the beneficiary/caregiver meets criteria for a *POC 2* that did not score on the Risk Identifier or for those who do not produce a score (Breastfeeding, Infant Transportation, and Substance Exposed Infant). This can occur at two different times:
    - Prior to signing the *POC 3*
      - Home Visitor must:
        - Document the addition of a new *POC 2* in the comments section of the Risk Identifier or on the *Contact Log*.
        - Write the date of the Risk Identifier as the "Date of Intervention Level Change"
        - Check the appropriate Intervention Level
    - After signing the *POC 3*
      - Home Visitor must:
        - Document the reason for the *POC 2* addition on the *PVPN* or *Contact Log*.
        - Write the date the new *POC 2* was added to the beneficiary's plan of care as the "Date of Intervention Level Change"
        - Check the appropriate Intervention Level
      - A nurse and a social worker must sign the *POC 3* to acknowledge the addition of the new POC.

<u>Plan of Care, Part 3 (*POC 3*)</u>

- Nurse and social worker must sign the *POC 3* to verify they are aware of and consent to the *POC 2* developed for the beneficiary.
  - Signatures must be within 10 business days of each other.
  - Case Manager must be established
  - Both signatures must be obtained prior to providing any additional services unlessan emergency is documented on the *PVPN* or *Contact Log*.

- Nurse and social worker must sign the *POC 3* within 10 business days of each other whenany additional *POC 2* is added throughout the course of care.

Beneficiary Transfers

- Provider receiving/requesting beneficiary records must:
  - Obtain a signature on *the Consent to Transfer MIHP Record to a Different Provider*.
  - Send signed *Consent to Transfer MIHP Record to a Different Provider* to sending provider.
  - Refrain from serving the beneficiary prior to receiving documents from the sending provider unless an emergency is documented on the *PVPN* or *Contact Log*.
  - Obtain a signature on the *Consent to Participate and Consent to Release Protected Health Information*.
  - Notify the beneficiary's medical provider of the transfer.
  - Use the *Forms Checklist for Transfers.*
  - Address high risk Plans of Care within the first three visits following transfer unless there is evidence that the high risk domain(s) have been addressed by the transferring agency.
  - It is strongly encouraged that both disciplines review the beneficiary record once received.

Note: Provider may contact MDHHS MIHP if the records are not received within ten business days.

- Provider sending beneficiary records must:
  - Send the following documents within 10 business days of receiving the signed *Consent to Transfer MIHP Record to a Different Provider*:
    - Full Risk Identifier
    - Risk Identifier Scoresheet
    - *POC 1*
    - All *POC 2*s
    - *POC 3*
    - All Professional Visit Progress Notes
    - All ASQ-3 and ASQ:SE-2
    - MCIR Documentation
  - Refrain from completing a *Discharge Summary*.

Forms/Documents

- General
  - Provider must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries.
    - Providers must use standardized forms developed by MDHHS MIHP.
    - MDHHS MIHP forms must be complete and accurate in accordance with form instructions.
- Altering Records
  - Home Visitor alters information on a program form by drawing a single line through the

error and writing their initials next to the error.
- The original information must remain visible. White-out, permanent marker or scratching out errors is not acceptable.
  - Only the Home Visitor who completed the original form may alter the record.
- Electronic record systems must have a tracking mechanism to identify who altered program documents and what content was changed.

- The following forms must be present, when applicable, and complete with respect to the required data elements indicated on the instructions:
  - *Forms Checklist*
  - *Contact Log*
  - *Consent to Participate*
  - *Consent to Release PHI*
  - *Beneficiary Status Notification*
  - *Maternal Prenatal Communication*
  - *Infant Care Communication*
  - *Risk Identifier*
  - *Risk Identifier Scoresheet*
  - *Plan of Care, Part 1*
  - *Contact Log*
  - *Plan of Care, Part 2*
  - *Plan of Care, Part 3*
  - *Professional Visit Progress Notes*
  - *All necessary MCIR printouts*
  - *All ASQ Information Summaries*
  - *Discharge Summary*
  - *Physician Orders*
  - *Notification of Multiple Charts Open*
  - *Consent to Transfer Records*
  - *Transfer Checklist*
- *Contact Log* must illustrate any required program element that can occur throughout the course of care but is not demonstrated in the chart. This includes:
  - Instances when a beneficiary was not seen in a given month at any point between the Risk Identifier date and Discharge Summary date.
  - A maternal beneficiary who did not receive a home visit once during pregnancy and once postpartum.
  - At least one visit conducted by both a nurse and a social worker.
  - Addressing all *POC 2* domains.
  - Discussing and/or developing a Safety Plan, under the required circumstances
  - Discussing and/or developing an Action Plan.
  - Initiating a referral for a beneficiary who scores for the Stress/Depression domain (moderate or high intervention level only).
  - Initiating a referral for a beneficiary whose *POC 2* includes the Food/Nutrition domain at a high risk intervention level.
  - A maternal beneficiary whose immunizations were not discussed, chart does not include a MCIR, or with whom infant immunizations were not discussed.
- Provider may document these items on the *PVPN* during the course of care. When a chart is closed, this information must be transferred to the *Contact Log*. Indicators relevant to the above items will be reviewed for closed charts using the *Contact Log* only.

Section 6 – Communication & Professional Visits

This section details specific requirements throughout the beneficiary's course of care. The purpose of professional visits and beneficiary-specific communication is to support beneficiaries and families during the perinatal period.

Communication with Medical Provider

- Provider must communicate with the beneficiary's medical provider using the *Beneficiary Status Notification* and appropriate *Communication Form* within 14 calendar days under the following circumstances:
  - Beneficiary enrolls in MIHP
  - Beneficiary transfers to a new MIHP provider
  - Beneficiary is discharged from MIHP
    - Provider must send a copy of the *Discharge Summary*.
- Documentation must be maintained in the beneficiary's chart.
- Provider must comply with HIPAA requirements.

Communication with Medicaid Health Plan (MHP)

- Provider must update and send the MHP Communication Tool at least monthly.
- Provider must comply with HIPAA requirements.

Note: Beneficiary does not have to provide consent for the provider to communicate with the Medicaid Health Plan but must consent to communication with medical provider.

Professional Visit Logistics

- The standard Maternal Infant Health Program includes nine professional visits. Information regarding additional visits for infants can be found below (see Infant-Specific Components and Physician Orders).
- Home Visitor must conduct a visit with each beneficiary each month.
  - If a beneficiary is not seen once in a given month, document the reason on the *Contact Log*.
  - If a beneficiary is seen more than once in a given month, document the reason on the *PVPN or Contact Log*.
- Nurse and social worker must each conduct a visit with the beneficiary during the course of care.
  - If either the nurse or social worker does not conduct a visit with the beneficiary during the course of care, there must be documentation in the *Contact Log* as towhy not.
- Home Visitor must conduct visits in the home. If a beneficiary/caregiver declines, the visit may be completed in the provider's office or at an agreed upon site in the community.
  - For a community visit, there must be documentation on the *PVPN* as to why.
  - Home Visitor must conduct at least one prenatal and one postpartum visit in the home, unless documentation on the *Contact Log* demonstrates the beneficiary declined.
  - Home Visitor must conduct at least 80% of infant visits in the home or a community setting.
- Home Visitor must visit the beneficiary for a minimum of 30 minutes. Documentation of this must be clear on the *PVPN*.
- Home Visitor must address all domains in the beneficiary's *POC 2* prior to discharge, or there must be documentation on the *Contact Log* that states why this did not occur.

- All documentation as to why a requirement did not occur must be from the beneficiary's perspective

Use of Telehealth in MIHP

- MIHP providers may provide up to 40% of all visits via telehealth (assessment visits and professional visits), and up to 60% of all visits must be provided in person (assessment visits and professional visits). These percentages are calculated across the total agency caseload. Initial assessment visits may be conducted via telehealth.
- In alignment with home visiting research demonstrating favorable outcomes for families, MDHHS MIHP strongly encourages home visits be provided early in the course of care. Providing in-home visits early in pregnancy and infancy can allow a more thorough lens of assessment during a time when early intervention can be maximized.
- As we move further into this post-pandemic period, MDHHS MIHP will continue to assess the complement of in-home visits versus telehealth and may re-evaluate whether a requirement regarding the number of home visits per beneficiary is necessary.
- Telehealth visits must include a dual audiovisual platform while assuring beneficiary privacy and security is maintained.
- Telephone-only visits are allowable only when a beneficiary barrier exists for use of an audiovisual platform (e.g., lacking smart phone or internet access). For professional visits conducted via telephone-only, documentation regarding the rationale must be entered on the *Professional Visit Progress Note* within the "If telehealth or other, why?" textbox. For Risk Identifiers conducted via telephone-only, documentation regarding the rationale must be located on the *Contact Log*.
- Appropriate use of telehealth will be determined by a combination of beneficiary preference and MIHP provider judgment. Examples of appropriate use are included in the Medicaid MIHP Telehealth Policy: Bulletin MMP 23-17.
- MIHP program codes that may be billed as telehealth are indicated on the program specific fee schedule (refer to the current MIHP fee schedule for code description and rate).
- MIHP Providers are required to follow all broader Medicaid telemedicine policy requirements.
- All MIHP requirements, as indicated in the Policy and Operations Guide, apply to billable telehealth services (i.e., duration of visit, number of allowable visits, etc.).

Telehealth, Cont'd: Program-Specific Documentation for Telehealth and Telephone-Only Services

- MIHP Providers must ensure a telehealth protocol is in place that complies with program and Medicaid requirements.
- Any required hard-copy documentation normally provided at the Assessment Visit must be discussed during the telehealth visit and presented at the first in-person visit.
- Consent
    - Verbal consent must be documented, and written consent obtained at the next

in-person visit. Verbal consents not able to be initialed, signed and dated by the beneficiary at the first in person visit, must have rationale of why this did not occur documented on the *Contact Log*.

  - Obtaining verbal consent is allowable for all MIHP Consent Forms (*Consent to Participate, Consent to Release PHI*, and *Consent to Transfer*). See the below guidance for documentation of verbal consent:
    - Applicable to all Consents:
      - In the Legal Representative text box write “Verbal Consent – MM/DD/YY”
      - At the next in-person visit, the beneficiary/caregiver must initial the verbal consent entry and sign and date the document.
    - Specific to *Consent to Release PHI*: In the “Other parties with whom information may be exchanged” section, write in “Telehealth,” the date verbal consent was obtained and “Verbal Consent Obtained.” At the first in-person visit, the beneficiary/caregiver must input the date and initial the “Telehealth” entry.
- Telephone-Only Documentation Reminder: For professional visits conducted via telephone-only, documentation regarding the rationale must be entered on the *Professional Visit Progress Note* within the “If telehealth or other, why?” textbox. For Risk Identifiers conducted via telephone only, documentation regarding the rationale must be located on the *Contact Log*.

<u>Professional Visit Content</u>

- Home Visitor must address at least one of the following at every visit, as documented on the *PVPN*:
  - *POC 2* risk domain interventions
  - Topics identified by the beneficiary
  - Topics identified through professional judgment of the Home Visitor
- Home Visitor must address all *POC 2* designated as high risk within the first three professional visits and appropriately document on the *PVPN*.
- Home Visitor must document on the *PVPN* or *Contact Log* if this requirement is not met.
- Home Visitor must document a detailed account of what transpired during each visit on the *PVPN*.
  - Beneficiary/caregiver’s response to the visit interventions/issues must be documented.
  - Beneficiary/caregiver’s feedback regarding the visit must be documented.
- Nurse or social worker with an IBCLC® certification may provide up to two lactation visits per beneficiary.
  - Lactation visits for maternal beneficiaries must occur postpartum.
  - Maternal Medicaid number is billed.
  - Lactation visits must be documented on the *MIHP* IBCLC® *Postpartum Lactation Support* and *Counseling PVPN*

Note: For additional specifications, please see Medicaid Provider Manual, Section 2.13.

MIHP Safety Plan

- Home Visitor must discuss/develop a written or verbal safety plan with the beneficiary/caregiver when any of the following domains are designated as high risk, and the *POC 2* intervention number for that domain must be documented as listed:
  - Stress/Depression: Intervention #13
  - Abuse/Violence: Intervention #12
  - Substance Exposed Infant: Intervention #9
  - Infant Safety: Intervention #6
- Home Visitor may discuss/develop a written or verbal safety plan with any beneficiary/caregiver for any reason. MDHHS MIHP encourages this practice.

Note: Beneficiary/caregiver's response to the Safety Plan must be documented (e.g., developed safety plan, declined to develop safety plan) in the Beneficiary Response to Intervention section.

- If the Home Visitor does not present the Safety Plan under the required circumstances, the reason why must be documented on the *Contact Log*.

MIHP Action Plan

- Home Visitor must assist every beneficiary/caregiver to create at least one Action Plan.
- Home Visitor must document the development or review of an Action Plan through the checkbox on the *PVPN*.
- If an Action Plan was not developed, the reason why must be documented on the *Contact Log.*

Referrals

- Home Visitor must make referrals throughout the beneficiary's course of care.
- Referrals must be documented on the *PVPN*.
- Home Visitor must follow up on referrals within three subsequent visits, or document on the *PVPN* or *Contact Log* the reason this did not occur. This includes referrals made at enrollment.
- Home Visitor must document the status of each referral in the "Outcome of Previous Referrals" section on the *PVPN*.
  - Required Referrals
    - Mental Health Referral – Stress/Depression Domain
      - Home Visitor must refer a beneficiary/caregiver for mental health services if their intervention level is moderate or high in the Stress/Depression domain.
        - Stress/Depression intervention #12 must be documented on the *PVPN* when the referral is discussed.
          - If a referral is made, document intervention #12 in the Domain section and the referral in the New Referrals section of the *PVPN.*
          - If the referral is declined, document intervention #12 in the domain section only.

- If the beneficiary/caregiver is already receiving mental health services, a referral is not required.
    - Home Visitor must document intervention #11 to indicate the beneficiary/caregiver is receiving mental health services.
- Registered Dietitian – Food/Nutrition Domain
    - An RD employed by the agency must provide nutrition counseling or the Home Visitor must refer a beneficiary/caregiver for RD services if their intervention level is high in the Food/Nutrition domain.
        - Food/Nutrition intervention #13 must be documented on the *PVPN* when the referral is discussed.
            - If a referral is made, document intervention #13 in the Domain section and the referral in the New Referrals section of the *PVPN.*
            - If the referral is declined, document intervention #13 in the domain section only.
        - Considerations for agencies who employ RDs
            - If a visit is conducted by the RD, the referral requirement is met and documentation of intervention #13 is not required.
            - If a visit is not conducted by an RD, documentation of intervention #13 is required.

Note: Documentation for referral for RD services must be specific to the beneficiary/caregiver need. Documentation of a general referral to an organization or program generally will not satisfy this requirement.

- If providing and billing for nutrition counseling, provider must obtain a physician order prior to providing this service.

- If any required referral is not discussed, documentation on the *Contact Log* must explain why.

Maternal-Specific Components

- Maternal beneficiaries must receive at least one home visit during pregnancy and one home visit postpartum. If either of these required home visits do not occur, the reason must be documented on the *Contact Log*.
- Maternity Outpatient Medical Services Program (MOMS) participants cannot receive postpartum visits.
- Immunizations - Michigan Care Improvement Registry (MCIR)
    - Home Visitor must discuss immunizations during care. Immunization assessment, education and documentation in the beneficiary record is a requirement of MIHP Medicaid Policy as documented in section 2.15.
        - Home Visitor must discuss the maternal beneficiary's immunization status at least once during the maternal course of care. This must be documented on the checklist of the *PVPN*.
        - Home Visitor must discuss infant immunizations at least once during the maternal course of care. This must be documented on the checklist of the

PVPN.

- The Michigan Care Improvement Registry (MCIR) immunization record must be pulled and reviewed **at the first visit** for all maternal beneficiaries. It is very important that pregnant beneficiaries are up to date on immunizations including Tdap, COVID-19 and annual flu vaccination.
  - MCIR documentation must be located in the MIHP beneficiary charts (or a screen shot of attempts). A MCIR pulled at or after discharge does not meet the MCIR documentation requirement.
  - If either the maternal or infant immunizations are not discussed during the course of care or the MCIR record is not accessed at the appropriate time, the reason must be documented on the *Contact Log*.

See the *Utilization of MCIR for MIHP Companion Guide* for additional guidance.

Infant-Specific Components

- Michigan Care Improvement Registry (MCIR)
  - The Michigan Care Improvement Registry (MCIR) is used for assessment of immunization, lead screening, and hearing screening for infant beneficiaries. For each assessment, the following timeframes and documentation are expected:
  - Immunization
    - Home Visitor must discuss the infant beneficiary's immunization status with the caregiver at **every** home visit. This must be documented on the checklist of the *PVPN*.
    - Home Visitor must discuss the caregiver's immunizations at least once during the course of care. This must be documented on the checklist of the *PVPN*.
    - The MCIR record must be reviewed and included in the chart **at least twice** during the infant's care as follows:
      - (1) As soon as possible following enrollment **but no later than the third professional visit.**
        - This promotes not only a current immunization assessment but serves as a trigger to discuss the importance of on-time vaccination and an opportunity to proactively identify and mitigate potential barriers to immunization.
      - (2) At the first professional visit **following the infant turning 5 months of age** (on or before date of first professional visit)**.**
        - If the infant is older than 5 months of age at enrollment, two separate MCIR reviews are still required (at the first professional visit following enrollment and at least one other professional visit prior to discharge).
      - (3) If the infant remains enrolled **beyond 16 months of age**, a MCIR record must be reviewed one additional time prior to discharge (for a total of three MCIR record reviews).
      - MCIR documentation must be located in the MIHP beneficiary charts (or a screen shot of attempts). A MCIR pulled at or after discharge does not meet the MCIR documentation requirement.
      - MCIR record may continue to be accessed at any time during the

course of care, not just at the required timeframes.
    - If immunization status is not discussed at a given visit or the MCIR is not reviewed at the appropriate timeframe, *PVPN* or *Contact Log* must illustrate the reason why.
    - Infant Lead Screening
        - Home Visitor must:
            - Discuss lead exposure prevention and provide Lead Fact Sheet at enrollment.
            - Discuss need for lead screening at 12 months of age at visit that occurs when an infant is between 10 and 12 months of age.
            - If infant continues to receive services beyond 12 months of age access MCIR and review results with caregiver.
    - Infant Hearing Screening
        - Home Visitor must:
            - Access MCIR to assess hearing screening results.
            - Discuss hearing screening results with the family as soon as possible following enrollment but no later than the third professional visit.

See the *Utilization of MCIR for MIHP Companion Guide* for additional guidance.

- Substance Exposed Infant Visits
    - Provider must add the Substance Exposed Infant *POC 2* to the beneficiary's chart when Substance Misuse scores on the Risk Identifier or as soon as circumstances meet criteria, as defined on the *POC 2*.
    - Home Visitor must utilize interventions from the Substance Exposed Infant *POC 2* within the first three visits once the *POC 2* is added to the beneficiary's plan of care.
    - Home Visitor must utilize interventions from the Substance Exposed Infant *POC 2* every visit after the first 18 visits.
    - Provider must obtain a physician order for any visits after 18 visits (see below).

Physician Orders

- Provider may request authorization from a physician for the following instances:
    - Beneficiary receives nutrition counseling from an internal RD.
    - Infant beneficiary demonstrates the need for additional visits beyond the standard nine.
        - Up to nine additional visits may be authorized.
        - Infant beneficiary is identified as substance exposed and would benefit from additional visits beyond 18.
            - Up to 18 additional visits may be authorized.
- Provider must obtain a physician order prior to administering services based on the above.
- Physician orders can only be authorized for 12 months and must be updated annually.
- The use of a physician order must be well documented on the checklist and evidence of service must be documented in subsequent progress notes.
- Physician orders may be authorized for:
    - Individual beneficiaries

  - All beneficiaries who meet criteria authorized by the physician
- Provider must maintain a current physician order in the beneficiary's chart.
- Entities approved to authorize physician orders include:
  - Physician
  - Physician Assistant
  - Nurse Midwife
  - Pediatric Nurse Practitioner
  - Family Nurse Practitioner
- Provider must ensure physician order includes:
  - Printed MIHP provider's agency name
  - Printed medical provider's name, address, phone number
  - Medical provider's signature and credentials (CNM, DO, MD, NP, PA)
  - Date of signature
  - Rationale for the visits
- Provider must add the date the order is implemented and the rationale for the order to the Forms Checklist.

Blended Visits

- Blended visits can occur under these instances:
  - Mother of enrolled infant becomes pregnant
  - Sibling of enrolled infant is born

  Note: Multiple Births is another form of blended visit but holds different requirements.See Multiple Births below.
- Provider may complete a Risk Identifier for each beneficiary in the instances stated above.
- Documentation specifications
  - Notification of Multiple Open Charts must be in each beneficiary's chart, unless using a single-family chart.
  - Home Visitor must use one *PVPN* for billing purposes:
    - Home Visitor must check the "Blended Visit" box on the *PVPN*.
    - Home Visitor must document information regarding the other beneficiary in the "Other Visit Information"' section of the *PVPN*.
    - *PVPN* must be filed in the billed beneficiary chart.

Note: All program requirements apply to all beneficiaries in these scenarios.

Multiple Births

- Provider must serve all infants in the instance of multiple births.
- Provider must complete all of the following documents for each infant:
  - *Consent to Participate*
  - *Consent to Release Protected Health Information*
  - Risk Identifier and Scoresheet
  - Plan of Care (*POC 1*, *POC 2*(s), and *POC 3*)
  - ASQ-3 assessments and Information Summary Sheets
  - ASQ: SE-2 assessments and Information Summary Sheets
  - Discharge Summaries
- Documentation Specifications

- *Notification of Multiple Open Charts* must be in each beneficiary's chart, unless using a single-family chart.
- Home Visitor must complete the *PVPN* for one identified infant for the entire course of care. Home Visitor must:
  - Check the "Blended Visit" box on the *PVPN*
  - Document information regarding the other infant(s) in the "Other Visit Information" section of the *PVPN*
  - File the *PVPN* in the chart of the infant identified as the beneficiary and whose Medicaid ID is used for reimbursement of all visits.

Developmental Screenings

- Required Screening Time Frame and Logistics
  - Bright Futures
    - Age adjustment must occur for infants born at gestational age of less than 40 weeks.
    - Home Visitor must repeat questionnaire within two weeks utilizing the appropriate Bright Futures or ASQ-3 questionnaires if the Risk Identifier scores for Infant Development.
  - Ages & Stages Questionnaires-3 (ASQ-3)
    - Age adjustment must occur for infants born at gestational age of 37 weeks orless.
    - Home Visitor must complete the age-appropriate ASQ-3 questionnaire within the first three visits.
    - Home Visitor must complete ASQ-3 questionnaire with the caregiver every three to four months for infant whose score is in the white area.
  - Ages & Stages Questionnaires: Social/Emotional-2 (ASQ:SE-2)
    - Age adjustment must occur for infants born at gestational age of 37 weeks orless.
    - Home Visitor must complete each of the following screenings throughout an infant's enrollment:
      - 2 months (1 month, 0 days – 2 months, 30 days)
      - 6 months (3 months, 0 days – 8 months, 30 days)
      - 12 months (9 months, 0 days – 14 months, 30 days)
      - 18 months (15 months, 0 days – 20 months, 30 days)
      - 24 months (21 months, 0 days – 26 months, 30 days)
      - 30 months (27 months, 0 days – 32 months, 30 days)
      - 36 months (33 months, 0 days – 41 months, 30 days)
  - Provider must follow guidelines outlined in the ASQ-3 and ASQ: SE-2 User Guides.
  - Home Visitor must document reason for any screening that is not completed at the appropriate visit or in the appropriate timeframe on the *PVPN* or *Contact Log*.
- Follow-Up
  - Home Visitor must provide ASQ-3 Learning Activities to caregiver in the following three circumstances:
    - Infant's score is in the gray area in one or more domain on the ASQ-3Information Summary
    - Caregiver declines referral to *Early On*
    - Infant was referred but did not qualify for *Early On* services

  - Home Visitor must rescreen infant in two months if infant's score is in the gray area on one or more of the domains on either the ASQ-3 or ASQ:SE-2
- Referral
  - Home Visitor must refer infant to *Early On* service provider in the beneficiary's county if infant's score is in the black area in one or more domain on either the ASQ-3 or ASQ:SE-2 Information Summary.
  - If the infant did not quality for *Early On* services, Home Visitor must resume conducting ASQ-3 and ASQ:SE-2 once that information is received.
- Documentation
  - ASQ-3 Information Summary
    - Home Visitor must complete Sections 1-4
  - ASQ:SE-2 Information Summary
    - Home Visitor must complete Sections 1-5
  - Information Summaries must be maintained in the beneficiary's chart
  - For ASQ-3 or ASQ:SE-2 completed by another entity, Summary must be obtained and filed in the beneficiary's chart
    - If Information Summary is not present in the chart, document attempts to acquire Summary on the *PVPN* or *Contact Log*.
  - Home Visitor must document reason for any screening that is not completed at the appropriate visit or in the appropriate timeframe on the *PVPN* or *Contact Log*.

Beneficiary Discharge

- Provider must discharge beneficiaries within 30 days of the end of eligibility.
  - Maternal beneficiaries are eligible for participation up to 60 days postpartum, or the last day of the month in which the 60th day postpartum falls.
  - Infant beneficiaries are eligible until they turn 18 months of age.
- *Discharge Summary* printout must be maintained in the beneficiary's chart.

Section 7 – Claims

Childbirth and Parenting Education

- Provider billing for childbirth or parenting education must follow curriculum consistent with Medicaid requirements. For more information, please see Medicaid Provider Manual, Sections 2.11 and 2.12.

Blended Visits / Multiple Births

- Blended Visits
  - Provider must bill each Risk Identifier using the Medicaid ID for the appropriate infant or maternal beneficiary.
  - Provider must bill subsequent visits according to the *PVPN* used for the visit (maternal or infant).
- Multiple Births
  - Provider must bill each Risk Identifier using the Medicaid ID for the individual infant.
  - Provider must select and consistently use one infant's Medicaid ID for subsequent visits for all siblings in the group.

Substance Exposed Infant

- Provider must use code 96167 for visits 19-36 when authorized.
- Provider may use code 96168 for additional time spent with the beneficiary.
  - Code 96168 indicates an additional 15 minutes spent with the beneficiary.
  - Provider may use code 96168 up to two times per visit.

Billing/Claims Issues or Disputes

- Billing concerns associated with MHPs, and Integrated Care Organizations (ICOs) must be addressed with the appropriate plan.
- Fee for Service concerns should be addressed with Medicaid Provider Support.
- If concerns remain unresolved, contact MDHHS MIHP for assistance.

Companion Guides

Additional information regarding many of these topics are posted on the website in Companion Guides. Providers will not be required to demonstrate compliance with information in the Companion Guides during the certification process. These documents are intended to provide guidance based on best practices and provider experiences. They will be updated periodically. Please refer to these documents to learn more.