**Clark county health department**

**POLICIES & PROCEDURES**

PRENATAL CARE COORDINATION (PNCC)

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**EFFECTIVE DATE**: 08/01/2012

**AUTHORIZED SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DATES OF REVIEW / REVISION & SIGNATURES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PURPOSE:** To provide clear and consistent guidelines when providing Prenatal Care Coordination Services in Clark County. These guidelines are in accordance with the requirements and recommendations of the State of Wisconsin Medicaid Prenatal Care Coordination Services Online Handbook.

**REFERENCE:** Wisconsin Medicaid Prenatal Care Coordination Services Online Handbook

**GOAL:** The goal of PNCC is to improve birth outcomes among women who are deemed at high risk for poor birth outcomes based on the Prenatal Care Coordination Pregnancy Questionnaire. Wisconsin Medicaid PNCC services are available to Medicaid-eligible pregnant women with a high risk for adverse pregnancy outcomes during pregnancy through the first 60 days following delivery. The main objectives for obtaining this goal include ensuring that women at high risk: are identified as early as possible in their pregnancy, receive individual psychosocial support and services, receive early and continuous prenatal care services, receive necessary health and nutrition education, are referred to available community services, as appropriate, and receive assistance in accessing and obtaining needed health and social services. PNCC services include outreach, initial assessment, care plan development, ongoing care coordination and monitoring, and health education and nutrition counseling services.

**REFERRAL:**

* Referrals may be received by WIC, local clinics, schools, etc.
* Attempt to contact potential client in WIC clinic or by phone to schedule risk assessment.
* If client does not respond after two phone calls, send letter offering PNCC information and services.
* If a client is referred for PNCC services and does not have Wisconsin Medicaid, refer her to the Western Region for Economic Assistance 1-888-627-0430, for phone or internet application to determine if she is eligible for Wisconsin Medicaid.

*Wisconsin Medicaid providers should always verify a recipient’s eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient’s coverage.*

**ASSESSMENT/ENROLLMENT:**

* Make a face-to-face contact with the potential client. If possible schedule the initial assessment within 10 working days after the request for service by a pregnant woman or after receiving a referral.
* Administer the Pregnancy Questionnaire in its entirety to determine the needs and strengths of the potential client, unless the client objects to a particular section or question.
	+ - If not completed entirely; document reason.
	+ Before administering the questionnaire, explain the assessment and care plan process, acknowledge the intrusiveness of some of the questions, and explain why you need to ask the questions. If necessary, share the confidentially policy with the client, including who will have access to the information provided.
	+ Screen all clients for alcohol, tobacco, and/or drug use at initial contact.
	+ Assess for depression at initial contact, using a standardized depression screening tool-Edinburgh Postnatal Depression Scale (EPDS).
* Enter the results of the Pregnancy Questionnaire in sphere; generate score, RN print, sign, and date.
* Inform potential clients who score less than 4 points on the Pregnancy Questionnaire that they are not eligible to receive PNCC services. Refer these women to other community resources as appropriate and instruct them to contact Public Health for reassessment if they experience a significant negative change in family, medical, social, or economic status during pregnancy. Provide them with the health department’s contact information; document.
	+ Note: Clients who are less than 18 years of age are eligible for PNCC services regardless of risk score.
* Inform potential clients who score 4 or more points on the Pregnancy Questionnaire that they are eligible to receive PNCC services. Provide information about PNCC services and answer client questions.
	+ Schedule an in person visit with client in 30 days or less after initial pregnancy questionnaire has been completed.
	+ Review and finalize the risk assessment in a face-to-face contact with the potential client.
	+ If the potential client is not interested in receiving services, try to determine the reason, document that services were declined, and inform the client that she may resume PNCC during her pregnancy if she desires. Also document that the client received a written copy of the health department’s address and phone number, and encourage calling if she changes her mind about receiving services.
* If the client would like to participate in PNCC, provide client with a copy of the Notice of Privacy Practices, have them sign the Notice of Privacy Practices form, Informed Consent to Release/Obtain Health Information form, and Consent for Medicaid Billing form.
* Assist client in accessing medical care.
* Provide client with written contact information of the care coordinator; document in client’s chart.

**CONFIDENTIALITY**:

* ForwardHealth supports clients’ rights regarding the confidentiality of health care and other related records, including a client’s billing information or medical claim records.
* Clients have a right to have this information safeguarded, and the provider is obligated to protect that right.
	+ Therefore, use or disclosure of any information concerning clients for any purpose not connected with program administration, including contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court, is prohibited unless authorized by the client.
	+ Clients may sign an Informed Consent to Release/Obtain Client Health Information form
		- The form needs to be signed by client, dated, and filled out completely.
		- The appropriate agencies/individuals to whom the information can be released needs to be clearly indicated and discussed with the client before release occurs
		- The client has the right to not sign the form

**CLIENT’S CHART/RECORD:**

* As defined in HFS 105.25(5) Wis. Admin. Code, the client’s chart must including the following information, as appropriate:
	+ Verification of pregnancy
	+ Completed pregnancy questionnaire; scored, signed, and dated
	+ Care plan; signed and dated as required
	+ Completed consent documents(s) for release of information
	+ Referrals and follow up
	+ A written record of all client specific care coordination and monitoring activities. Record must include documentation of the following info:
		- Client’s name, date of contact, full name and title of person who made the contact, a clear description of the reason for and nature of the contact, results of the contact, length of time of the contact (number of minutes or the exact time, and where or how the contact was made.
			* Client information will be held confidential.
			* Providers may release client-specific information if:
				+ The client has granted written authorization
				+ Client has signed and dated the Informed Consent to Release/Obtain Health Information form specifying whom the information can be released to.
* Every client will be entered into the SPHERE database, and will have a sphere ID number. This number should be recorded in client’s written record.
	+ Sphere documentation should include:
		- Client’s demographic/household information
		- All individual activities:
			* Prenatal Assessment
			* Initial prenatal care plan and updates
			* Health teaching
			* Referrals
			* Prenatal ongoing monitoring
			* Postpartum Assessment
			* Infant Assessment
			* Other activities as appropriate
* Reduction or Termination of PNCC Services
	+ - If provider needs to reduce or terminate care coordination services, notify client in advance and document this in the client’s record.
		- This decision should be mutually agreed upon by the provider and client.
		- Chart must include a statement, signed and dated by client, indicating agreement with the decision to terminate services.
			* If unable to obtain a signature from client (ex. Client misses meetings and does not follow through on referrals, but states she wants to continue receiving services), the chart must include documentation of all attempts to contact the client.
		- Provider may re-open a client’s case; must document in chart why the case has been closed and re-opened.

**CARE PLAN:**

* Wisconsin Medicaid reimburses for the development of one care plan for each recipient per pregnancy.
* The Pregnancy Questionnaire must be completed prior to the development of the care plan. The care plan must be based on the results of the Pregnancy Questionnaire and include:
	+ Identification and prioritization of all strengths and problems identified during the initial assessment (including those related to health and nutrition education.)
	+ Identification and prioritization of all services to be arranged with the client, including names of service providers (including health care providers)
	+ A description of client’s informal support system, including collaterals, and activities planned to strengthen if necessary
	+ Appropriate referrals and planned follow up
	+ Expected outcome of each referral
	+ Progress or resolution of identified priorities
	+ Documentation of unmet needs and gaps in service
	+ Planned frequency, time, and place of contacts with recipient
	+ Identification of individuals who participated in the care plan development
	+ The client’s responsibility in the plan’s implementation
* Develop a written individualized care plan for each client and include the client in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate.
* Make a note in the care plan if the recipient does not want to address issues identified in the Pregnancy Questionnaire.
* Inform the client that the care plan can be changed at any time, and as often as necessary; document this in client’s chart.
* The client and provider who developed the care plan must sign and date the plan.
* At a minimum, review and update the care plan every 60 days or sooner if the client’s needs change. Update care plan in sphere.
* Update the care plan within 30 days after delivery.
* All updates to the care plan must be signed or initialed and dated by the provider and client.
	+ The provider may initial updates to the care plan if a signature page is included in the client’s chart.
* Provide the client with the RN-care coordinator’s contact information, and person who is available as back up. Document this information has been given to client.

**ONGOING CARE COORDINATION AND MONITORING:**

* Ongoing care coordination and monitoring activities must be based on the recipient’s written care plan. Medicaid will NOT cover ongoing care coordination and monitoring services that are not based on the recipient’s care plan.
* At a minimum, contacts or visits should occur no less than every 30 days.
	+ Ensure intensity and frequency of contacts with the client corresponds to the level of need and/or risk identified by the pregnancy questionnaire.
		- For example, schedule frequent face to face visits if the client is in crisis, violence in the home, or client is a first time parent with no support system.
		- If necessary call or visit client daily or weekly.
		- If possible, schedule more frequent visits during the early months of pregnancy.
* All Client and collateral contacts and attempted contacts must be documented, even if client does not respond. Document:
	+ The client’s name, date of contact, full name and title of the person who made the contact, clear description of the reason for and nature of the contact, length of time of the contact, and where or how the contact was made.
* Covered activities include
	+ Recipient Contacts
		- Contacts may be face-to-face, telephone, email, text, or written, as appropriate.
		- If client fails to keep care coordination appointment (ex. Home visit made and client was not home), call client within 1 to 2 days to reschedule. Continue to call client; if no response mail letter with provider’s contact information.
	+ Collateral Contacts
		- A Collateral Contact is anyone who has direct supportive contact with the recipient such as a family member, friend, guardian, housemate, or school official.
		- Since the purpose of contacts with Collateral is to mobilize services and support on behalf of the recipient, the provider is required to identify the role of the Collateral in the recipient’s care plan.
		- Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals. Do not include time spent discussing or meeting on non-client specific issues.
		- Medicaid will not reimburse collateral contacts if there is no recipient contact during the month for which the provider is billing.
	+ Information and Referral
		- Provide clients with information on community resources and programs, and help them to gain access to needed services.
		- Make referrals as needed.
			* Whenever possible, provide written referrals. They must include:
				+ The provider’s name, address, and phone number
				+ Client’s name
				+ Date referral is made
				+ Name, address, and phone number of the agency/provider to which the client is being referred
				+ Reason for referral
		- Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance; document follow up with client and service provider.
		- Keep a copy of all written referrals in client’s chart (or noted, if verbal).
		- Medicaid reimburses information and referral under ongoing care coordination and monitoring.
	+ Assessment and Care Plan Updates
		- Update the pregnancy questionnaire as often as needed, and may also administer other assessment instruments periodically, if appropriate, to determine the recipient’s progress toward meeting established goals. Updates to the care plan or assessment may be billed using procedure code H1002. If updated occur during a home visit; use code H1004.
		- At a minimum, review and update the care plan every 60 days or sooner if the client’s needs change.
			* On an ongoing basis, the provider must:
				+ Determine which services identified in the care plan have been or are being delivered
				+ Determine if the services are adequate for the recipient’s needs
				+ Provide supportive contact to ensure that the client is able to access services, is receiving services, or is engaging in activities specified in care plan
				+ Monitor client’s satisfaction with the service
				+ Identify changes in the client’s circumstances that would require an adjustment in the care plan

Document in client’s chart

* + - Provider and recipient are required to sign and date all updates to the care plan; provider may initial updates to the care plan if a signature page is included in the recipient’s file.
	+ Recordkeeping
		- Wisconsin Medicaid considers recordkeeping a reimbursable ongoing care coordination and monitoring activity; only if a client contact occurred during the month for which the provider is billing.
		- Reimbursable recordkeeping activities include time spent on: documenting the pregnancy (obtaining a signed pregnancy verification form a physician), updating care plans, documenting client and collateral contacts, preparing and responding to correspondence to and for the client, documenting the client’s activities in relation to the care plan, and determining and documenting the pregnancy outcome, including the infants birth weight and health status.
	+ Provision of Services in Urgent Situations
		- When ongoing care coordination services are provided in an urgent situation (ex. The client is pregnant and homeless, without food), the provider is required to: document the nature of the urgent situation, complete the pregnancy questionnaire and care plan as soon as possible, but no later than 30 days following the actions taken to alleviate the urgent situation
		- If a client exhibits behavior that may be dangerous to herself or others, immediately refer her to a mental health provider; ensure follow up within 24 hours.
	+ Frequency of Ongoing Monitoring
		- Discuss and document the planned frequency of ongoing contacts and monitoring with the client (and client’s collaterals, if appropriate).
		- At a minimum, contacts should occur every 30 days

**Prenatal Services**

* + **Psychosocial Services**
		- Psychosocial refers to those concerns about relationships and support systems, fears about personal safety of other family members, fears about past or current physical or substance abuse, depression or other mental health problems, worries about ability to meet basic needs for food and shelter, and significant stress about ability to cope with the current pregnancy
		- Reassess client’s psychosocial risk status at least once each trimester and update care plan as necessary
			* Utilize psychosocial assessment checklist
			* Assessment should include clients:
				+ Strengths
				+ Weaknesses
				+ Support system
				+ Environment
				+ Actual and potential stressors
				+ Attitude toward pregnancy
				+ Past experiences with pregnancy
		- Services are provided to assist the pregnant woman in:
			* Resolving relationship problems that may adversely affect her health and outcome of her pregnancy
			* Identifying and accessing other services that will support her efforts to maintain a healthy pregnancy, continue positive health behaviors and provide a safe home for herself and her children
			* Understanding and dealing with the social-emotional aspects of pregnancy and parenting
			* Evaluating behaviors that may interfere with having a health pregnancy and infant such as substance abuse, poor nutrition, and high-risk sexual behavior
		- Assist client in accessing and appropriately using the health care delivery system
			* Ensure client can:
				+ Identify her Primary/Ob/Gin providerand has their phone number/address
				+ Knows proper procedure for obtaining medical information or care after hours
				+ Knows when to use hospital ER
				+ Knows how to schedule, reschedule, and cancel appointments
		- Refer client for counseling and support in the grief process when there is an early pregnancy loss (before 20 weeks)
		- If client desires to have an elective abortion, refer to appropriate medical provider counseling
			* Inform client WI Medicaid does not cover pncc services following an elective abortion
		- Refer clients with complex psychosocial needs to additional community or mental health services
			* Clark County Community Services and/or client’s medical provider
* Wisconsin Medicaid covers health education and nutrition counseling if the need for it is identified in the Pregnancy Questionnaire and it is included in the client’s individualized care plan.
* Health Education and Nutrition Counseling is provided in a face-to-face setting with the client.
* Assess knowledge and understanding of basic nutrition and dietary practices and how these factors could affect the pregnancy outcome for both the mother and baby.
* Refer those with more intensive nutritional-related needs to a dietitian if necessary.
* Assess client’s knowledge and understanding of medical status and health practices and the impact on pregnancy outcome. Reassess the client periodically and provide ongoing education as necessary.
* Provide basic and in-depth (if necessary) health education and nutrition information.
	+ - Refer her to a mental health provider; ensure follow up within 24 hours.
	+ **Health Education**
		- Medicaid covers health education if the need for it is identified in the pregnancy questionnaire and it’s included in the client’s care plan.
		- Provide basic health information to the client
			* Ensure information is easy to understand
			* Culturally appropriate
			* Shared in a non-judgment/non-threatening manner
			* Intent of providing basic information about pregnancy is to help client positively adjust to her new condition
			* Utilize the PNCC Prenatal/Postpartum Health Education Topic Checklist
		- Provide or refer clients for in-depth health education services if necessary
		- Ensure that the interventions address those high risk medical conditions and behaviors that can be alleviated or improved through education
			* + Utilize prenatal health education topic checklist
				+ Refer client to additional support or information as needed
			* Provide education on safe infant sleep, and assist client in obtaining a crib through the Cribs for Kids Program, if needed.
			* Complete a visual assessment of the sleep environment and provide problem solving solutions for unsafe environments.
	+ **Nutrition Counseling**
		- Medicaid covers nutrition counseling if the need for it is identified in the pregnancy questionnaire and it’s included in the client’s care plan.
		- Refer women with more intensive nutritional-related needs to a dietician if necessary.
		- Assess the client’s knowledge and understanding of basic nutrition and dietary practices and how these factors could affect the pregnancy outcome for both her and the baby
			* If possible, do this assessment during first visit
			* Ensure care plan addresses the client’s education needs
			* Utilize the PNCC Prenatal/Postpartum Health Education Topic Checklist
			* Conduct periodic reassessments throughout the pregnancy, sign, date, and document.
* Assess clients for alcohol, tobacco, and/or drug use at every visit.
	+ All clients who report use during pregnancy will receive education, referral, and follow-up services.
	+ Women who use tobacco during pregnancy should be offered and enrolled in the First Breath Program for education, assistance, and support to stop tobacco use.
	+ Provide information from the Wisconsin Tobacco Quit Line to clients using tobacco and to those exposed to secondhand smoke.
* Monitor to ensure client has a primary medical provider in the first trimester, and is taking prenatal vitamins
* Assess for depression at initial contact, once a trimester thereafter, and once during the postpartum period (after two weeks postpartum) at a minimum, using a standardized depression screening tool-Edinburgh Postnatal Depression Scale (EPDS).
	+ Make referral to medical provider for all clients identified as at high risk for depression, and follow-up on that referral within 2 weeks.
* Provide contraceptive information to clients during the third trimester of pregnancy.
	+ Inform clients of Family Planning services available through the Clark County Reproductive Health Clinic.
	+ Assist client in obtaining condoms and emergency contraception prior to delivery.
		- Ideally, client will have Plan B and condoms in hand by her third trimester.
			* Refer as appropriate
	+ Ensure client has chosen her primary method of birth control, and has a plan for continuation of those services.

**Postpartum Services**

* + Postpartum Services
		- Postpartum PNCC services are covered for up to 60 days after delivery. (Postpartum services are covered only if the client received PNCC services prior to delivery.)
		- During the postpartum period, providers are required to:
			* Make at least one face to face visit with the client
			* Encourage the client to choose a primary health care provider for the baby
				+ Assist in obtaining information on providers if necessary
			* Inform the client of the importance of immunizations and well-child checkups for the baby
				+ Assist with making appointments, if needed
		- If client has a stillbirth or there is a sudden, unexpected infant death, refer the client to counseling and support and the Infant Death Center of Wisconsin.
		- Refer the client for additional support and assistance in learning how to care for her child if the child is identified as having a special health care need, or a medical risk condition (prematurity, low birth weight).
* Assess client’s knowledge and understanding of basic postpartum care. Provide information as necessary. At a minimum include the following topics in the assessment:
	+ Personal hygiene
	+ Nutrition during breastfeeding, including the influence of tobacco, alcohol, and other drugs or nutrition if formula feeding
	+ Guides to successful breastfeeding, breast care, and routine self-breast checks
	+ Physical activity
	+ Recognition of minor gynecologic problems
	+ Family planning
	+ Prevention of STI
	+ Continuity of basic primary and reproductive health care
		- Utilize the PNCC Prenatal/Postpartum Health Education Topic Checklist
		- Document the assessment, information or referral provided, and any follow up.
* Assess mother’s interpersonal relationship with the infant including strengths, weaknesses, support system, social environment, stresses, and attitude toward infant and past experiences with parenting.
* Assess knowledge and understanding of appropriate newborn care and feeding practices and how these factors affect growth and development. Provide information and make referrals as appropriate. At a minimum include the following topics in your assessment:
	+ Infant’s hunger and fullness cues
	+ Infant nutrition and appropriate feeding practices
	+ Successful breastfeeding
	+ Food and/or formula preparation and storage
	+ Bathing, skin and cord care, and diaper rash prevention
	+ Normal growth and development
	+ Taking infant’s temperature, treatment of nausea, vomiting, dehydration, and fever
	+ Infant nurturing and stimulation
	+ Effects of secondhand smoke on infant
	+ Injury prevention and safety including car seats, falls, poisoning, choking, and safe sleep
	+ Appropriate use of infant’s primary health care providers versus the emergency room
		- Utilize prenatal/postpartum health education topic checklist
* Assess knowledge of steps involved in obtaining appropriate and reliable child care.
	+ Provide information or refer the client for assistance if deficiencies are found in the following areas:
		- Knowledge regarding available resources for checking provider references
		- Evaluating child care settings for safety
		- Obtaining financial assistance for child care
		- Appropriate monitoring of the child care provider
		- Reporting suspected child abuse or neglect by the child care provider
* Provide breastfeeding information and access to local support during early postpartum.
* Assess for depression during the postpartum period (after two weeks postpartum), using a standardized depression screening tool-Edinburgh Postnatal Depression Scale (EPDS).
* Update the care plan within 30 days after delivery
* Refer women who require services beyond the 60 day postpartum period to other community resources before discharge from the PNCC program.
* Document the last day of service, the date the client is discharged from PNCC.

**BILLING/COVERED SERVICES:**

All claims submitted to Wisconsin Medicaid must include allowable HCPCS procedure codes for PNCC services. Claims or adjustment requests received without the appropriate HCPCS codes will be denied.

The following requirements apply to HCPCS procedure codes used for PNCC services:

* Updates to the assessment or care plan may be billed using procedure code H1002 or, if provided in the home, procedure code H1004.
* Use procedure code H1004 for follow-up visits provided in the home. The only valid POS for H1004 is "12" (home). For all other ongoing care coordination, indicate procedure code H1002.
* When submitting claims for development of an initial care plan, use procedure code H1002 and modifier "U2" and bill a quantity of "1."
* When submitting claims for the initial assessment, indicate procedure code H1000 and enter a quantity of "1."

For all other procedure codes, one unit of service is equal to 15 minutes.

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| **Procedure Code** | **Procedure Code Description** | **Required Modifier and Description** |
| H1000 | Prenatal care, at-risk assessment |  $40.40 ( 1 Unit Maximum) |
| H1002 | Prenatal care, at-risk enhanced service; care coordination | **U2**Initial care plan development $48.79 (1 Unit Maximum) |
| H1002 | Prenatal care, at-risk enhanced service; care coordination | $8.28; Each 15 Minutes (1 Unit=15 Minutes)  |
| H1003 | Prenatal care, at-risk enhanced service; education | $12.63; Each 15 Minutes(1 Unit=15 Minutes)  |
| H1003 | Prenatal care, at-risk enhanced service; education | **TT**Individualized service provided to more than one patient in same setting$12.53; Each 15 Minutes(1 Unit=15 Minutes) |
| H1004 | Prenatal care, at-risk enhanced service; follow-up home visit | $10.81; Each 15 Minutes(1 Unit=15 Minutes)  |
|  | Subsequent Pregnancy | **U1** |
| *Note:* Prenatal care coordination services are limited to $887.46 per member, per pregnancy. |

* Use modifier U1 with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. When submitting claims for the second risk assessment, the modifier representing the risk assessment score must also be indicated.
* Submit billing form to Program Assistant on the last day of each month; make a copy of billing sheet and keep in client’s chart
* Physical assessments and their documentation may be completed on members (pregnant/postpartum women and infants) receiving PNCC services however the time for the physical assessment and documentation of physical assessments are not billable PNCC services. (ex. Taking infant weight). Document code (743) in client’s chart if performing these types of assessments. Code 743 denotes that the time spent for physical assessments and their documentation are not billable PNCC services*.*
* When billing for chart prep and charting/documentation, it has to match date of service to client.
* You may bill for phone calls, emails and texts using H1002-care coordination. If the client does not answer your phone call you cannot bill for time spent calling or time spent charting. If a home visit is made and the client is not home, you cannot bill for the visit or charting time. If emailing and texting, you must have confirmation of receipt that the message was received by client, meaning you must print the email or text and keep a copy in the client’s chart.
* When billing for care coordination (H1002) group together units for the date of service. For example in July, 15 minutes or 1 unit gathering client’s chart materials and 30 minutes or 2 units charting = 3 units total under H1002. Describe details either in client’s chart in the progress note documenting activities, or describe on the billing log sheet under “documentation of activities.”
* **1st visit**: Use code H1000-At risk assessment | H1002 charting/documentation | H1004 for depression screening (if in home); if not in home use H1002 | H1002 for 1st breath program (use H1004 instead of H1002 if in the home.) You may bill for health teaching H1003 on the first visit ONLY if you have documented that the Prenatal At-Risk Health Assessment has been completed, the care plan has been created and that the client verbally agrees to the care plan and will sign the hard copy at next visit. (Documentation MUST follow the order of billable events.)
* **2nd visit**: Use code H1002-U2 for care plan development | H1003 for health teaching based on their care plan | H1004 for depression screening and ongoing monitoring (if in home); if not in home use H1002 | H1002 for charting/documentation, chart prep, and gathering educational materials.
* In-between visits: Use H1002-care coordination if calling client to set up visit, prepping chart, contacting doctor, WIC, etc.
* **Subsequent visits**: Use H1003 for health teaching based on their care plan, | H1004 for depression screening and ongoing monitoring (if in home); if not in home use H1002 | H1002 charting/documentation, chart prep, and gathering educational materials.

**NONCOVERED SERVICES:**

* Diagnostic, treatment, or other direct services including diagnosis of a physical or mental illness and administration of medications
	+ Health education and nutrition counseling services are covered.
* Ongoing care coordination and monitoring services that are not based on the client’s current care plan
* Ongoing care coordination and monitoring services that are not necessary to meet the PNCC benefit goal
* Transportation (provider or contact mileage or travel time)
* Interpreter services
* Missed appointments (no shows)

**MISCELLANEOUS:**

* Provider will maintain a current list of appropriate community resources for referral purposes-Clark County Family Resource Guide.
* To provide client customer satisfaction information, and to ensure quality service, a pncc evaluation tool will be given to each pncc client at the postpartum home visit.
	+ The data will be collected, analyzed, and reviewed on a bi-annual basis.
* The policy will be reviewed on an annual basis by all staff members who are care coordinators.
	+ Steps will be taken to correct problem areas, if needed
	+ Chart audits will be conducted on a bi-annual basis.
	+ New RN’s who will be PNCC care coordinators will receive proper orientation.
* If a client is hearing impaired or does not speak or understand English, provider interpreter.
	+ A current list of available contracted interpreters is located in the shared nursing drive under “interpreters.”
	+ Do not use family members or children as interpreters.