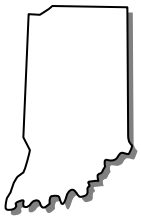


P R O V I D E R B U L L E T I N

B T 2 0 0 9 1 4 M A Y 2 1 , 2 0 0 9

To: Service Providers to Pregnant Women

Subject: Notification of Pregnancy (NOP)

Overview

Early prenatal care can address potential health risks that contribute to poor birth outcomes. In addition, earlier enrollment of pregnant women in Medicaid case management programs is associated with better birth outcomes. The Office of Medicaid Policy and Planning (OMPP) data shows that some low-income pregnant women do not seek prenatal services in the earliest stages of pregnancy, which often leads to untreated health risks. The OMPP Neonatal Quality Committee, made up of Indiana health professionals, has identified this as a focus area for prenatal care. This bulletin introduces the implementation of the Notification of Pregnancy (NOP) form, a committee initiative. It is the goal of this initiative to improve the identification of health-risk factors of expectant mothers as early as the first trimester of pregnancy.

Recognized providers for NOP will be eligible for reimbursement of $60 for successful submission of the NOP form using Web interChange. This enhanced reimbursement will be available for NOP forms submitted on or after July 1, 2009. NOP reimbursement will only be available for pregnant women enrolled with a Hoosier Healthwise managed care organization (MCO). The submitted information will be utilized by the woman's Hoosier Healthwise MCO to determine her risk level associated with the pregnancy and to identify areas for additional follow-up care. One NOP per member, per pregnancy is reimbursable.

Recognized Providers for NOP

Providers must be enrolled with Indiana Health Coverage Programs (IHCP) in one of the following specialties to complete and submit an NOP form for reimbursement:

- Family or general practitioner
- Pediatrician
- Internist
- Obstetrician or gynecologist
- Neonatologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally qualified health center
- Medical clinic
- Rural health clinic

- Outpatient hospital
- Local health department
- Family planning clinic
- Nurse practitioner clinic

Notification of Pregnancy Process

To submit an NOP form, the recognized provider must access the NOP form using Web interChange. Use the following link to log on to Web interChange: https://interchange.indianamedicaid.com. For technical assistance with Web interChange, please contact the EDI helpdesk at 1-877-877-5182.

Step 1. Once logged on to Web interChange, select the *Eligibility Inquiry* function to verify the member's eligibility.

> *Note: If the member is not enrolled with a Hoosier Healthwise MCO, the NOP options will not display.*

Step 2. On the *Eligibility Inquiry* screen, the recognized provider will have access to two buttons: **Go to NOP** and **Print blank NOP**. To complete the NOP online, click **Go to NOP**. To complete a hard copy to be entered online later, click **Print blank NOP**.

a. When the *Go to NOP* button is selected, an NOP form displays, prepopulated with basic member data as contained in the eligibility verification system (EVS). Once the recognized provider progresses through each screen and enters all pertinent information, the NOP can be submitted. The completed online NOP can also be printed any time after submission by using the *NOP Inquiry* function in Web interChange.

b. When the *Print blank NOP* button is selected, a **blank, printable** PDF copy of the NOP form displays. When this option is chosen, the recognized provider can complete the form by hand, but also must enter the information online using the *Go to NOP* function for successful submission and reimbursement. The PDF version cannot be submitted electronically via Web interChange. As noted above, when *Go to NOP* is selected, prepopulated member data displays.

c. Web interChange will check for potential duplicate NOPs. If a duplicate is identified, the recognized provider will be asked to provide a reason explaining why the new NOP is not a duplicate. The recognized provider can choose from three reasons related to the prior pregnancy: (1) member abortion; (2) member preterm delivery; or (3) member miscarriage. The provider can continue the process without identifying a reason; however, the duplicate NOP will not be reimbursed.

Billing Guidelines

Billing guidelines for NOP are as follows:

1. NOP can only be billed for a woman enrolled in Hoosier Healthwise/Risk-Based Managed Care (RBMC) using procedure code 99354 with modifier TH and submitted to the MCO of record on the date of service.

2. Recognized provider reimbursement for an NOP that is correctly completed and submitted is $60 per member, per pregnancy. Refer to the *Form Requirements* section of this bulletin for a description of a complete NOP. Recognized providers must submit the completed NOP via Web interChange within five calendar days of the date of service to be reimbursed. If the timeline is not met, the submission does not qualify for the $60 reimbursement.

> *Note: The date of service is the date the member risk assessment is completed by the recognized provider.*

3. Duplicate NOPs, those for the same woman and the same pregnancy, do not qualify for the $60 reimbursement. Only one NOP per member, per pregnancy is eligible for reimbursement. Recognized providers will receive a systematic message if the NOP appears to be a duplicate.
4. NOPs for pregnant members with gestations of 30 weeks or more are not eligible for the $60 reimbursement.
5. NOPs completed for women covered by traditional fee-for-service are not eligible for the $60 reimbursement.

Form Requirements

Specific fields on the NOP form are required and must be completed for successful submission of a complete NOP form. Completion of the NOP form requires the recognized provider to check all fields specific to that member and pregnancy.

Prepopulated* member data (identified by an asterisk in the list below) will display as provided in the EVS when the recognized provider completes the NOP through Web interChange. If a recognized provider is completing the printed PDF NOP, it is not necessary to complete prepopulated information, as it will automatically appear when the paper form is entered in Web interChange.

1. At the header level, enter biographical information:
   - Person completing the form
   - Date of service
   - Member name*****
   - Member address*
   - Member telephone number*****
   - Date of birth and age*****
   - Member RID*****
   - Physician name*****
   - Physician telephone*****
   - The Physician's National Provider Indicator (NPI) or Legacy Provider Indicator (LPI)*****
   - Pre-pregnancy weight
   - Current weight
   - Body mass index (BMI)
   - Height
   - Delivery system – member selection of Anthem, MDwise, or MHS*****
   - Race
   - Ethnicity
   - Member's primary language
   - Date of first prenatal visit
   - Date of last menstrual period (LMP)
   - Number of weeks pregnant
   - Whether the patient is taking prenatal vitamins
   - Toxicology order

* Indicates a field that is prepopulated electronically when the NOP is completed on Web interChange.

2. Section 1: Maternal Obstetrical History – Conditions identified in this pregnancy and past pregnancies must be identified in this section. If no current or historical conditions apply, the recognized provider must select **If none above apply, please check here**. This section is a required field.

   The following question must also be answered in Section 1:
   < 12 months between births Yes/No. The system will not allow the user to continue if the recognized provider has left this question unanswered.

3. Section 2: Previous Infant/Findings – This section refers to the history of birth outcomes a member may have had with previous pregnancies. This section may not apply to all members. Please check all relevant birth outcomes the woman experienced with any of her previous pregnancies.

4. Section 3: Maternal Medical History – Conditions identified in this pregnancy and past medical history must be checked in this section. If no current or historical conditions apply, the recognized provider must select **If none above apply, please check here**. This section is a required field.

   The following questions must also be answered in Section 3:
   HIV/AIDS tested Yes/No. The system will not allow the user to continue if the recognized provider has left this question unanswered.
   ER or hospitalization in last 6 mos. Yes/No and **If yes, how many?** The system will not allow the user to continue if the recognized provider has left this question unanswered.

5. Section 4: List All Current Medications – List any and all current medications. This is an open field that allows the recognized provider to list as much detail as necessary. If no medications are entered, the recognized provider must choose **None**, or the system will not allow the completion of the NOP.

6. Section 5: Psycho-Neurological History – If the member has a condition that applies to this section, the diagnosis must be checked. If there are no current or historical conditions to report, the recognized provider must select ***If none above apply, please check here***.

7. Section 6: Substance Abuse/Use History – If the member is currently using or has a history of substance abuse/use, this must be indicated in this section. If there is no current or historical use, the recognized provider must select ***If none above apply, please check here***.

8. Section 7: Tobacco History – If the member is currently using cigarettes/tobacco or has a history of use, this must be indicated in this section, or the system will not allow the completion of the NOP.

9. Section 8: Social Risk Factors – Social risk factors often lead to referrals for support services outside the recognized provider's office. If the member does not identify social risk factors from the list, the recognized provider should select ***If none above apply, please check here***.

10. Section 9: Diagnosis of Pregnancy Risk – The recognized provider must determine the diagnosis of pregnancy risk as a Normal Pregnancy or a High Risk Pregnancy. The recognized provider must also indicate Gravida and Para and should list any other medical or psychological problems not addressed elsewhere on the form.

11. Section 10: Referrals – The recognized provider is encouraged to identify services to which the pregnant woman was referred. This will better prepare the MCOs to follow up with the woman about these referrals.

> *Note: If a required field is left blank, the recognized provider will be prompted to complete the appropriate section of the NOP. Recognized providers have the opportunity to move throughout the NOP, prior to submission, to correct or revise information.*

12. The final step in the Web interChange design of the NOP is to click on ***Review and Submit***. After submission of the NOP, the system will prompt the recognized provider to ***Print NOP*** or ***Close***, along with one of the following messages as the final step of the Web interChange process for NOP:
    - The NOP has been successfully submitted.
    - The NOP submission is greater than five days from the date of service. A claim for this NOP should not be submitted.
    - The member is 30 or more weeks pregnant at the date of service. A claim for this NOP should not be submitted.
    - This NOP has been determined to be a duplicate submission. A claim for this NOP should not be submitted.

> *Note: If the NOP is determined to be complete and successfully submitted, a claim must be submitted to the MCO on record for the date of service. The billing code for the NOP is 99354 TH, and reimbursement is $60.*

The recognized provider that initiated and completed the NOP will have access to the completed and stored NOP through Web interChange. Any recognized provider who matches his or her NPI/LPI to an NOP with any corresponding RID number can view the submitted NOP at any time. The completed NOP can be printed any time after submission. Once the NOP is submitted, the details cannot be amended or revised.

Since the goal of the prenatal initiative is to improve the identification of health-risk factors of expectant mothers as early as the first trimester of pregnancy, the submitted NOP data will be sent to the woman's Hoosier Healthwise MCO to determine the health-risk level associated with her pregnancy and the need for prenatal care coordination.

Web Screen Examples

Eligibility Inquiry on NOP Qualified Member

Figure 1 – Eligibility Inquiry Screen

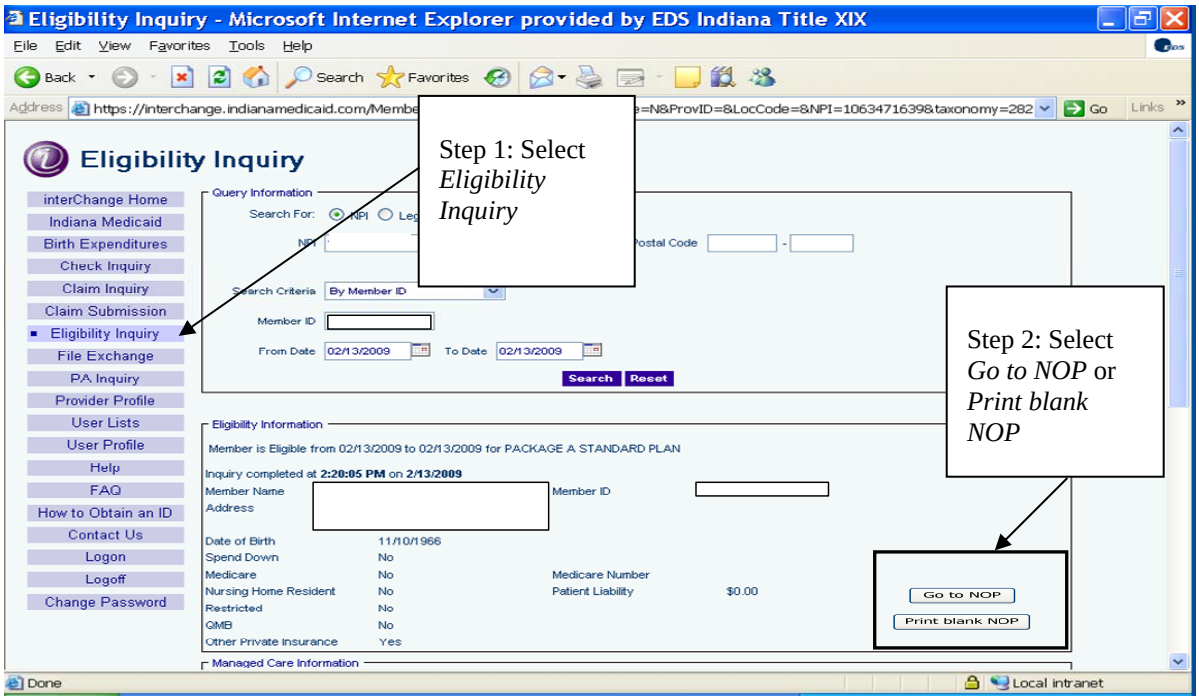


Figure 2 – Notification of Pregnancy "Begin" Screen

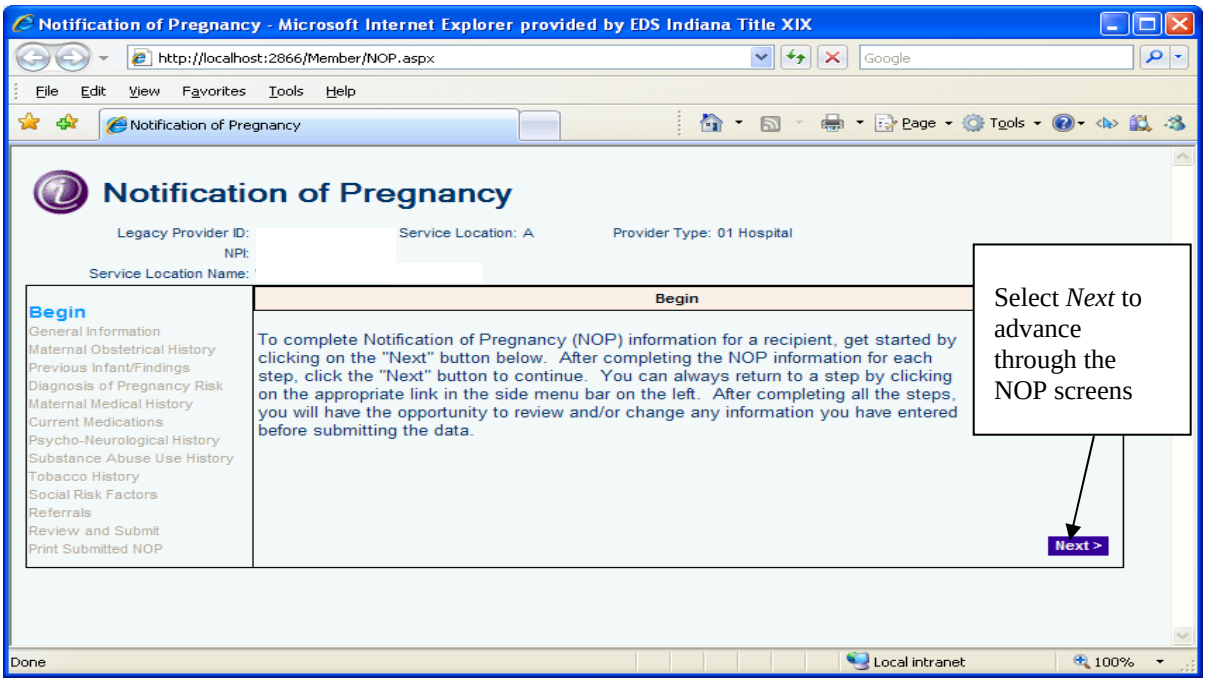
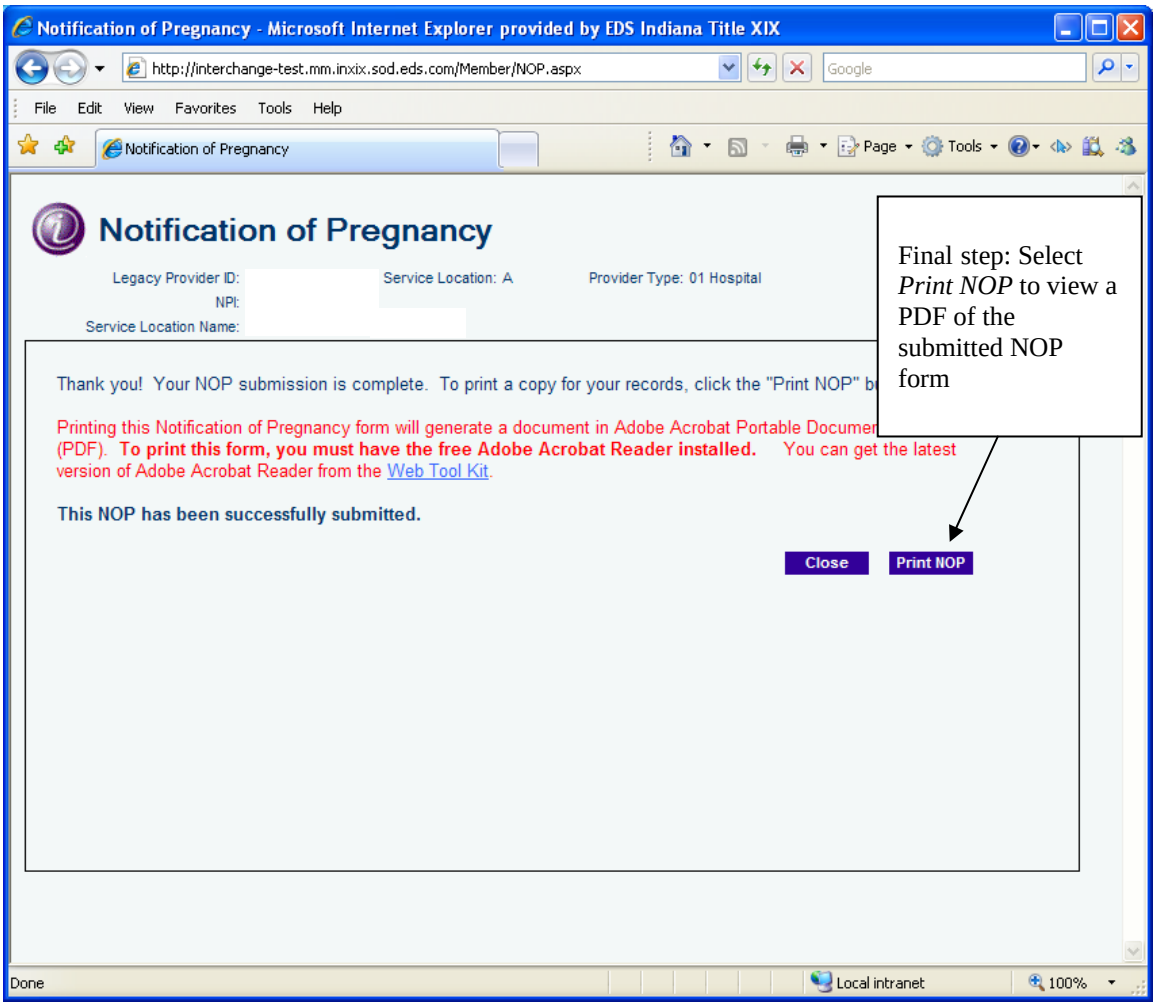


Figure 3 – Notification of Pregnancy – Maternal Obstetrical History Screen

Figure 4 – Review and Submit Screen



NOP Paper Form (PDF Version)

Figure 5 – Notification of Pregnancy Form (Page 1 of 2)

Notification of Pregnancy

Date of service: _____

Member name:

Member address:

Member telephone:

DOB (MM/DD/YYYY):
_____ **Age:**_____ yrs

Taking prenatal vitamins? ◻ Yes ◻ No

1. Maternal Obstetrical History

Check all that apply:
◻ Preterm labor ◻ Hx ◻ Current
◻ Tocolytics used ◻ Hx ◻ Current
@ ____ weeks' gestation
◻ PROM ◻ Hx ◻ Current
◻ Gestational diabetes ◻ Hx ◻ Current
◻ Preg – Ind HTN ◻ Hx ◻ Current
◻ Placenta previa ◻ Hx ◻ Current
◻ Placenta abruption ◻ Hx ◻ Current
◻ Multiple gestation ◻ Hx ◻ Current
◻ Pre-eclampsia ◻ Hx ◻ Current
◻ Eclampsia ◻ Hx ◻ Current
◻ Incompetent cervix ◻ Hx ◻ Current
◻ Cerclage placement ◻ Hx ◻ Current
◻ Cervix dilation
> 2 cm < 35 wks ◻ Hx ◻ Current
◻ Lack of maternal
weight gain ◻ Hx ◻ Current
◻ SABS/TABS ◻ < 3x ◻ ≥ 3x
◻ Hx of cone biopsy
◻ Reduction w/ or w/o complications
◻ Current hypermesis < 10 lbs wt loss
◻ Current hypermesis > 10 lbs wt loss
◻ Vaginal bleeding > 2 episodes
◻ Prior C-Section
◻ Rh negative
◻ Previous fetal/neonatal demise
◻ **If none of the above apply, please check here.**
< 12 months between births ◻ Yes ◻ No

2. Previous Infant/Findings

◻ Stillbirth >28 wks
◻ Preterm birth < 30 wks
◻ Preterm birth 30-36 wks
◻ Birth weight < 2500 gms
◻ Birth weight > 4000 gms

9. Diagnosis of Pregnancy Risk

◻ V22 – Normal pregnancy
◻ V23 – High-risk pregnancy
◻ Gravida _____
◻ Para _____
List any other medical/psychological problems not included above or other issues which may place the member at risk: _____
_____
_____
_____

Member RID:

Physician name:

Physician telephone:

NPI/LPI:

Pre-pregnancy weight (lbs)	**Current weight (lbs)**

BMI > 30 ◻ Yes ◻ No
BMI < 19 ◻ Yes ◻ No
Height _____ ft _____ in

Toxicology ordered? ◻ Yes ◻ No

3. Maternal Medical History

Check all that apply:	**Controlled?**		**On meds?**	
◻ Thyroid condition	◻ Yes	◻ No	◻ Yes	◻ No
◻ Cardiac condition	◻ Yes	◻ No	◻ Yes	◻ No
◻ Hypertension	◻ Yes	◻ No	◻ Yes	◻ No
List blood pressure _____/_____				
◻ Seizure disorder	◻ Yes	◻ No	◻ Yes	◻ No
◻ DM (I or II)	◻ Yes	◻ No	◻ Yes	◻ No
Hemoglobin A1c	◻ ≥ 9	◻ ≤ 9		
◻ Asthma/COPD	◻ Yes	◻ No	◻ Yes	◻ No
Rescue inhaler	◻ < 3x/mo		◻ > 3x/mo	
◻ Sickle cell anemia	Recent crisis?		◻ Yes	◻ No
◻ Cancer	◻ Hx	◻ Current		
◻ Pyelonephritis	◻ Hx	◻ Current		
◻ STIs	◻ Hx	◻ Current		
◻ Chronic UTIs	◻ Hx	◻ Current		
◻ Eating disorder	◻ Hx	◻ Current		
◻ Hx of gastric bypass				
◻ Systemic lupus				
◻ Prior exposure to teratogenic substances				
◻ Anemia				
◻ Current DVT/pulmonary embolism				
◻ Other coagulation disorder				
◻ Auto-immune disorder				
◻ Current uterine anomalies/fibroids				
◻ Renal condition				
◻ Periodontal/dental problems				
◻ Hepatitis B or C				
◻ History of transplant				
◻ **If none of the above apply, please check here.**				

HIV/AIDS tested ◻ Yes ◻ No
ER or hospitalization in last 6 mos. ◻ Yes ◻ No
If yes, how many times?_____

4. List All Current Medications

◻ **None**
◻ **Other** _____
_____
_____

10. Referrals

◻ Indiana Family Helpline – **1-800-433-0746**
◻ Tobacco Quit Line – **1-800-QUIT-NOW**
◻ WIC (breastfeeding classes, formula, social services, nutrition/foods)
◻ Childbirth/parenting classes
◻ Domestic violence referral
◻ Mental health/substance use treatment
◻ Prenatal Substance Use Prevention Program (PSUPP) – **1-800-433-0746**

Delivery system:
◻ MDwise ◻ MHS ◻ Anthem

Race:
◻ White ◻ Black ◻ Am Indian ◻ Asian
◻ Other _____

Ethnicity:
◻ Hispanic ◻ Non-Hispanic

Primary language:
◻ English ◻ Spanish ◻ Other_____

First prenatal visit (MM/DD/YYYY): _____

LMP (MM/DD/YYYY): _____
 # weeks pregnant _____

5. Psycho-Neurological History

Check all that apply:
◻ Clinical depression ◻ Hx ◻ Current
On meds? ◻ Yes ◻ No
◻ Postpartum depression ◻ Hx ◻ Current
◻ Suicide attempt/thought ◻ Hx ◻ Current
◻ Borderline personality
disorder ◻ Hx ◻ Current
◻ Other Axis I diagnosis ◻ Hx ◻ Current
List _____
◻ **If none of the above apply, please check here.**

6. Substance Abuse/Use History

Check all that apply:
◻ Marijuana ◻ Cocaine/crack
◻ Amphetamines ◻ Narcotics/heroin
◻ Alcohol ◻ Sedatives/tranq
◻ Methadone ◻ Inhalants/glue
◻ Other_____
If now using, are you ready to quit in the next 30 days? ◻ Yes ◻ No
◻ **If none of the above apply, please check here.**

7. Tobacco History

Current cigarette/tobacco use ◻ Yes ◻ No
If yes, counseled on tobacco/smoking? ◻ Yes ◻ No
If you quit smoking, when did you quit (MM/DD/YYYY)? _____
Counseled on second-hand smoke exposure? ◻ Yes ◻ No
Have you used cigarettes/ tobacco in the last 12 mos? ◻ Yes ◻ No
Are you ready to quit in the next 30 days? ◻ Yes ◻ No

8. Social Risk Factors

Have you been hit, slapped, kicked, or hurt during this pregnancy? ◻ Yes ◻ No
Do you feel safe in your own home? ◻ Yes ◻ No
In the past month, was there any day when you or anyone in your family went hungry because you didn't have enough money or food? ◻ Yes ◻ No

◻ Homeless/lives in a shelter ◻ Lives alone
◻ Transportation problems ◻ Unemployed
◻ Education ≤ 10th grade ◻ No phone
◻ Learning disability/MR ◻ Unstable home
◻ Rape: ◻ Hx ◻ Current ◻ No family support
◻ **If none of the above apply, please check here.**

Person completing form (please print) :_____ **Date (MM/DD/YYYY) :** _____

MD signature: _____ **Date (MM/DD/YYYY):** ____/____/____

Figure 5 – Notification of Pregnancy Form (Page 2 of 2)

Supplemental Information – Notification of Pregnancy

9. Diagnosis of Pregnancy Risk	5. Psycho-Neurological History
4. Current Medications	**6. Substance Abuse/Use History**