Division of Public Health
Agreement Addendum
FY 08-09

	Women's and Children's Health/Women's Health Branch
Local Health Department Name	**DPH Section/Branch Name**
746 High Risk Maternity Clinic	Kathy Blue, (919) 707-5683 Kathy.Blue@ncmail.net
Activity Number and Description	**DPH Program Contact Name, Telephone Number (with area code) and Email**
06/01/2008-05/31/2009	
Service Period MM/DD/YYYY-MM/DD/YYYY	**DPH program signature (only required for <u>negotiable</u> agreement addendum)**
07/01/2008-06/30/2009	
Payment Period MM/DD/YYYY-MM/DD/YYYY	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision # _____ (please do <u>not</u> put the Aid to County revision # here)**

I. <u>Background</u>:
The High Risk Maternity Clinic (HRMC) program provides funds for tertiary-level prenatal care services for low-income, high-risk, pregnant women. These clinics assure medically complicated pregnancies have access to risk-appropriate perinatal services, according to the American College of Obstetrics and Gynecology (ACOG) clinical guidelines. High Risk Maternity Clinics provide care to women referred from local health departments with no HRMC within the designated catchment area.

Each year in North Carolina, about ten women die from pregnancy related conditions, hundreds of babies are born premature and with birth defects. High Risk Maternity Clinics provide care for the conditions that cause maternal and infant mortality and morbidity. With the rise in older mothers, the increase in women who are obese during pregnancy, and women who use substances such as tobacco and alcohol, HRMCs provide the specialized care and support that these women need.

II. <u>Purpose</u>:
The purpose of this agreement addendum is to assure that local health departments will provide low-income pregnant women with identified medical high-risk conditions in NC obtain access to early and continuous prenatal care. Prenatal care services include: management of their high risk medical conditions, screenings for psychosocial and nutrition problems, health and behavior intervention, nutritional counseling, and referrals for those patients with serious medical, nutritional, and psychosocial needs.

______________________________ ______________________________
Health Director Signature (use blue ink) Date

Local Health Department to complete: (If follow up information is needed by DPH)	LHD program contact name: ____________ Phone number with area code: ____________ Email address: ____________

<u>Signature on this page signifies you have read and accepted all pages of this document.</u>

III. Scope of Work and Deliverables:

Instructions: Read the entire Agreement Addendum and fill in the blanks. Complete, sign and return all relevant pages. The County Health Director signature is required on page one.

The High Risk Maternity Clinic Program has a negotiable Agreement Addendum. Please complete the Non-Medicaid Services and Other Program Services sections below along with the appropriate worksheets (attached). Women's Health Branch staff will review and approve.

Non-Medicaid Services (Attachment A) **Amount $___________**

The Health Department will provide Non-Medicaid Services in FY09 that meet or exceed the total dollar value of all services budgeted. Program service data as of August 31, 2008 will provide the documentation. This information will be reported through Health Services Information System (HSIS) or a compatible reporting system.

Other Program Services (Attachment B) **Amount $ ______________**

The Health Department's estimated cost of non-Medicaid service deliverables is less than the total amount of Department of Health and Human Services (DHHS) funds budgeted in the High Risk Maternity Clinic budgetary estimate//DPH Aid to Counties Database (WIRM). Subject to Women's Health Branch (WHB) approval, my Health Department will use the remaining DHHS funds to further the program's goals and objectives. Information describing how these funds are to be used should be completed on Attachment B and returned.

Total HRMC Budget Estimates (Section B + Section C) **Total Amount $___________**

The contract ensures that all low-income patients at local health departments are seen, regardless of their ability to pay. There will be no charge for women from households at less than 100% of poverty. Women with an identified medical risk are eligible for this program. Special emphasis is placed on addressing racial disparities, in order to close the gap in fetal and infant death, as well as promote healthier behaviors to reduce the number of high-risk pregnancies.

SECTION D: QUALITY ASSURANCE DELIVERABLES (see pages 2-8)

My Health Department will meet or exceed the quality assurance deliverables listed in Section D. A HRMC will provide high risk maternity clinic services to patients referred by local health departments, at a minimum, from the agreed upon multi-county area. HRMCs must meet NC Administrative Code requirements found in 10A NCAC 43C. Interruption of services or inability to meet required quality assurance deliverables shall be reported within 14 days to the Women's Health Branch Regional Nurse Consultant.

All medical services will be provided by a board-certified OB/GYN and have an identified perinatalogist available for referral. Psychosocial assessments and counseling shall be conducted by a Licensed Clinical Social Worker.

The Contractor shall:

- Assure that women at high risk of infant or fetal death receive appropriate prenatal care as determined by site visit and record review,
- Provide services in accordance with ACOG guidelines on high risk maternity care as determined by site visit and record review,
- Provide data on the demographics and number of clients served reporting through the state's Health Services Information System (HSIS) and/or a compatible data system, and

- Conduct quarterly quality assurance review to assure the policies and procedures outlined below are carried out.

Services required and the schedule and conditions to be adhered to, is detailed as follows:

1. The 5A method for tobacco cessation shall be provided to all pregnant and postpartum women using the 5As (ask, advise, assess, assist, arrange) as recommended by ACOG and referral made to appropriate community resource, or the NC Tobacco Use Quit Line at 1-877-QUIT-NOW. (Guidelines for Perinatal Care, Sixth Edition (*ACOG), p. 94-96*)

2. All High Risk Maternity Clinics shall have a physician as the lowest level of provider for medical clinical services.

3. Women's Health Branch funded HRMCs may serve patients with very high risk and moderately high risk medical conditions. A HRMC may provide a single consultative visit, continuing care, or co-managed care between the HRMC and the referring health department or private physician.

4. The High Risk Maternity Clinic shall have written agreements between the clinic and all contracted providers and agencies detailing the duties, responsibilities and privileges in relationship to the goals and contracted services required by the HRMC. This includes written agreements with other local health departments from which the HRMC receives referrals in the catchment area, as well as agencies that are responsible for any part of the contracted services.

5. Persons referred to the HRMC for a single consultative visit (rather than continuing care) need only be provided with services to address the specific referral concern. A policy and protocol detailing the high risk conditions the HRMC accepts on referral, and with whom the responsibility of follow-up lies shall be developed. A memorandum of understanding shall be developed between the HRMC and the referring care provider to assure that the client's comprehensive prenatal care needs are met. A follow-up evaluation report shall be sent to the referring source.

6. A policy delineating responsibility for all components of prenatal care shall be developed to guide the care provided to clients being co-managed by the HRMC and another provider. Follow-up reports are required to be sent to the referring source of care.

7. Persons receiving continuing care in HRMCs shall have the following services documented in their HRMC or current low risk prenatal medical record. These requirements reflect **minimum expectations**. The actual content of care, beyond these minimal standards, provided to any individual client must be governed by appropriate clinical practice and the specific needs of the client.

   A. After informed consent for prenatal services is signed *(ACOG, Committee Opinion, No. 237, June 2000: ACOG Today, Nov/Dec 2004, p.6)*, the following health history components at the initial prenatal visit shall be assessed: medical; family; surgical; neurologic; immunity and immunization (TD, Rubella, Hepatitis B, Varicella); substance use, including alcohol, tobacco, and illicit drugs; current medications (prescription and non-prescription); menstrual; contraceptive; infection; gynecologic and obstetrical; psychosocial; nutrition; genetic history (both maternal and paternal including cystic fibrosis); domestic abuse and violence; risk factors for STDs; assessment of socioeconomic, educational, and cultural context; and environmental exposures, including environmental tobacco smoke (ETS). (*ACOG, p. 4, 83-85, 371-372)*

   B. The following <u>physical examination</u> components shall be assessed: HEENT; thyroid; lungs; breast; heart; abdomen; extremities; skin; lymph nodes; pelvis (including uterine size or fundal height); and blood

pressure. (*ACOG p. 372-375*) Record weight and height for all women at the initial prenatal visit. Determine pre-pregnancy weight and calculate body mass index (BMI). (*ACOG, Committee Opinion, No. 315, September 2005;ACOG p. 89).*

C. The following components on all subsequent routine scheduled visits shall be assessed: interim history/routine screening questions (fetal movement, contractions, leakage of fluid, vaginal bleeding); weight; blood pressure; fetal heart rate; fundal height (after 14 weeks); and fetal presentation greater than or equal to 36 weeks. *(ACOG, p. 100-101, 373-379)*

D. The following Laboratory studies will be documented in the record:

(1) Syphilis screen on the initial visit and a repeat syphilis screen between 28 and 30 weeks. (*HIV/STD Prevention and Care Branch, ACOG, p. 101; CDC-MMWR, 9/22/06, 10A NCAC 41A.0204 (e))*
(2) Screening for hepatitis B on the initial visit, unless known to be infected, and follow-up of an infant born to an infected mother to assure he/she receives prophylactic treatment. (*10A NCAC 41A.0203 (d)(1); CDC-MMWR, 9/22/06; ACOG, p. 101)*
(3) HIV testing at the initial visit and the third trimester (preferably before 36 weeks of gestation) unless she declines the tests (i.e., opt-out screening). Documentation of refusal must be in the patient's record. (*10A NCAC 41A.0202 (14); CDC-MMWR, (09/22/06*), ACOG p.101)
(4) Screenings for Gonorrhea on initial visit and repeated in the third trimester if less than 25 years of age. *(*10A NCAC 41A.*0204(e), CDC-MMWR, (9/22/06); ACOG p. 332-333)*
(5) Screening for Chlamydia on the initial visit and repeated in the third trimester if less than 25 years of age. *(CDC STD Treatment Guidelines. MMWR 9/22/06;* 10A NCAC 41A.*0204 (e); ACOG p. 101, 334-335)*
(6) Quardruple serum screening will be offered, optimally between 15-20 weeks of gestation, to clients who give informed consent for the test. Clients who refuse the test should have this informed refusal documented in the chart. *(ACOG, p. 106-107)*
(7) Screening at initial visit for Blood Group, RH Determination, and Antibody Screen (repeated as indicated). Antibody Titer will be done if positive Antibody Screen and repeated as indicated. (ACOG, p. 101)
8) Screening at initial visit for Rubella immune status, unless previous vaccinations or laboratory test indicating immunity or disease is documented in patient's record. Immunization dates must be completed and verifiable. (*ACOG, p. 101*) Policy and Protocol for providing Rubella vaccine post-delivery if patient "not immune" are required. *(ACOG, p. 101)*
(9) Pap Test (if indicated). *(ACOG, p. 101)*
(10) Urine Dipstick for glucose and protein at each visit. *(ACOG, p. 100, 373)*
(11) Urine culture (specific for Group B Streptococcal bacteria) will be done at initial visit, and repeated if needed. *(ACOG, p. 374)* Women with any quantity of Group B Streptococcal bacteria during pregnancy shall be treated according to current standards of care for urinary tract infection in pregnancy. (*MMWR, August 16, 2002, V. 51, No. RR-11, p. 11; ACOG p. 327-330*)
(12) Hgb/Hct screening on initial visit and in third trimester. Hgb/Hct screen in second trimester as needed. *(ACOG, p.101, 374-375)*
(13) Screening at 24-28 weeks for diabetes with 50 grams. glucose and 3 hour Oral Glucose Tolerance Test (OGTT) if indicated. *(ACOG, p. 104,375)*
(14) Screening if indicated for Hgb electrophoresis with informed consent documented in the chart, or documentation that client refused test. *(ACOG, p. 84)* Screening for other genetic disorders (e.g. beta thalassemia, alpha thalassemia, Tay-Sachs disease, Canavan disease,and familial dysautonomia (Ashkenazi Jews)) should be provided based on the client's racial and ethnic background and the family background (cystic fibrosis, Duchenne's muscular dystrophy, fragile X syndrome, mental retardation). *(ACOG p. 84-85)*

(15) Screening for Group B Strep at 35-37 weeks. (*ACOG, p. 326-330; MMWR, August 16, 2002, V. 51, #RR-11)*

(16) HRMCs shall develop a policy concerning use of fetal fibronectin testing for asymptomatic clients at high risk for preterm delivery due to a previous preterm delivery or a current multifetal gestation and for clients with symptoms suggestive of preterm labor. There is no requirement that the fetal fibronectin test be utilized in the clinic, but agencies may elect to do so in consultation with their Medical Directors. It is not appropriate to utilize this test for routine screening of asymptomatic low risk women, nor should it be utilized in any event before 24 weeks 0 days, and no later than 34 weeks 6 days of gestation, in the presence of ruptured membranes or when cervical dilation is greater than or equal to 3 cm. *(ACOG Committee Opinion, 187, Sept 1997; ACOG, p. 164)*

E. The health department shall offer influenza vaccine to all pregnant women during influenza season as defined by the Immunization Branch and document the date the vaccine was given or refused included in the client chart. *(www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430al.htm;ACOG Today, Vol 48, Issue 6, July 2004;ACIP, Prevention and Control of Influenza, April 2004; Vaccinate Women, Vol. 3-No 1, August 2004, p.1; ACOG p. 103)*

F. For the presence of <u>abnormal findings</u>, there shall be documentation that *(ACOG, p. 7-8, 85,100-118):*

- Significant problems identified (medical, nutrition, psychosocial, etc.)
- A plan of care was identified for each of these problems
- Patients were managed for abnormal findings
- Consultation with other specialists was sought if indicated
- Indicated diagnostic / monitoring tests were completed:
    - Fetal Activity-Non Stress
    - Fetal Activity-Stress
    - Ultrasound
    - Amniocentesis
    - Blood glucose surveillance
- Patients were hospitalized when needed in order to treat / monitor their high risk conditions *(ACOG, p. 11-12, 387-388)*
- The hospital delivery was providing a level of care appropriate to the patient's high risk condition. *(ACOG, p. 11-12, 387-388)*

G. Nutrition components shall include documentation of:

(1) Record weight and height for all women at the initial prenatal visit. (*ACOG 9/2005*)

(2) Determine pre-pregnancy weight and calculate body mass index (BMI) to identify gestational weight gain recommendations as per the Institute of Medicine guidelines. For obesity class III patients (BMI 40+), gaining less than the minimum weight gain recommendation may be appropriate. *(ACOG 9/2005)*

(3) Screening performed by a nutritionist, nurse, physician, or physician extender. If there is no record of screening prior to admission to High Risk Maternity Clinic, it will be done at the initial HRMC visit.

- Dietary recall, food frequency or trigger questions may be used to screen at the initial visit.
- Weights at routine visits plotted on weight gain grid; determination of a pre-pregnancy weight is required.
- Identification of significant nutrition problems at any time during pregnancy will result in referral to the nutritionist for a complete assessment (anthropometric, biochemical, clinical, dietary, eco-social), and care plan development. *(ACOG, p. 89-93)*

(4) Management

- Plans for nutrition intervention for each identified nutrition problem were outlined.
- Patient received follow-up for identified nutrition problem(s).

- Patients with any high risk conditions listed below received medical nutrition therapy (MNT) by a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN)*. *Licensed by the North Carolina Board of Dietetics/Nutrition. *(Division of Medical Assistance bulletin, June 2001)*
  - (a) Conditions which impact on length of gestation or birth weight where nutrition is the underlying cause such as severe anemia (Hgb <10gm/dl; Hct <30%), underweight preconceptionally (<19.8 BMI) complicated by inadequate weight gain during pregnancy, intrauterine growth retardation, very young maternal age (under age of 16), multiple gestation, substance use.
  - (b) Metabolic disorders such as diabetes, thyroid dysfunction, maternal PKU or other inborn errors of metabolism.
  - (c) Chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes, or renal disease.
  - (d) Autoimmune diseases of nutritional significance such as systemic lupus erythematosus.
  - (e) Eating disorders such as severe pica, anorexia nervosa or bulimia nervosa.
- Prenatal supplement containing folic acid and iron was provided. (*ACOG,p. 79-83)*
- Patient referred to WIC services at initial visit if not already enrolled.

H. Psychosocial components will include documentation in the record of:

(1) A psychosocial screening through the completion of the psychosocial components of the DHHS 3965 Risk Screening form, rev 7/06. Psychosocial screening can be performed by a social worker, nurse, physician or physician extender and is to be completed at the initial HRMC visit.

(2) Assessment, Management and Follow-up of psychosocial conditions identified through the psychosocial screening.

- A psychosocial assessment was conducted on a patient with positive findings from the psychosocial risk screening and these results were referenced in the Licensed Clinical Social Worker's (LCSW) assessment.
- A plan of care for each identified psychosocial problem was documented. *(ACOG, p. 7)*
- Patient received services from the LCSW for the identified psychosocial problem(s) and/or was referred for services outside the clinic. The LCSW followed up on the patient if they were referred for psychosocial services outside the agency to make sure the patient received the needed services.

I. (1) All patients will receive specific education about their individual risk condition(s). *(ACOG, p. 88-99)*

(2) Provision of basic prenatal education must be clearly documented in the medical record. It may be provided in an individual or group format. Appropriately trained members of the maternal health team can provide the education components. These include Nurse, Nutritionist, Social Worker, Physician, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, Health Educator, etc. For example, if the social worker or the nutritionist provides education on a given topic, this education need not be repeated by another member of the health team.

Educational topics to be offered to each patient shall include the *following (ACOG, p. 85-124, 221, 232, 235)*

- Scope of care provided (including what is expected at the first prenatal visit and anticipated schedule of visits); lab studies that may be performed; options for intrapartum care; office policies; emergency coverage and cost; and expected course of pregnancy.
- Physician coverage for labor and delivery
- Adverse signs and symptoms to report (e.g. bleeding, rupture of membrane, decreased fetal movement).

- Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety* and daily activity; travel; alcohol and tobacco consumption, caution about drugs (illicit, prescription, and non-prescription); use of safety belts; sauna and hot tub exposure; vitamin and mineral toxicity; prevention of HIV infection and other STDs; environmental exposure; and nausea and vomiting during pregnancy.
- Educational programs available (refer to childbirth education classes, which should provide information on labor, pain relief, delivery, breastfeeding, infant care, postpartum period).
- Importance and benefits of breastfeeding
- Advise on avoiding eating certain fish with high levels of mercury, including shark, swordfish, king mackerel and tilefish *(ACOG, p.90-92)* and advise not to eat hot dogs or luncheon meats unless they are steaming hot and to avoid unpasteurized soft cheeses. *(ACOG, p. 331)*
- Options for intrapartum care
- Planning for discharge and child care; choosing the child's physician.
- Cost to the patient for prenatal care and delivery (e.g. insurance plan participation). *(ACOG, p. 88-94)*
- Safe sleep education must be provided to all maternity patients. (Free educational materials are available at http://www.nchealthystart.org/index2.html) *(ACOG, p. 232-233)*
- Education on Family Planning.

*Warning signs to terminate exercise while pregnant include: chest pain, vaginal bleeding, dizziness, headache, decreased fetal movement, amniotic fluid leakage, muscle weakness, calf pain or swelling, preterm labor, or regular uterine contractions *(ACOG, p. 94)*

J. Follow-up and tracking components will include documentation in the record of:

- Follow-up for missed appointments
- Follow-up of referrals indicating patient received services for which referred (inter and intra-agency)
  (ACOG, p. 7-8)

K. Post delivery components will include documentation in the record that:

- Patient was referred for postpartum examination
- Postpartum follow-up for specific high risk condition was provided or patient was referred for this service *(ACOG, p. 170-172)*
- Pregnancy outcome summary was completed on all Maternal Health patients (whether in the MCC program or receiving any prenatal service) within 30 days of discontinuation of services and submitted through Health Services information System (HSIS). *(HSIS User's Manual, 5L-1 Revised July 1, 1991; ACOG, p.16)*

8. The High Risk Maternity Clinic shall have written policies in place that address the following:

A. A list of high risk conditions that are considered indications for acceptance to the high risk clinic and approved by the Perinatal Health and Family Support Unit.

B. A list of high risk conditions that are considered indications for consultation from and /or referral to other providers and approved by the Perinatal Health and Family Support Unit. *(ACOG, p. 387-388)*

C. A system for flagging charts of patients who need special diagnostic tests or therapeutic services, or who have an abnormal laboratory result for which follow-up must be assured.

D. Protocols and procedures for the outpatient management of prenatal conditions served in the clinic.

E. Procedures and guidelines for the psychosocial risk screening process, referrals to the HRMC LCSW, and the provision of clinical social work services and nutrition services to high risk maternity patients.

F. Procedures for assuring that the multiple disciplines function as a team.

G. Mechanisms for patient referral and coordination of services among agencies, hospitals, other providers and written agreements with referring agencies.

H. Identification, follow-up and referral as indicated of pregnant women who have a past or current substance use issue (including alcohol, nicotine, and other drugs). *(ACOG, p. 96-97)* Policies must include confidentiality and release of information / medical records. (*Women's Health Resource Manual, Vol. One, Section 2-A, 5/2001 or Responding to Prenatal Substance Use-A Guide for Local Health Departments, 6/2000)*

I. Identification, follow-up and referral as indicated for pregnant and postpartum women who are experiencing domestic violence. The minimum standard for identification is the use of the three recommended ACOG screening questions administered at the first prenatal contact, each trimester and postpartum. *(Responding to Violence Against Women, A Guide for Local Health Departments 8/04, ACOG screening questions. P. 99; ACOG. p.98-100;, http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585)*

J. Universal Prenatal Screening for vaginal and rectal Group B Streptococcal colonization of all pregnant women at 35-37 weeks gestation to include documentation, transfer of results to delivering hospital, and follow-up regarding treatment of the mother and infant. Collaboration with local obstetricians and pediatricians, local hospital staff, and tertiary care center staff is required to formulate a community wide accepted policy. *(ACOG, p. 326-331; MMWR, August 16, 2002, v.51, #RR-11)* All prenatal clinics providing prenatal care through 35-37 weeks are required to have this policy.

K. Provision of Rubella *(ACOG, p. 324)* and recommendation for Varicella *(ACOG, p. 327)* vaccine post-delivery if patient "not immune".

L. Increase staff awareness of disparities in health status and service delivery, especially disparities related to race/ethnicity, disability, education, and socioeconomic status. (Healthy People 2010, ACOG p.84)

M. The maternity nurse supervisor, Licensed Clinical Social Worker, and nutritionist shall have active electronic mail membership and direct access to the Internet. HRMC funds can be used to finance and maintain hardware, software and subscription linkage to the current local market values.

IV. Performance Measures/Reporting Requirements:

Benchmarks will be reflected by county in the process outcome objectives, POOs (Attachment D).

1. Increase the percentage of women having live births who had adequate prenatal care as defined by Kessner Index during the period of June 2008 – May 2009.

2. Increase the percent of women with live term singleton births who gain weight within the National Academy of Sciences –Institute of Medicine (IOM) recommended total weight gain ranges during pregnancy *(ACOG, Committee Opinion, No. 315, September 2005)* during the period of June 2008 – May 2009.

3. Decrease the percentage of women having live births who smoked during pregnancy during the period of June 2008 – May 2009.

Reporting Requirements:

Local health departments will enter program service data at least quarterly into the Health Services Information System (HSIS) and/or a compatible reporting system.

V. <u>Performance Monitoring and Quality Assurance</u>:

The High Risk Maternity Clinic Program Supervisor, Maternal Health Nurse Consultant, Women's Health Branch Nutritionist and Social Work Consultant will utilize a team approach for the monitoring process. The monitoring activities will include: development of a pre-monitoring plan 4-6 months prior to the designated monitoring month; on site monitoring visits at least every third year; technical assistance via phone, email, or on-site as needed; and review of audit charts.

Consequences:

High Risk Maternity Clinics that have several out-of-compliance issues will be revisited within a year to view progress. Out-of-compliance issues of a chronic nature may result in the high risk funds being suspended or permanently discontinued.

Failure to provide this level of services for a two-year period or to expend all HRMC funds for a two-year period may result in the loss of up to 5% of funds. Administrative code 10A NCAC 43C is to be followed. It states: "(a) If a local provider imposes any charge on clients for high risk maternity clinic services such charges: (1) Will be applied according to a public schedule of charges; (2) Will not be imposed on low income individuals (equal or less than 100% of Federal Poverty level) or their families; (3) Will be adjusted to reflect income, resources, and family size of clients" (**.0304 Client and Third Party Fees)** and " (a) ….client must meet following: (1) financial eligibility requirements, if any, established by the clinic; these requirements shall not be more restrictive than the official Federal Poverty Guidelines; and (2) medical eligibility requirements established by the clinic…." (**.0305 Client Eligibility)**

VI. <u>Funding Guidelines or Restrictions</u>: (if applicable)

Attachment A
Non-Medicaid Services

Instructions: Complete and return the worksheet to calculate non-Medicaid services (Section B deliverables). Retain a copy in health department files for your reference. Local agencies must use the reimbursement rates for each service type in estimating the total cost of Section B deliverables. Note: The CPT rates listed are based on current figures in 2007. Please use most current figures.

TOTAL ESTIMATED COST OF SECTION B DELIVERABLES: $_________________________

_______________ Non-Medicaid patients (unduplicated number) will be served in the High Risk Maternity Clinic. (HSIS Report "Maternal Health Patient Characteristics" Item XII-A through C).

MATERNAL HEALTH WORKSHEET						
CPT Code*	**Service Type**	**Estimated # of services**	**X**	**CPT Rate**	**=**	**Total**
99201	Office/Outpatient Visit, New			$62.10		
99202	Office/Outpatient Visit, New			$93.15		
99203	Office/Outpatient Visit, New			$132.48		
99204	Office/Outpatient Visit, New			$194.58		
99205	Office/Outpatient Visit, New			$244.26		
99211	Office/Outpatient Visit, Est.			$34.16		
99212	Office/Outpatient Visit, Est.			$56.93		
99213	Office/Outpatient Visit, Est.			$78.66		
99214	Office/Outpatient Visit, Est.			$122.13		
99215	Office/Outpatient Visit, Est.			$182.16		
59425	Antepartum Care Only 4-6 visits			$338.53		
59426	Antepartum Care Only 7 or more visits			$593.54		
59025	Non-stress Test			$ 26.87		
76815	Ultrasound, limited, Fetal size, heart beat, position.			$ 78.81		
76805	Ultrasound > 14 weeks 0 days, single or first gestation, fetal & maternal evaluation, includes interpretation			$ 120.48		
S9442	Childbirth Class			$19.09		
T1017	MCC, 6 units per month/ per patient			$29.30		
90384	RG,IG Full Dose, IM			$99.00		
90385	RG, IG Minidose, IM			$11.84		
99501	Home Visit for Postnatal Assessment			$ 60.00		
96152	Health & Behavior Intervention			$ 19.97		
S9445	MOW, 7 units per month/ per patient			$ 16.50		
81025	Pregnancy Test			$8.84		
97802	Medical Nutrition Therapy, Initial, each 15 min.			$ 15.80		
97803	MNT, Reassessment, each 15 min.			$ 15.80		
T1001	Maternal Care Skilled Nurse Home Visit			$ 88.00		

Attachment A (continued)

MATERNAL HEALTH WORKSHEET						
CPT Code	**Service Type**	**Estimated # of services**	**X**	**CPT Rate**	**=**	**Total**
57452	Colposcopy w/o Biopsy			$ 94.18		
87070	GBS culture specimen, bacteria, must precede 87077			$ 12.03		
87077	GBS culture, bacteria, aerobic isolates, confirmation test for GBS			$ 11.29		
36415	Venipuncture, DMA Only			$ 3.00		
J3490	17P/per one unit of coverage			$ 20.00		
85013	Hematocrit			$ 3.31		
85018	Hemoglobin			$ 3.31		
81000	Urinalysis, Non-Auto w/scope			$ 4.43		
81001	Urinalysis, Auto w/scope			$ 4.43		
81002	Urinalysis, Non-Auto w/o scope			$ 3.57		
87210	Wet mount, simple stain, for bacteria			$ 5.33		
87086	Urine culture, colony count			$ 11.28		
87591	GenProbe-GC Culture			$ 34.26		
87491	GenProbe-Chlamydia			$ 34.26		
82947	Glucose, Fasting Blood Sugar (FBS)			$ 5.48		
82948	Glucose, blood reagent strip			$ 4.43		
82950	Glucose (post glucose dose, includes glucose)			$ 6.64		
82951	GTT (3 specimens + glucose)			$ 17.99		
82270	Fecal occult blood			$ 4.54		
83986	Assay of fluid acidity			$ 5.00		
86580	TB intradermal			$ 8.09		
90772	Administration code for 17P			$ 16.62		

(Current as of 07/07)

Other Tests

CPT Code	Service Type	Estimated # of services	X	CPT Rate	=	Total

Attachment B
Other Program Services

If the total estimated cost of non-Medicaid service deliverables is less than the total amount of DHHS funds budgeted in the Jigh Risk Maternity budgetary estimate/ DPH Aid to County Database (WIRM), provide information on how the local agency will use the remaining DHHS funds to further the program's goals and objectives. List only activities that are not Medicaid reimbursable and not part of the cost of the service deliverables in Attachment A. The total estimated cost of Attachment A and Attachment B deliverables must equal or exceed the total DHHS funds budgeted. Make copies as needed.

Best Practices:	Other C's Which May Be Considered WITH APPROVAL:
• Smoking Cessation	• Computer Hardware/Software/Internet needed to meet requirements of HRMC Agreement Addenda
• Breastfeeding	• Incentives
• SIDS Reduction / Safe Sleep	• Prenatal Vitamins
• Weight Management Counseling	
Reduction Barriers:	• Staff Development (must be prorated to % of staff time assigned to HRMC)
• Transportation	• Equipment: Specify
• Interpreter Services	• Pap Test Kits

1. Best Practice Deliverable: ____
   Brief Description of Proposed Project and Outcome(s) to be achieved:
   ____
   ____
   Timeline: ____
   Position, Title, and FTEs required to achieve this deliverable: ____________________
   ____
   New Deliverable? ______Yes _______No Estimated Cost: $________________

Other C's which may be considered:

2. Other C Deliverable: ____
   Brief Description of Proposed Project and Outcome(s) to be achieved:
   ____
   ____
   Timeline: ____
   Position, Title, and FTEs required to achieve this deliverable:____________________
   ____

New Deliverable? ______Yes _______No Estimated Cost: $_________________

3. Transfer of HRMC Funds:

My Health department requests to transfer HRMC funds to HMHC funds. These funds will be utilized to serve additional maternity patients by providing Section B maternity non-

Medicaid clinical service deliverables that meet or exceed the dollar value of all services budgeted.

Number of additional maternity patients to be served: ____________________________

Amount requested to transfer: $_____________