Questions Need Clarifications
WH Agreement Addendum Webinar
March 10, 2016; 9-11 am

Webinar Decision Stated: Email Q & As to the WH Nurse & OBCM listservs & post the document on the website under WH AA Webinar – March 10, 2016. Email MG FINAL approved Q & A doc to post & email.

Depression Tool Questions:

1. What depression tools are considered validated?
Answer - Edinburgh and PHQ9

2. Can we use the depression screening questions provided by the state or do we need to use a screening tool such as Edinburgh?
Answer - Edinburgh and PHQ9

We can use the PHQ2 first, then if positive findings use PHQ9 or Edinburgh?
Answer - Yes.

3. With regards to the depression screen slide 11 why not just get rid of the psychosocial risk screen form if this does not meet requirements for depression screen?
Answer - PHQ2 is a vetted screening (for brief interviewing), if found positive – the move to completing the Edinburgh or the PHQ9 administered by a provider.

4. Just to clarify further, the questions that we are using from the Maternal Psych Screening tool, are not valid enough? Do we need to be using something more or different?
Answer - See answer to Question 3 above. This answers the question.

Drug & Smoking Cessation Questions:

1. Can a social worker do smoking cessation counseling or does it have to be a nurse? Can the social worker charge for it?
Answer - January 2009 Medicaid Bulletin http://www.ncdhhs.gov/dma/bulletin/pdfbulletin/0109bulletin.pdf:
In addition **to physicians, nurse practitioners, and health departments**, these codes can be billed "incident to" the physician by the following professional specialties**: licensed psychologists, licensed psychological associates, licensed clinical social workers, licensed professional counselors, licensed marriage and family counselors, certified nurse practitioners, certified clinical nurse specialists, licensed clinical addictions specialists or certified clinical supervisors**. Practitioners must continue to follow the guidelines for services provided "incident to" the physician. Refer to the article titled Modification in Supervision When Practicing "Incident To" a physician in the October 2008 general Medicaid bulletin (http://www.ncdhhs.gov/dma/bulletin/1008bulletin.htm) for additional information.

More information is available at: http://www.ncdhhs.gov/dma/bulletin/pdfbulletin/0109bulletin.pdf

Physicians, Nurse Practitioners and Physician Assistants enrolled under their own NPI number may bill for tobacco cessation counseling.

REGISTERED NURSE BILLING
In addition to the previously published list of providers of smoking cessation, local health departments can bill for these services when provided by an RN who has demonstrated competence in the tobacco cessation program **in use in their agency**. These services are being provided under the supervision of the MD, NP or PA.
http://www.ncdhhs.gov/dma/bulletin/0900Bulletin.htm#

The full Billing Guidelines is available at
http://publichealth.nc.gov/lhd/docs/BillingforTobaccoCessationCounselinginLHD-09-17-2014.pdf

2. Is there a standard state consent for MH drug screening?
Answer - No, this is not a standard state consent.

3. Is Maternal Health drug screening recommended?
Answer – No**,** complete a validated screening questionnaire to identify, refer (if appropriate) and prescribe subsequent follow-up of patients who have a current use or a History of substance use. This includes alcohol, nicotine, illicit drugs, herbal remedies, prescriptions or over-the-counter medications. Process must include assurance of confidentiality and a signed understanding to release medical records to outside authorities if deemed necessary by law. An informed written consent shall be obtained at the initiation of care, and verbal consent(s) given subsequently before performing a drug screen test until the conclusion of care. (*Guidelines for Perinatal Care*, 7thed.,pp.127-130; http://whb.ncpublichealth.com/Manuals/section2confidentiality.pdf)

4. Under what circumstances do we send a drug screening?
Answer - Not unless provider suggests such

Budget Questions:

1. Does the equipment have to be approved if under $2000?
Answer - Yes, equipment request will be submitted with AA's, reviewed by State Nurse Consultant (Debbie Farb or Sarah Conte) – if approved, then forwarded onto Phyllis Johnson and Joseph Scott as the budget is being reviewed. Health Department will know their requests have been approved by the feedback given when the AA has either been accepted or denied.

2. What types of equipment can be purchased with the budget? Technical only? or also Clinical Medical Equipment?
Answer - Both types of equipment can be purchased, approval must be gained through the Health Department's Regional Consultant (may want to touch base with them; then by the State Nurse Consultant (Debbie Farb or Sarah Conte); and finally Budgetary personnel (on the state level, Phyllis Johnson or Joseph Scott). Equipment must be necessary for them to perform or delivery agreed upon in the AA. The amount should be prorated across the programs that will utilize the equipment.

3. What is equipment is needed that costs more than $2000, such as NST or ultrasound machine? Can these still be purchased as capital outlay equipment?
Answer – Counties need to justify the purchase of an Ultrasound machine. Counties must justify the for all equipment items.

4. If we spend our funds on Non-Medicaid Services, what would we put in the detailed budget? In both the FP/MH AA.
Answer – The detailed budget should include how the funds are being spent within your health department. This may include staff salaries, fringe, training, supplies, patient services, etc.

5. Is the Office of State Budget revised mileage reimbursement correct?
Answer - The Office of State Budget issued a memo which states the mileage reimbursement has dropped from $.57.5 cents per mile to $.54 cents per mile - this was on January 8, 2016.

6. Where on the Family Planning budget form do we record expenses for Birth Control items?
Answer - Please record birth control items under "Operational Expenses, Capital Outlays / Supplies and Materials / Other.

7. So if later in the year we find that we need to purchase equipment what steps do we follow to get that approved? Would a new budget form be required for submission?
Answer – Yes, if changes in the budget are needed mid-year you have to submit a revision. The revision would also go through the approval process as it did initially.

8. If our providers and nurses are involved in multiple programs do we calculate how much time they spend in each based on annual numbers? So they might be full time, but the number of family planners might equal 60% so that would be their time?
Answer - You need to submit a separate Family Planning and Maternal Health budget. Should they spend time in

both programs, then the percent time in each program is recorded in the appropriate program budget.

9. Regarding list of staff in our budget: is there a way to give totals only, or group together somehow? We have over 40 people that touch the Family Planning program. Listing each with Salary info will be cumbersome.
Answer - If you are charging any percent (1% or to 50%), of any staff person's time, it needs to be listed out on the form you see on your screen. The actual amount you get from your budgetary estimate regardless of how many people assist in delivering services.

10. Would taxi services for maternity patients be added under the "travel" budget line; would interpreter services be added under the "administrative personnel costs".
Answer - Interpreter services - Under salary/fringe
Taxi services – make it a line item under a Subcontractor budget (out-sourcing)

11. Does the agency complete the budget forms only for the amount of money received for the program?
Answer – Yes, that is correct, only completed for the funding that the state allocates

MH Assurance Questions:

1. Our Health Department assures Maternal Health Services. In the past this was listed together in the AA as to which areas we had to assure. Which parts fall under MH Assurance now?
Answer -
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E. #1 and #2
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A. General Services
B. Quality Assurance
C. Policies/Procedures
D. Prenatal/Postpartum Services
E. Laboratory & Other Services
F. Medical Therapy
G. Nutrition Services
H. Psychosocial Services
I. Patient Education

Lead Screening Questions:

1. We know we are supposed to screen for lead levels in pregnancy, but does the state lab provide lead level testing? If not, then the only option is to send these lead levels to a private lab? This will be very expensive. If the state lab does not do the lead level testing then who pays for these tests, the patient, the agency? This will be very cost prohibitive. Also, if Environmental health analysis of the home environment is needed, then do those staff members code their time to the MH budget?
Answer - No, the state lab does not provide lead testing.

Historically, the LHDs have been required to assure that patients receive all applicable laboratory testing at their initial and subsequent OB visits, with charges for those tests subject to the sliding fee scale. That means that, for lead or any other required prenatal lab, the LHD must assure that patients do not receive a bill for these services from an outside laboratory.

Where a patient has Medicaid coverage, if the LHD's contract with the hospital states that the hospital will bill Medicaid for those labs and accept any Medicaid payment as payment-in-full, that should be fine. However, for patients who are not covered by Medicaid, there must be some mechanism in place to assure that the patient never receives a bill for laboratory services, because the patient must never be charged more for a required service than she would have been responsible for according to the sliding fee scale. The lead screening isn't any different from other prenatal labs; LHDs that provide prenatal services must have a mechanism for assuring that patients are not billed by a laboratory directly for ANY required prenatal lab. Hence, the Women's Health Branch has historically recommended that the LHD have a contract with the lab that stipulates that, for patient who does not have Medicaid, the laboratory will bill the LHD and accept the Medicaid reimbursement rate as payment in full for the lab services.

Then, the LHD may bill the patient for those charges based on the sliding fee scale. If the hospital, as your laboratory provider, is waiving laboratory charges for all of LHD's maternal health patients who don't have Medicaid through some sort of "indigent patient" designation, then that would be acceptable, but that should be stipulated in HD's contract with the hospital lab.

3. Why was question 8 added to the Lead Risk Questionnaire? This will make many screens positive that would not have been.
Answer - Question #8 has been revised by the staff at UNC and you can find the revised version of this document on the Women's Health Branch website.

Lab/Billing Questions:

1. MH AA: If outside labs are provided through LabCorp once LabCorp bills third party does the remaining balance need to be put on a sliding fee scale (SFS).
Answer - Yes

2. Can you address the previous question about MH SFS for outside tests through LabCorp
Answer - Yes, it is on the SFS.

3. LabCorp will not do a SFS
Answer - Madison Co HD is required to have a SFS since they accept Title V funding from the state.

Weight Graph Questions

1. Does it have to be the actual weight graph or documented in the weight range that we have in our EMR flow sheet? Do we have to plot prenatal weights on the paper form or can we plug it into EMR documentation?
Answer - It doesn't matter how/where gestational weight gain/loss is captured – min/max on flow sheet, paper or electronic prenatal graph, or elsewhere in the EMR as long as this information is documented somewhere in the record AND used to determine the appropriate gestational weight gain range for the patient based on their pre-pregnancy weight. Furthermore, the recommended weight gain range must be shared with the patient (so patients are empowered and/or have a context for managing their weight during pregnancy).

2. Our EMR doesn't have a wt. graph....it calculates the min. and max wt. ...is this sufficient?
Answer **-** If your EMR will graph out trends you can use it (using the weight gain intervals), or you must plot them with each visit.