

Maryland Medicaid Program Women’s Reproductive Health Services

This series of Factsheets replaces the HealthChoice Self-Referral Manual and the OB/GYN/Family Planning Provider Services Manual.

Most women of childbearing age are enrolled in Managed Care Organizations (MCOs). However it is common for beneficiaries to have regular or straight fee-for-service (FFS) Medicaid before MCO enrollment and for short periods of time after breaks in Medicaid eligibility. Also some services, referred to as “carve outs”, are not covered by MCOs but are covered by FFS Medicaid. In addition it is important to understand that beneficiaries can self-refer to out-of-network providers for certain services. Therefore providers need to understand both the FFS and MCO systems.

Medicaid’s Community Liaison and Care Coordination Division, which works closely with MCOs and local health departments to ensure that women receive medically necessary and appropriate reproductive health services, has prepared this Overview and the accompanying Factsheets on the following topics:

- Factsheet #1. Self-Referral Provisions for HealthChoice Members**
- Factsheet #2. Family Planning Services**
- Factsheet #3. Maryland Family Planning Waiver Program**
- Factsheet #4. Long-Acting Reversible Contraceptives (LARCs)**
- Factsheet #5. Permanent Sterilizations**
- Factsheet #6. Abortion Services**
- Factsheet #7. Obstetrics and Gynecology**

The Medicaid program covers a wide variety of services including but not limited to:

- General
 - Medically necessary services rendered within the limitations of the CPT, Medicaid, Medicare, and NCCI guidelines, provided by providers who are participating providers with the Program
- Evaluation and Management (E&M)
 - E&M codes related to providing check-ups and care for individuals with acute or chronic health care conditions
- Anesthesia
 - Services rendered by an anesthesiologist other than for cosmetic surgery
- Surgery
 - Medically necessary surgical procedures
 - Abortions, sterilizations, and hysterectomies under the limitations detailed in the ***Women’s Reproductive Health Services Factsheets and the Professional Services Provider Manual and Fee Schedule*** available on the Program’s website: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

- Drugs and injectables
 - Drugs dispensed by the physician acquired from a wholesaler or specialty pharmacy
 - Injectable drugs administered by the physician
 - Medicine codes, including administration codes for the “Vaccines for Children Program”
- Other Services
 - Unlisted services and injectable drugs when accompanied by a medical report, surgery notes, a wholesaler invoice, and/or any other documentation as requested.

For specific information, go to the **Professional Services Provider Manual and Fee Schedule** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Lab Tests

Providers and clinics should only bill, as a part of the office visit, for labs and cytopathology services that are provided in their facility. If lab and/or cytopathology results are performed by an outside lab, the provider or clinic may not bill Medicaid for the test(s); the lab should bill Medicaid directly.

Fee-for-Service Billing

Providers rendering services under Medicaid’s “Fee-for-Service” program must bill using the CMS-1500 and submit claims within 12 months of the rendered service date. If a claim is received by the Program within the 12-month limit but is rejected due to erroneous or missing data, providers can resubmit the claim within 60 days of rejection OR within 12 months of the date the service was rendered. If the Program rejects a claim because of late receipt, the recipient may not be billed for that claim. Under no circumstances may a Medicaid recipient be billed for a Medicaid covered service. If a provider submits a claim and receives neither payment nor rejection within 90 days, the claim may be resubmitted.

Claims can be submitted in any quantity at any time within the filing statute of limitations, which is 12 months from the date of service. The following statutes are in addition to the initial claim submission:

- 12 months from the date of service of the IMA-81 (Notice of retro eligibility)
- 120 days from the date of the Medicare Explanation of Benefits (EOB)
- 60 days from the date of Third Party Liability EOB
- 60 days from the date of the Maryland Medicaid Remittance Advice (RA)

The Program **will not** accept computer-generated reports as proof of timely filing. The **only** documentation that will be accepted is a *remittance advice, Medicare or third party EOB, IMA-81* and/or a returned date stamped claim from the Program.

Paper claim submissions may take up to 30 days from date of receipt to process. Invoices are processed weekly. Payments are issued weekly and sent to the provider’s “pay-to-address”.

Claims should be mailed to the following address:

Claims Processing
Department of Health and Mental Hygiene
P.O. Box 1935
Baltimore, MD 21203

Electronic claim submissions are processed faster. Claims submitted electronically must be done in the ANSI ASC X12N 837P format, version 5010A. A signed *Submitter Identification Form and Trading Partner Agreement* must be submitted, as well as testing before transmitting such claims.

Companion guides to assist providers with electronic transactions can be found on the DHMH website: <http://dhmh.maryland.gov/HIPAA/Pages/transandcodesets.aspx>. Testing information can be found on the DHMH website:

<http://dhmh.maryland.gov/hipaa/pages/testinstruct.aspx>. If you have problems with your electronic claims submission, please send inquiries to: dhmh.ediops@maryland.gov

eClaims allows for direct billing through the e-Medicaid website. This service enables certain provider types that bill using the CMS-1500 to submit their single claims electronically. Claims that require attachments cannot be submitted through this new feature. Claims will be processed the same week they are keyed and payment will follow the next week.

To become an eClaim user, the administrator from the provider's office must register users by going to the eMedicaid website: <https://encrypt.emdhealthchoice.org/emedicaid>. For questions regarding this new feature, how to register, or to determine if your provider type can submit eClaims, please email your questions to: dhmh.emedicaidmd@maryland.gov.

Go to **CMS-1500 Billing Instructions** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx> for additional information regarding billing.

Payment in Full and Maximum Payment

The fee schedule for professional services lists the *Current Procedural Terminology (CPT)* codes and the maximum fee paid for each procedure. A provider using CPT coding selects the procedure or service that most accurately identifies the service performed. Providers are paid either the lesser of their usual and customary charge or the maximum allowable fee. All payments made by the Program to providers shall be considered payment in full for services rendered. Providers are prohibited from collecting additional payment from Program recipients or recipients' families for either covered or denied services; such action constitutes an overpayment and is in violation of both Federal and State regulation. Refer to the **Professional Services Provider Manual and Fee Schedule** at:

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Under no circumstances may a Medicaid provider bill a Medicaid beneficiary or MCO member for a Medicaid covered service. For provider transmittals, go to:

<https://mmcp.dhmh.maryland.gov/MCOupdates/Pages/Home.aspx>

Other Third Party Insurance

In general, the Program is always the payer of last resort. If a recipient is covered by other federal or third-party insurance (i.e. Medicare or commercial insurance), the provider must seek payment from that source first before billing FFS Medicaid. There is an exception for prenatal care. Providers may first bill the Program for prenatal care even if the recipient has other insurance. For more information, see the **Professional Services Provider Manual and Fee Schedule** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Medicare Crossover Claims

Some women of reproductive age have Medicare. *If a beneficiary has Medicare they will not be enrolled in an MCO.* The Program is the payer of last resort and follows Medicare guidelines. Physician services that are not medically necessary are not covered under the Program. When a provider bills Medicare B for services rendered to a Medicaid recipient, and the provider accepts assignment on the claim, the payments are made automatically. In the uncommon event that a provider is not paid within four weeks of receipt of the Medicare payment, the provider should submit a hardcopy CMS-1500 form to the Program.

Providers should only submit claims to Medicare for services rendered to patients who are dually eligible for both Medicare and Medicaid. The Program must receive Medicare/Medicaid Crossover claims within 120 days of the Medicare payment date. This is the date on Medicare's "Explanation of Benefits" form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing. In general, the Program will only pay up to the maximum of its allowed amount. For additional information regarding Medicare Crossover claims, go to **CMS-1500 Billing Instructions** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Hospital Admissions

Pre-authorization by Telligen, the Program's Utilization Control Agent (UCA) is required for all elective hospital admissions for recipients covered under Medicaid's fee-for-service program. It is the hospital's responsibility to obtain pre-authorization by using Qualitrac to submit level of care requests. For more information regarding Qualitrac, go to <http://www.telligenmd.qualitrac.com/home> or call at 888-276-7075.

For questions regarding Medicaid's women's reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Websites and Resources

CMS-1500 Billing Instructions

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Code of Maryland Regulations (COMAR)

http://www.dsd.state.md.us/COMAR/subtitle_chapters/10_Chapters.aspx

Electronic Claim Submission

<http://dhmh.maryland.gov/hipaa/pages/testinstruct.aspx>

<http://dhmh.maryland.gov/HIPAA/Pages/transandcodesets.aspx>

EPSDT/Maryland Healthy Kids Program

<https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx>

EVS User Guide

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Formulary Information

www.epocrates.com

HealthChoice MCO Program

<https://mmcp.dhmh.maryland.gov/healthchoice/Pages/Home.aspx>

HealthChoice Provider Brochure

[https://mmcp.dhmh.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%20\(1\).pdf](https://mmcp.dhmh.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%20(1).pdf)

ICD 10

The Maryland Medical Assistance Program began accepting ICD-10 codes on **October 1, 2015**.

<https://mmcp.dhmh.maryland.gov/Pages/ICD-10-Conversion.aspx>.

For general questions about ICD-10, send an email to dhmh.icd10@maryland.gov

Medicaid Provider Information

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Professional Services Provider Manual and Fee Schedule

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Program Transmittals

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

<https://mmcp.dhmh.maryland.gov/mcoupsdates/Pages/Home.aspx>

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

<http://www.marylandsbirt.org/>

Women's Reproductive Health Services

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Frequently Requested Phone Numbers

Maryland Medicaid:

- Beneficiary Services/Pharmacy Access: 410-767-5800
- Eligibility Services: 410-767-1594
- HealthChoice Member Helpline: 1-800-284-4510
- HealthChoice Provider Helpline: 1-800-766-8692
- Helpline for Pregnant Women: 1-800-456-8900
- Maryland Pharmacy Program: 410-767-1455
- Mental Health and Substance Use: 1-800-888-1965
- Office of Health Care Quality: 410-402-8000
- Provider Enrollment/Services (covered services, coding, etc.): 410-767-5340
- Provider Relations (billing, claims, other issues): 410-767-5503

HealthChoice Managed Care Organization (MCOs) Contacts for Providers:

- Amerigroup Community Care: 410-859-5800
- Jai Medical System, INC.: 888-524-1999
- Kaiser Permanente: 301-816-2424
- Maryland Physicians Care: 800-953-8854
- MedStar Family Choice: 800-905-1722
- Priority Partners: 410-424-4500
- Riverside Health of Maryland: 410-878-7709
- United Health Care: 800-487-7391

Maryland Medicaid Program Self-Referral Provisions for HealthChoice Members

A self-referral service is a health care service for which, under specified circumstances, Managed Care Organizations (MCOs) are required to pay an out-of-network provider without a referral or authorization by the primary care provider (PCP). MCOs are required to pay for self-referral services at the Medicaid FFS rate. When accessing self-referral services, beneficiaries must use in-network pharmacy and laboratory services.

Beneficiaries who are enrolled in MCOs can self-refer for the following services:

- Family planning services
- Pregnancy-related services initiated prior to MCO enrollment
- Prenatal, intrapartum, and postpartum services performed at a free-standing birth center located in Maryland or a contiguous state
- Newborn's initial medical exam in the hospital
- Child in State supervised care - initial medical exam by EPSDT certified provider
- School-based health center services
- Emergency services
- HIV/AIDS annual diagnostic and evaluation service visit
- Renal dialysis services provided in a Medicare certified facility

Self-referral for Family Planning

- All women with Medicaid Assistance are covered for family planning services and are free to choose the Medicaid family planning provider of their choice; see *Factsheet #2*
- HealthChoice members may go to an out-of-network provider for family planning services without a referral from their primary care provider (PCP), with the exception of permanent sterilization procedures; see *Factsheet #5*
- The scope of services covered under this self-referral provision is limited to those services required for contraceptive management.
- This self-referral provision does not apply to problem oriented GYN visits; those services require approval from the MCO.
- For additional information regarding Medicaid's reproductive health services and self-referral services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Billing MCOs

- Submit claims for self-referral services to the beneficiary's MCO within six (6) months of the date of service.
- For self-referred family planning related services the appropriate ICD-10 diagnosis code (Z30 series) must be indicated on the claim form in order for the MCO to recognize that the preventive medicine or E&M code is related to a family planning service.
- Go to the **HealthChoice Provider Brochure** for MCO contact information at:

[https://mmcp.dhmh.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%20\(1\).pdf](https://mmcp.dhmh.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%20(1).pdf)

Maryland Medicaid Program Family Planning Services

All women enrolled in FFS Medicaid and MCOs have family planning benefits. Family planning services provide individuals with the information and means to prevent unplanned pregnancy and maintain reproductive health, including medically necessary and appropriate office visits and contraceptive methods and services.

- Federal law allows Medicaid beneficiaries to receive family planning services from any qualified provider of their choice. See *Factsheet #1*.
- Some women are enrolled in a limited benefit program under Medicaid's **Family Planning Waiver Program**. See *Factsheet #3*.
- Women enrolled in MCOs are allowed to self-refer to an out-of-network provider for family planning services without a referral from their PCP, with the exception of permanent sterilization procedures. See *Factsheet #1 and #5*.
- The scope of services covered under this self-referral provision is limited to those services required for contraceptive management and does not apply to problem oriented GYN visits, which require approval from the MCO. See *Factsheet #1*.
- Both Medicaid FFS and MCOs cover all FDA-approved contraceptive methods, products and devices, including **long acting reversible contraceptives (LARCs)** such as intrauterine devices and contraceptive implants. See *Factsheet #4*.
- **Emergency Contraception (EC)** is a second chance to help prevent an unplanned pregnancy following unprotected sex, contraceptive failure or sexual assault. EC is available at pharmacies without a prescription regardless of age. Medicaid FFS limits dispensing of EC to 1 pack per 30 days. See *Factsheet #3*.
- Beneficiaries can obtain 12 latex condoms per dispensing without a prescription.
- MCOs have their own provider manuals and billing instructions for services that are covered by the MCOs. Contact the MCO for specific coverage questions & billing instructions.
- For additional MCO information, go to the **HealthChoice Provider Brochure** [https://mmcp.dhmh.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%0\(1\).pdf](https://mmcp.dhmh.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%0(1).pdf)
- For additional information on Medicaid's FFS Pharmacy Program, go to: <https://mmcp.dhmh.maryland.gov/pap/pages/paphome.aspx>
- **Contraceptive products** that are available at the pharmacy with a prescription include diaphragm, cervical cap, contraceptive ring and patches.

- Codes for Contraceptive Products
 - 57170 Diaphragm fitting with instructions
 - A4266 Diaphragm
 - A4261 Cervical Cap
 - J7303 Contraceptive vaginal ring
 - J7304 Contraceptive hormone patch
 - 99070 Other contraceptive product not listed
- Providers should only use A- and J- codes for contraceptives supplied during an office visit.
- Report the NDC/quantity when billing drugs, products, and devices identified by A- and J- codes.
- Providers must bill no more than their acquisition cost. To facilitate claims processing FFS Medicaid sets a fee for each code. However if the provider can document that their acquisition cost was greater than the set fee, attach a copy of the invoice to the claim form for verification and the acquisition cost will be paid.
- See *Factsheet #4* for A- and J- codes for LARCs.
- For additional information, go to the **Professional Services Provider Manual and Fee Schedule**: <https://mmcp.dhmd.maryland.gov/Pages/Provider-Information.aspx>
- For additional information regarding Medicaid's women's reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Maryland Medicaid Program Family Planning Waiver Services

Medicaid Family Planning Waiver Program (FPP)

Maryland Medicaid Family Planning Waiver Program is a limited benefits program for low-income women. Family planning services provide individuals with the information and means to prevent unplanned pregnancy and maintain reproductive health. Benefits are limited to services related to contraceptive management.

- There are no premiums, copays or deductibles
- All FDA-approved contraceptive methods, products and devices, including long acting reversible contraceptives (LARCs) such as IUDs (Intrauterine Devices) are covered. See *Factsheet #4, Long-Acting Reversible Contraceptives*.
- Permanent sterilizations may be covered. See *Factsheet #5, Permanent Sterilization* for more details on the requirements for the procedures.

Services Not Covered by the FPP

Women in this limited benefits program do not have coverage for services that are not specifically listed below. Some examples of **specifically excluded services** are: diagnostic and treatment services for infertility; gynecological treatment or cancer treatment; treatment for HIV-AIDS related conditions; and prenatal care and delivery

Refer low-income pregnant women to www.marylandhealthconnection.gov or their local health department to apply for full Medicaid benefits.

FPP Waiver Covered Services

The Waiver Program recognizes office visit codes and preventive visit codes as family planning services when billed with a contraceptive management diagnosis code. Use the appropriate E&M code for new and established patients for family planning visits, based on the complexity of services provided during the visit or the appropriate preventive code. The provider must use the appropriate ICD-10 code from the “Z30” (encounter for contraceptive management) series.

The services below are covered when performed as part of a family planning/contraceptive management visit:

- Pelvic Exams
- Screening test, such as pap smears, labs and/or screening for sexually transmitted infections
- Advice about birth control methods
- FDA-approved contraception and contraceptive devices including emergency contraception
- Long Acting Reversible Contraceptives (IUD & contraceptive Implants); see *Factsheet #4*
- Screening and treatment for vaginitis and UTIs
- Screening for HIV
- Permanent sterilization for women age 21 and older; see *Factsheet #5*
- Human Papilloma Virus (HPV) vaccine

HPV Vaccine Codes

90649-SE (VFC stock)	HPV vaccine, quadrivalent, 3 dose schedule administration fee
90650-SE (VFC stock)	HPV vaccine, bivalent, 3 dose schedule administration fee
90649	HPV vaccine, quadrivalent, 3 dose schedule
90650	HPV vaccine, bivalent, 3 dose schedule

For individuals under age 19 providers must obtain vaccine through the Vaccines for Children Program. The SE modifier is used for the administration of VFC vaccine. Administration fees will only be paid when administering VFC vaccines. For beneficiaries age 19 and over providers must bill the acquisition cost of the vaccine and the charges for administration are part of the E&M code.

Oral Contraceptives - A maximum six-month supply may be dispensed per prescription. Prescribers must complete a (FDA) *Med-Watch Form* and forward to the Maryland Pharmacy Program for review before the Program will reimburse at the “brand” rate for prescriptions dispensed as “brand medically necessary”. For additional information or to obtain the form, go to: <https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Prescriptions - Maryland law allows pharmacists to accept verbal prescriptions, with the exception of Schedule II controlled substances, from prescribing providers via phone for Medicaid recipients. Providers must use tamper-resistant prescription pads for written prescriptions. See *General Provider Transmittal #63* on the Program’s website: <https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Emergency Contraception (EC) is a second chance to help prevent an unplanned pregnancy following unprotected sex, contraceptive failure or sexual assault. EC is available at pharmacies without a prescription regardless of age. Medicaid FFS limits dispensing of EC to 1 pack per 30 days.

Condoms – Beneficiaries can obtain 12 latex condoms per dispensing without a prescription.

Contraceptive products that are available at the pharmacy with a prescription include diaphragms, cervical cap, contraceptive rings and patches.

Codes for Contraceptive Products

57170	Diaphragm fitting with instructions
A4266	Diaphragm
A4261	Cervical Cap
J7303	Contraceptive vaginal ring
J7304	Contraceptive hormone patch
99070	Other contraceptive product not listed

See ***Factsheet #4*** for codes for LARCs

Providers should only use A- and J- codes for contraceptives supplied during an office visit. Report the NDC/quantity when billing drugs, products, and devices identified by A- and J- codes. Providers must bill no more than their acquisition cost. To facilitate claims processing a fee is set for each code. However, if the provider can document that their acquisition cost was greater than the set fee, attach a copy of the invoice to the claim form for verification and the acquisition cost will be paid.

Lab Tests

Providers and clinics should only bill, as a part of the office visit, for labs and cytopathology services that are provided in their facility. If lab and/or cytopathology results are performed by an outside lab, the provider or clinic may not bill Medicaid for the test(s); the lab should bill Medicaid directly.

For additional information, go to the **Professional Services Provider Manual and Fee Schedule** on the Program's website:

<https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Other drugs covered by the FP Waiver Program include drugs to treat sexually transmitted infections, urinary tract infections and vaginitis in the following drug classes:

- Anti-fungals
- Anti-virals (for HSV)
- Cephalosporins
- Macrolides
- Miscellaneous beta-Lactams
- Penicillins
- Sulfonamides
- Tetracyclines
- Metronidazole
- Other miscellaneous antibiotics, not otherwise noted above

For additional information on Medicaid's FFS Pharmacy Program, go to:

<https://mmcp.dhmf.maryland.gov/pap/pages/paphome.aspx> or call at 410-767-1455.

For Family Planning Waiver Program questions, go to:

<https://mmcp.dhmf.maryland.gov/familyplanning/pages/Home.aspx> or call at 1-855-692-4993.

For FP Waiver claim inquiries, call Provider Relations at 410-767-5503.

Call the Community Liaison and Care Coordination Division at 410-767-6750 for questions regarding FP Waiver Program services.

Maryland Medicaid Program Long-Acting Reversible Contraceptives (LARCs)

Long acting reversible contraceptives (LARCs) such as intrauterine devices and contraceptive implants, are recommended by the American Congress of Obstetrics and Gynecology (ACOG).

- Medicaid FFS will reimburse for all LARCs, including those placed immediately postpartum.
- The use of LARCs reduces the risk of unplanned pregnancy and improves the health of mother and newborn by facilitating healthy spacing between pregnancies.
- Medicaid does not require preauthorization for LARCs.

Intrauterine Device (IUD)

Intrauterine devices include the copper IUD and the hormonal IUD. IUDs can only be billed in conjunction with an insertion code for same date of service. The insertion and/or removal of IUDs are reported using one of the following CPT codes:

58300	Insertion of IUD
58301	Removal of IUD
J7300	Intrauterine device, copper T380A
J7297	Intrauterine device, levonorgestrel-releasing, 52 mg/3yrs
J7298	Intrauterine device, levonorgestrel-releasing, 52 mg/5yrs
J7301	Intrauterine device, levonorgestrel-releasing, 13.5 mg
J7307	Etonogestrel implant, including implant & supplies

Contraceptive Implants

11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
11976	Removal, contraceptive capsules

The CPT procedure codes do not include the cost of supplies. Report the supply separately using the proper HCPCS code. Use the appropriate ICD-10 code from the “Z30” (encounter for contraceptive management) series.

Providers should only use A- and J- codes for contraceptives supplied during an office visit. Report the NDC/quantity when billing drugs, products, and devices identified by A- and J- codes. Providers must bill no more than their acquisition cost. To facilitate claims processing a fee is set for each code. However if the provider can document that their acquisition cost was greater attach a copy of the invoice to the claim form for verification and the acquisition cost will be paid. For additional information, go to the **Professional Services Provider Manual and Fee Schedule** on the Program’s website:

<https://mmcp.dhmd.maryland.gov/Pages/Provider-Information.aspx>

For questions regarding Medicaid’s women’s reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Maryland Medicaid Program Permanent Sterilization Procedure

Medicaid Fee-For-Service and MCOs are required to cover permanent sterilization procedures but only if ALL the following conditions are met:

1. The individual is at least 21 years of age at the time consent is obtained;
 2. The individual is not mentally incompetent;
 3. The individual is not institutionalized;
 4. The individual has voluntarily given informed consent as described in Part I of the **Sterilization Consent** form (HHS 687, HHS 687-1) available at <https://mmcp.dhmd.maryland.gov/pages/provider-information.aspx>;
 5. At least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery;
 6. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
 7. An individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date on the consent form).
 8. The Sterilization Consent form (HHS 687, HHS 687-1) must be completed and kept in the patient's record for all sterilization procedures (55250, 55450, 58699-58615, and 58670-58671). A sterilization/tubal ligation procedure must be billed on a separate CMS-1500 claim form. If the procedure was performed on the same date of service as another procedure, a modifier-51 is required in Block #24D for the second or subsequent procedure.
- **Beneficiaries who are not enrolled in an MCO (FFS or the Family Planning Waiver) do not need preauthorization for the procedures.**
 - **Permanent sterilization is not a self-referral service. MCO members must use in-network providers and the provider needs preauthorization from the MCO.**

Female Sterilization

58565	Surgical Hysteroscopy w/bilateral fallopian tube cannulation to induce occlusion
58340	HSG - injection uterus/tubes x-ray, 3-month post procedure
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by device (band/clip/falope ring, vaginal or suprapubic approach)
58670	Surgical laparoscopy with fulguration of oviducts (with or without transaction)
58671	Surgical laparoscopy with occlusion of oviducts by device (band/clip/falope ring)

Male Sterilization

55250	Vasectomy, excision unilateral-bilateral
55450	Ligation of vas deferens

For questions regarding Medicaid FFS reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Maryland Medicaid Program Abortion Services

Medicaid covers abortion for the following five medical reasons:

- Risk to life of the mother
- Risk to mother's current or future somatic health
- Risk to mother's current or future mental health
- Fetal genetic defect or serious deformity or abnormality
- Mother was a victim of rape or incest

Always check EVS. Abortion is never covered for women in the following eligibility categories:

- **C13P - Hospital Presumptive Eligibility,**
- **P02 and P11 - Pregnant women who are eligible for Medicaid based on pregnancy**
- **P10 - Family Planning Waiver Program**
- **X02 - Women eligible for emergency services only**

Maryland Medicaid does not claim any federal match for abortion procedures and MCOs are not permitted to cover the abortion procedure. For MCO members, abortion claims must be submitted to the Medicaid FFS program for the following:

- Abortion procedures
- Related services provided at a hospital on the day of the procedure or during an inpatient stay;
or
- An abortion package as may be provided by a freestanding clinic

Bill the MCO for any related services, not indicated above, that are performed as part of a medical evaluation prior to the actual abortion procedure. This includes the service for which the provider who performs the procedure completes a *Certification for Abortion Form (DHMH 521)*.

The **Certification of Abortion** (DHMH 521) form must be completed and kept in the patient's medical record for services related to the termination of a pregnancy (except spontaneous abortion or treatment of ectopic pregnancy) or for medical procedures necessary to voluntarily terminate a pregnancy for victims of rape and incest. These include surgical CPT procedures 59840-59841, 59850-59852, 59855-59857, and 59866 and anesthesia code 01966. The form is available on the DHMH web at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

The medical record must reflect the medical necessity for the therapeutic abortion as determined by the certifying physician. The specific condition for which the abortion is being performed must be documented in the record. Completion of the certification form (DHMH 521) alone is not sufficient to serve as documentation, nor is it sufficient to render a clinical opinion and/or diagnosis without supporting evidence in the medical record. Lack of acceptable documentation in the medical record will cause the Program to deny payment, or in cases where payment has been made, the Program will require repayment from the provider.

Abortion and abortion related services can be billed electronically. If billing electronically, the DHMH 521 is not required to be submitted with the claim. **Indicate the appropriate 2-alpha character condition code in Block 10d** of the claim form. Refer to the Program's **CMS-1500 Billing Instructions** for complete details at:

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Medical Abortion: Termination of Early Pregnancy with Mifepristone (Mifeprex®)

- For medically induced abortion through the administration of Mifepristone, also known as RU-486, use the unlisted CPT medicine code **S0190**.
- “Medical Abortion” must be written on the *CMS-1500 claim* below the procedure code in **Block 24D**.
- The ICD code for **legally induced abortion** or **failed attempted abortion** must be the primary diagnosis on the claim.
- The date of service on the DHMH 521 and the CMS-1500 claim form is the date that the patient signs the required Patient Agreement and takes the 600 mg oral dose of Mifepristone.
- The fee for this procedure includes all medically necessary office or out-patient clinic visits over a two-week period for administration of the drugs and appropriate follow-up, and the actual cost of the drugs.
- Do not bill for office visits in addition to procedure code **S0190**.

For additional information, go to the **Professional Services Provider Manual and Fee Schedule** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

For questions regarding Medicaid's women's reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Maryland Medicaid Program OB/GYN Services

Obstetrical Care

Most pregnant women enrolled in Medicaid must enroll in HealthChoice, Medicaid's managed care program. HealthChoice beneficiaries who do not select an MCO are auto-assigned to an MCO. For additional information about HealthChoice, go to:

<https://mmcp.dhmh.maryland.gov/healthchoice/Pages/Home.aspx>.

Providers must check EVS at each visit prior to rendering services to determine if the beneficiary is enrolled in an MCO. Providers who are contracted with MCOs should refer to the MCO's provider contract, provider manual, preauthorization procedures and billing instructions. Go to the **HealthChoice Provider Brochure** for MCO contact information at:

<https://mmcp.dhmh.maryland.gov/healthchoice/pages/HealthChoice-Helplines.aspx>.

Pregnant women often access care on a fee-for-service basis prior to enrollment in the MCO. This occurs because some women apply for Medicaid during pregnancy or are only eligible for Medicaid because they are pregnant. Certain women are not eligible for MCO enrollment. For example, women with temporary Hospital Presumptive Eligibility coverage and women with dual coverage (Medicare and Medicaid) will not be enrolled in MCOs.

Self-referral Provisions and Continuity of Care

- If a woman has initiated prenatal care with an out-of-network provider prior to MCO enrollment, she may continue to see that provider during her pregnancy. The provider must be willing to bill the MCO. See *Factsheet #1*.
- When accessing self-referral services, beneficiaries must use in-network pharmacy and laboratory services.
- The MCO is required to reimburse an out-of-network provider at the Medicaid fee for service rate.
- Continuity of Care provisions also require MCOs to allow newly enrolled women to continue to see an out of network provider when the woman has already initiated prenatal care.
- Medically necessary services related to prenatal care such as lab tests, prenatal vitamins and prescription drugs, sonograms, and non-stress tests are covered.
- Prenatal care providers must use the appropriate evaluation and management code (E&M) in conjunction with the appropriate ICD-10 pregnancy code for each prenatal visit.
- **Medicaid does not reimburse physicians for “global” maternity care services. Providers must bill deliveries separately from prenatal care.**

CPT Code	Description
99201	Office visit, new patient, minimal
99202	Office visit, new patient, moderate
99203	Office visit, new patient, extended
99204	Office visit, new patient, comprehensive
99205	Office visit, new patient, complicated

99211	Office visit, established patient, minimal
99212	Office visit, established patient, moderate
99213	Office visit, established patient, extended
99214	Office visit, established patient, comprehensive
99215	Office visit, established patient, complicated

Maryland Prenatal Risk Assessment Process

The Program will reimburse prenatal care providers an additional fee for completion of the **Maryland Prenatal Risk Assessment (MPRA)**. See page 5 for sample MPRA. Use HCPCS code H1000. (The program does not use code 99420.) Only one risk assessment per pregnancy will be reimbursed. To complete the MPRA process, providers must:

- 1) Fill out the **MPRA** form (DHMH 4850) at the first prenatal visit;
- 2) Fax the form to the local health department (addresses and fax numbers are on the form); and
- 3) Develop a plan of care based on the women’s risk factors.
 - The MPRA identifies women at risk for low birth weight, pre-term delivery and other health care conditions that may put mother and/or infant at risk.
 - The local health departments use the MPRA’s to identify women who may benefit from local programs, or who may need assistance navigating the health care system.
 - LHDs are required to forward the MPRA’s to the MCO.
 - The MCOs use the MPRA’s to identify members that are pregnant and link them to care coordination and case management services.

Enriched Maternity Services

The Program will reimburse prenatal care providers an additional fee when “enriched” maternity services are provided. Use HCPCS code H1003. (The Program does not use codes 99411 and 99412.) Only one unit of service per prenatal and postpartum visit will be reimbursed. An “Enriched Maternity Service” must include all of the following:

- 1) Individual prenatal health education;
- 2) Documentation of topic areas covered (see page 7 for sample *Enriched Maternity Services*);
- 3) Health Counseling; and
- 4) Referral to community support services.

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

The Program will reimburse for alcohol and/or substance use structured screening and brief intervention codes W7000, W7010, W7020, W7021 and W7022, the SBIRT (Screening, Brief Intervention, and Referral to Treatment) procedure codes. When billing with H1003 the provision of this service must be in addition to the alcohol and substance use counseling component of the “Enriched Maternity Service”.

The Program will reimburse separately for smoking and tobacco use cessation 99406 and 99407. However, when billing with H1003 the provision of this service must be in addition to the smoking and tobacco use/cessation counseling component of the “Enriched Maternity Service.”

For more information about SBIRT (Screening, Brief Intervention, and Referral to Treatment), go to: <http://www.marylandsbirt.org/>

Intrapartum & Postpartum Care

- Providers must bill deliveries separately from prenatal care. The Program does not use procedure codes 59400, 59425, 59426, 59510, and 59610.
- If other procedures are performed on the same date of service, list the code for delivery on the first line of **Block 24** of the *CMS-1500* form. List the modifier in column **24D** for the second or subsequent procedure.
- For vaginal deliveries performed in a “home” or “birthing center”, use codes 59410 and 59614, with the appropriate place of service code “12 or 25” indicated in **Block 24B** of the *CMS-1500* form. Use the unlisted maternity care and delivery code 59899 for supplies used for a vaginal delivery.
- Use code 59430 for postpartum care services only. Postpartum care includes all visits in the hospital and office, after the delivery. Postpartum care is not payable as a separate procedure, unless it is provided by a physician or group other than the one providing the delivery service.

Refer to the Program’s **Professional Services Provider Manual and Fee Schedule** and **CMS-1500 Billing Instructions** on the Program’s website:

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Gynecology

Use the appropriate Preventive Medicine codes for routine annual gynecologic exams:

99383 - 99387 for new patients

99393 - 99397 for established patients

Use the appropriate E&M codes for problem-oriented visits:

99201 - 99205 for a new patient

99211 - 99215 for an established patient

Providers may only bill the Program for laboratory procedures which they perform or are performed under their direct supervision. Physicians’ service providers cannot be paid for clinical laboratory services without both a **Clinical Laboratory Improvement Amendment (CLIA)** certification and approval by the Maryland Laboratory Administration, if located in Maryland. Laboratory procedures that the physician refers to an outside laboratory or practitioner for performance must be billed by that laboratory or practitioner.

Interpretation of laboratory results or the taking of specimens other than blood is considered part of the office visit and may not be billed as a separate procedure. Specimen collection for Pap smears is not billable by a physician. For specific information regarding pathology and laboratory services, refer to the **Medical Laboratories Provider Fee Schedule** in **COMAR 10.09.09**. For additional information, contact Physicians Services at 410-767-1462.

Hysterectomy

Medicaid will pay for a hysterectomy only under the following conditions:

- The physician who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; AND
- The individual or her representative, if any, has signed a written acknowledgement of receipt of that information (patients over the age of 55 do not have to sign); OR
- The physician who performs the hysterectomy certifies, in writing, that either the individual was already sterile at the time of the hysterectomy and states the cause of the sterility; OR
- The hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible; the physician must include a description of the nature of the emergency.

The Program will not pay for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

Regulations require physicians who perform hysterectomies (not secondary providers, i.e. assisting surgeons or anesthesiologists) to complete the “**Document for Hysterectomy**” form (DHMH 2990), which is available at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>. The completed DHMH 2990 must be kept in the patient’s medical record.

For a list of procedure codes, refer to the FFS Program’s **Professional Services Provider Manual and Fee Schedule** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Hospital Admissions

Pre-authorization by Telligen, the Program’s Utilization Control Agent (UCA) is required for all elective hospital admissions for recipients covered under Medicaid’s fee-for-service program. It is the hospital’s responsibility to obtain pre-authorization by using Qualitrac to submit level of care requests. For more information regarding Qualitrac, go to <http://www.telligenmd.qualitrac.com/home> or call at 888-276-7075.

For questions regarding Medicaid’s women’s reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

MARYLAND PRENATAL RISK ASSESSMENT

REFER TO INSTRUCTIONS ON BACK BEFORE STARTING

Date of Visit: ____ / ____ / ____

DEMOGRAPHIC INFORMATION	Provider Name: _____ Provider Phone Number: _____ - _____ - _____ Provider NPI#: _____ Site NPI#: _____		
	Client Last Name: _____ First Name: _____ Middle: _____ House Number: _____ Street Name: _____ Apt: _____ City: _____ County (If patient lives in Baltimore City, leave blank): _____ State: _____ Zip Code: _____ Home Phone #: _____ - _____ - _____ Cell Phone#: _____ - _____ - _____ Emergency Phone#: _____ - _____ - _____ SSN: _____ - _____ - _____ DOB: ____ / ____ / ____ Emergency Contact: _____ _____ / _____ / _____ (Name/Relationship)		
ASSESSMENT INFORMATION	Race: <input type="checkbox"/> African-American or Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> American Native <input type="checkbox"/> More than 1 race <input type="checkbox"/> White		
	Language Barrier? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify Primary Language _____ Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown		
Payment Status (Mark all that apply): <input type="checkbox"/> Private Insurance Specify: _____ <input type="checkbox"/> MA/HealthChoice _____ <input type="checkbox"/> _____ <input type="checkbox"/> Medicaid/MCO (if _____) Applied for MA Specify Date: ____ / ____ / ____ <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown			
Educational Level Highest grade completed: _____ GED? <input type="checkbox"/> Yes <input type="checkbox"/> No Currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Transferred from other source of prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, date care began: ____ / ____ / ____ Other source of prenatal care: _____ Trimester of 1st prenatal visit: ____ 1st ____ 2nd ____ 3rd LMP: ____ / ____ / ____ Initial EDC: ____ / ____ / ____			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> Complete all that apply <input type="checkbox"/> # Full-term live births <input type="checkbox"/> # Pre-term live births <input type="checkbox"/> # Stillbirths <input type="checkbox"/> # Spontaneous abortions <input type="checkbox"/> # Therapeutic abortions <input type="checkbox"/> # Ectopic pregnancies <input type="checkbox"/> # Children now living </td> <td style="width: 50%; vertical-align: top;"> Check all that apply <input type="checkbox"/> History of pre-term labor <input type="checkbox"/> History of fetal death (> 20 weeks) <input type="checkbox"/> History of infant death w/in 1 yr of age <input type="checkbox"/> History of multiple gestation <input type="checkbox"/> History of infertility treatment <input type="checkbox"/> First pregnancy </td> </tr> </table>		Complete all that apply <input type="checkbox"/> # Full-term live births <input type="checkbox"/> # Pre-term live births <input type="checkbox"/> # Stillbirths <input type="checkbox"/> # Spontaneous abortions <input type="checkbox"/> # Therapeutic abortions <input type="checkbox"/> # Ectopic pregnancies <input type="checkbox"/> # Children now living	Check all that apply <input type="checkbox"/> History of pre-term labor <input type="checkbox"/> History of fetal death (> 20 weeks) <input type="checkbox"/> History of infant death w/in 1 yr of age <input type="checkbox"/> History of multiple gestation <input type="checkbox"/> History of infertility treatment <input type="checkbox"/> First pregnancy
Complete all that apply <input type="checkbox"/> # Full-term live births <input type="checkbox"/> # Pre-term live births <input type="checkbox"/> # Stillbirths <input type="checkbox"/> # Spontaneous abortions <input type="checkbox"/> # Therapeutic abortions <input type="checkbox"/> # Ectopic pregnancies <input type="checkbox"/> # Children now living	Check all that apply <input type="checkbox"/> History of pre-term labor <input type="checkbox"/> History of fetal death (> 20 weeks) <input type="checkbox"/> History of infant death w/in 1 yr of age <input type="checkbox"/> History of multiple gestation <input type="checkbox"/> History of infertility treatment <input type="checkbox"/> First pregnancy		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> Psychosocial Risks: Check all that apply. <input type="checkbox"/> Current pregnancy unintended <input type="checkbox"/> Less than 1 year since last delivery <input type="checkbox"/> Late registration (more than 20 weeks gestation) <input type="checkbox"/> Disability (mental/physical/developmental) specify _____ <input type="checkbox"/> History of abortion within past 6 months <input type="checkbox"/> Tobacco use, Amount _____ <input type="checkbox"/> Alcohol use, Amount _____ <input type="checkbox"/> Illegal substances within past 6 months <input type="checkbox"/> Resides in home prior to 1970s Rent _____ Own _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Lack of social/emotional support <input type="checkbox"/> Exposure to long-term stress <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Other psychosocial risk (specify in comments box) <input type="checkbox"/> None of the above COMMENTS ON PSYCHOSOCIAL RISKS: _____ </td> <td style="width: 50%; vertical-align: top;"> Medical Risks: Check all that apply. Current Medical Conditions of this Pregnancy: <input type="checkbox"/> Age ≤15 <input type="checkbox"/> Age ≥ 45 <input type="checkbox"/> BMI < 18.5 or BMI > 30 <input type="checkbox"/> Hypertension (> 140/90) <input type="checkbox"/> Anemia (Hgb < 10 or Hct < 30) <input type="checkbox"/> Asthma <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Diabetes: Insulin dependent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaginal bleeding (after 12 weeks) <input type="checkbox"/> Genetic risk: specify _____ <input type="checkbox"/> Sexually transmitted disease, Specify _____ <input type="checkbox"/> Last dental visit over 1 year ago <input type="checkbox"/> Prescription drugs <input type="checkbox"/> History of depression/mental illness, Specify _____ Depression assessment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other medical risk (specify in comment box) <input type="checkbox"/> None of the above COMMENTS ON MEDICAL RISKS: _____ </td> </tr> </table>		Psychosocial Risks: Check all that apply. <input type="checkbox"/> Current pregnancy unintended <input type="checkbox"/> Less than 1 year since last delivery <input type="checkbox"/> Late registration (more than 20 weeks gestation) <input type="checkbox"/> Disability (mental/physical/developmental) specify _____ <input type="checkbox"/> History of abortion within past 6 months <input type="checkbox"/> Tobacco use, Amount _____ <input type="checkbox"/> Alcohol use, Amount _____ <input type="checkbox"/> Illegal substances within past 6 months <input type="checkbox"/> Resides in home prior to 1970s Rent _____ Own _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Lack of social/emotional support <input type="checkbox"/> Exposure to long-term stress <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Other psychosocial risk (specify in comments box) <input type="checkbox"/> None of the above COMMENTS ON PSYCHOSOCIAL RISKS: _____	Medical Risks: Check all that apply. Current Medical Conditions of this Pregnancy: <input type="checkbox"/> Age ≤15 <input type="checkbox"/> Age ≥ 45 <input type="checkbox"/> BMI < 18.5 or BMI > 30 <input type="checkbox"/> Hypertension (> 140/90) <input type="checkbox"/> Anemia (Hgb < 10 or Hct < 30) <input type="checkbox"/> Asthma <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Diabetes: Insulin dependent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaginal bleeding (after 12 weeks) <input type="checkbox"/> Genetic risk: specify _____ <input type="checkbox"/> Sexually transmitted disease, Specify _____ <input type="checkbox"/> Last dental visit over 1 year ago <input type="checkbox"/> Prescription drugs <input type="checkbox"/> History of depression/mental illness, Specify _____ Depression assessment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other medical risk (specify in comment box) <input type="checkbox"/> None of the above COMMENTS ON MEDICAL RISKS: _____
Psychosocial Risks: Check all that apply. <input type="checkbox"/> Current pregnancy unintended <input type="checkbox"/> Less than 1 year since last delivery <input type="checkbox"/> Late registration (more than 20 weeks gestation) <input type="checkbox"/> Disability (mental/physical/developmental) specify _____ <input type="checkbox"/> History of abortion within past 6 months <input type="checkbox"/> Tobacco use, Amount _____ <input type="checkbox"/> Alcohol use, Amount _____ <input type="checkbox"/> Illegal substances within past 6 months <input type="checkbox"/> Resides in home prior to 1970s Rent _____ Own _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Lack of social/emotional support <input type="checkbox"/> Exposure to long-term stress <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Other psychosocial risk (specify in comments box) <input type="checkbox"/> None of the above COMMENTS ON PSYCHOSOCIAL RISKS: _____	Medical Risks: Check all that apply. Current Medical Conditions of this Pregnancy: <input type="checkbox"/> Age ≤15 <input type="checkbox"/> Age ≥ 45 <input type="checkbox"/> BMI < 18.5 or BMI > 30 <input type="checkbox"/> Hypertension (> 140/90) <input type="checkbox"/> Anemia (Hgb < 10 or Hct < 30) <input type="checkbox"/> Asthma <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Diabetes: Insulin dependent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaginal bleeding (after 12 weeks) <input type="checkbox"/> Genetic risk: specify _____ <input type="checkbox"/> Sexually transmitted disease, Specify _____ <input type="checkbox"/> Last dental visit over 1 year ago <input type="checkbox"/> Prescription drugs <input type="checkbox"/> History of depression/mental illness, Specify _____ Depression assessment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other medical risk (specify in comment box) <input type="checkbox"/> None of the above COMMENTS ON MEDICAL RISKS: _____		

Form Completed By: _____

Date Form Completed: ____ / ____ / ____

DHMH 4850

revised April 2015

DO NOT WRITE IN THIS SPACE

9005

Maryland Prenatal Risk Assessment Form Instructions

Purpose of Form: Identifies pregnant woman who may benefit from local health department **Administrative Care Coordination (ACCU)** services and serves as the referral mechanism. ACCU services complement medical care and may be provided by public health nurses and social workers through the local health departments. Services may include resource linkage, psychosocial/environmental assessment, reinforcement of the medical plan of care, and other related services.

Form Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for ALL pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- **NEW** - Enter both the provider and site/facility NPI numbers.
- Print clearly; use black pen for all sections.
- Press firmly to imprint.
- White-out previous entries on original completely to make corrections.
- If client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

Faxing and Handling Instructions:

- Do not fold, bend, or staple forms. **ONLY PUNCH HOLES AT TOP OF FORM IF NECESSARY.**
- Store forms in a dry area.
- **Fax the MPRAF to the local health department in the client's county of residence.**
- To reorder forms call the local ACCU.

Definitions (selected): Data may come from self-report, medical records, provider observation or other sources.

DEFINITIONS	
Alcohol use	Is a "risk-drinker" as determined by a screening tool such as MAST, CAGE, CAGE-4, OR 4P.
Current history of abuse/violence	Includes physical, psychological abuse or violence with the client's environment within the past six months
Exposure to long-term stress	For example: partner-related, financial, safety, emotional
Genetic risk	At least one a genetic/hereditary
Illegal substances	Used illegal substances within the past 6 months (e.g. cocaine, heroin, marijuana, PCP) or is taking methadone/buprenorphine
Lack of social/emotional support	Lack of support from family/friends. Isolated
Language barrier	In need of interpreter, e.g. Non-English speaking, auditory processing disability, deaf
Oral Hygiene	Presence of dental caries, gingivitis, tooth loss
Preterm live birth	History of preterm birth (prior to the 37 th gestational week)
Prior LBW birth	Low birth weight birth (under 2,500 grams)
Sickle cell disease	Documented by medical records
Tobacco use	Used any type of tobacco products within the past 6 months

Client's Local Health Department Addresses (rev 04/2015) (FAX to the ACCU in the jurisdiction where the client resides)

Mailing Address	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD #8 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU HealthCare Access Maryland 201 E. Baltimore St, Ste. 1000 Baltimore, MD 21202	410-649-0526 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3 rd Floor Baltimore, MD 21212	410-887- 8741 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd, P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7 th St., P.O. Box 10 Denton, MD 21629	410-479-8023 Fax: 410-479-4871
Carroll County ACCU 290 S. Center Street Westminster, MD 21156	410-876-4941 Fax: 410-876-4959
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5145 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway, P.O. Box 1050 White Plains, MD 20695	301-609-6803 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-228-3223 Fax: 410-228-8976
Frederick County ACCU Antevue Lane Frederick, MD 21701	301-600-3341 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7770 Fax: 301-334-7771
Hampden County ACCU 100 Days Street Bellaire, MD 21014	410-838-1500 Fax: 443-643-0344
Howard County ACCU 8930 Stanford Blvd. Columbia, MD 21045	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7039 Fax: 410-778-7019
Montgomery County ACCU 1335 Piccard Drive, 2 nd Floor Rockville, MD 20850	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9314 Piscataway Rd., Ste. 247B Clinton, MD 20735	301-856-9449 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4481 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St., P.O. Box 316 Leonardtown, MD 20650-0316	301-475-6772 Fax: 301-475-4350
Somerset County ACCU 7920 Crisfield Highway Westover, MD 21871	443-523-1740 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6568
Worcester County ACCU 9730 Healthway Dr. Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

Enriched Maternity Services Record

Name: _____ **MA#:** _____
Date Risk Assessment Completed: _____

I. Counseling Topics

Dates & Initials of Provider

1. Benefits and recommended schedule of prenatal care, preventive dental care; and safety measures;					
2. Normal changes and minor discomforts of pregnancy;					
3. Preterm labor education;					
4. Preparation for labor and deliver;					
5. Risks of using alcohol, tobacco, drugs (OTC & Rx), and illegal substance;					
6. Importance of postpartum care and family planning;					
7. Need for arranging pediatric care and use of infant car seat;					
8. Nutrition education to include:					
a. Relation of proper nutrition to a healthy pregnancy;					
b. Benefits of breastfeeding;					
c. Nutritional requirements during pregnancy and postpartum;					
d. Appropriate weight gain during pregnancy;					
e. Benefits of, and preparation for, breastfeeding;					

II. Care coordination and referral to support and specialty services.