Better beginnings for **mothers** and **babies.**

right from the start

Maternity Services

Overview

Ensuring access to healthcare for low-income women and children in West Virginia has been an ongoing concern for state and federal officials. The Office of Maternal, Child and Family Health (OMCFH), Perinatal Programs, has worked to develop special initiatives that extend support services to pregnant women and infants at risk of adverse health outcomes. This initiative has not only expanded the state's capacity to finance healthcare for women and children, but has also strengthened the delivery of care by establishing care protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling, which contribute to improved patient well-being.

One of the Perinatal Programs' component activities is limited funding of prenatal, delivery, postpartum and routine newborn hospital care for low-income, medically-indigent pregnant women who are determined to be ineligible for Medicaid, have no insurance to cover obstetrical care and have a monthly income below 185% of the Federal Poverty Level. Because there is a need to identify these women for billing and reporting purposes, they are often referred to as RFTS Maternity Services clients. Care for this population is paid for using federal (Title V) monies in conjunction with state appropriations to increase access for the targeted population. RFTS Maternity Services supports comprehensive prenatal care as outlined in the American College of Obstetricians and Gynecologists (ACOG) guidelines. This helps to ensure West Virginia women have the benefit of appropriate healthcare during the course of their pregnancy.

Eligibility

Determining factors of eligibility for Maternity Services:

1. **West Virginia residency;**
2. **Application denied for Medicaid coverage for pregnancy;**
3. **Gross income up to 185% of the Federal Poverty Level (FPL);**
4. **Verification of pregnancy with estimated due date;**
5. **No insurance or insurance does not cover pregnancy.**

Presumptive Eligibility

If clients are unable to pay for care and have no third party resource (insurance, Medicaid), they are less likely to seek prenatal care and providers may be hesitant to render services. To overcome this obstacle and assure access to early prenatal care, RFTS Maternity Services acts as a guarantor of payment for initial prenatal exams and associated laboratory/diagnostic tests. However, RFTS Maternity Services is the payer of last resort. If the client is approved for Medicaid or another third party source, the practitioner is paid by that source. The two categories of presumptive eligibility that may be assigned by RFTS Maternity Services are:

Presumptive (PM) - If the client has not applied for Medicaid or eligibility has not been determined, the client may feel she cannot seek prenatal care because she has no means of payment. To surmount this obstacle to care, RFTS Maternity Services agrees to pay for the initial prenatal visit, the associated laboratory diagnostic testing and the initial ultrasound (if indicated). The PM number does NOT cover any other diagnostic tests or services, or any additional prenatal visits. The presumption is that the client will be approved for Medicaid or RFTS Maternity Services coverage by the time the invoice is presented for payment.

Backdated (SM) - The client has been approved for Medicaid coverage, but coverage was not backdated to cover the initial prenatal visit and associated laboratory diagnostic assessments. RFTS Maternity Services may pay for these services incurred before the effective date of Medicaid coverage if the client was income eligible.

Categories and Codes

- Pregnant teens ≤ 19 years of age regardless of family income **(MM)**
- Income-eligible and medically indigent pregnant women ≥ 20 years of age **(MX)**
- Income-eligible non-citizens **(MA)***

* Prenatal care only; client must apply for Emergency Medical Coverage at the local DHHR office within thirty days of delivery. The Emergency Medical application also allows the DHHR to assess Medicaid eligibility for the newborn.

Non-covered Services

The following is a partial list of services **NOT COVERED** by RFTS Maternity Services for payment:

- Hospitalization at any time other than for delivery
- Observation status at the hospital
- Intermediate or intensive care for the mother or newborn
- Any service/care that is not pregnancy-related
- Emergency room charges/care
- Ambulance services
- Family planning services/postpartum sterilization (woman must be referred to the OMCFH Family Planning Program)
- Infant care rendered after discharge from the hospital
- Prescriptions
- Specialist referrals/consults

Covered Services

RFTS Maternity Services covers only **ROUTINE** pregnancy related care and treatment. Within the limitations stated, RFTS Maternity Services normally pays for the following types of service for sponsored clients at established RFTS Maternity Services rates:

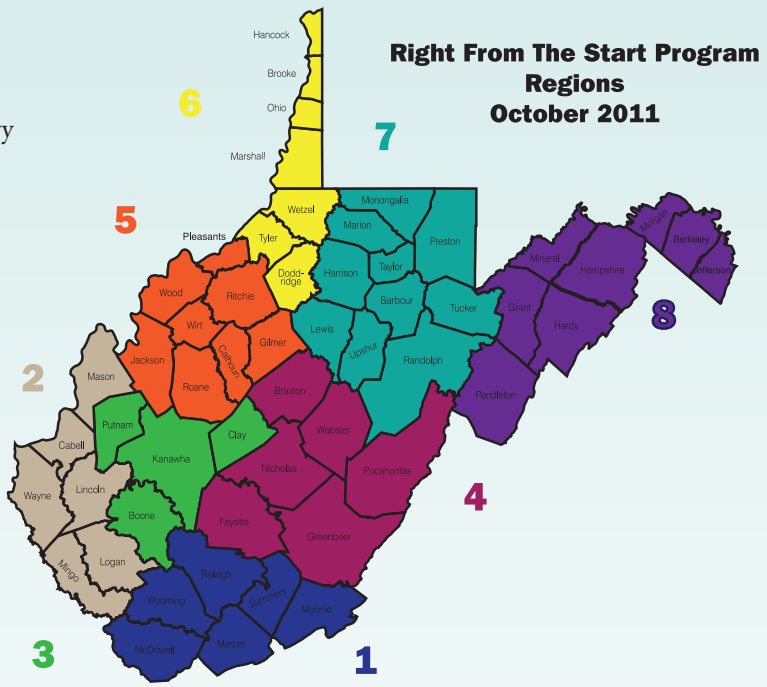
- Routine prenatal care
- Laboratory and diagnostic assessments in accordance with ACOG standards
- Ultrasound and radiologic examinations
- Delivery charges (vaginal and c-section), hospital supplies, laboratory work (limited to one thousand dollars [$1,000.00])
- Anesthesia (at time of delivery)
- One postpartum examination to include routine laboratory and diagnostic tests
- Routine newborn care rendered during the mother's hospitalization for delivery, which includes newborn examination, circumcision and discharge
- RFTS Program services comparable to those provided to Medicaid recipients:
  - Service Care Plan
  - Care Coordination
  - Enhanced Prenatal Care (Health Education)
  - Travel reimbursement for transportation to medical appointments
- Prenatal vitamins and iron tablets are supplied by the OMCFH to participating prenatal providers or local health departments for their pregnant clients covered under RFTS Maternity Services.
- Clients may use non-contracted practitioners; however, contracted providers must accept RFTS Maternity Services rates as payment in full for services rendered. They must also abide by RFTS Maternity Services policies and procedures.

Billing Procedures

- Practitioners and healthcare facilities are to bill RFTS Maternity Services using the CMS 1500 billing form or the UB 92 billing form with attached itemization.
- Only standard CPT codes and service descriptions used by Medicaid and approved by RFTS Maternity Services will be eligible for reimbursement. A list of covered RFTS Maternity Services codes may be obtained on the RFTS website: www.wvdhhr.org/rfts. Providers may contact OMCFH to obtain required user name and passcode.
- The client's assigned RFTS Maternity Services ID number must be included on the billing form to receive reimbursement.
- Invoices should be submitted within sixty (60) days from the date of service to:

  Office of Maternal, Child and Family Health
  RFTS Maternity Services
  350 Capitol Street, Room 427
  Charleston, West Virginia 25301-3714

- Payment of an invoice by RFTS Maternity Services constitutes payment in full. The client is not to be billed the balance after payment is received from RFTS Maternity Services.



www.wvdhhr.org/rfts

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