

**PRENATAL CARE ASSISTANCE PROGRAM  
(PCAP)**

**MEDICAID  
POLICY GUIDELINES  
MANUAL**



**NEW YORK STATE  
DEPARTMENT OF HEALTH  
OFFICE OF MEDICAID MANAGEMENT**

## Table of Contents

<b>SECTION I – PROGRAM INFORMATION</b> .....	<b>3</b>
PCAP PROVIDERS.....	3
RELEVANT CLINIC SPECIALTY CODES.....	4
PCAP RATE CODES.....	4
<b>SECTION II – MEDICAID ELIGIBILITY</b> .....	<b>5</b>
EXPANDED MEDICAID ELIGIBILITY .....	5
PRESUMPTIVE ELIGIBILITY .....	5
<i>PCAP and Presumptive Eligibility Screening</i> .....	6
<b>SECTION III – BILLING GUIDELINES FOR PCAP VISITS</b> .....	<b>7</b>
PCAP INITIAL VISIT/PRENATAL EVALUATION .....	7
<i>Initial Visit: Included Services</i> .....	7
PCAP SUBSEQUENT VISITS/PRENATAL FOLLOW-UP VISITS .....	8
<i>Level I, II and III Sonograms</i> .....	10
<i>Non-Stress Tests and Biophysical Profiles</i> .....	11
<i>HIV Counseling and Testing Services</i> .....	11
<i>Required Services Provided by an Outside Vendor</i> .....	11
<i>Referral for Specialty Prenatal Care Services Not Offered by the PCAP</i> .....	12
<i>Referral for Non-Prenatal Services</i> .....	12
POSTPARTUM CARE VISIT.....	13
SERVICES INCLUDED IN PCAP RATES.....	14
SERVICES NOT INCLUDED IN PCAP RATES .....	14
<i>Physicians Subcontracted with a PCAP</i> .....	15
<i>Fetal Monitoring</i> .....	15
PAY AND SEEK .....	15
<i>Prenatal Care Service ICD-9-CM Diagnosis Codes</i> .....	16
<b>SECTION IV – PCAP QUESTIONS</b> .....	<b>17</b>
GENERAL INFORMATION QUESTIONS .....	17
BILLING PROCEDURES.....	17
MEDICAID POLICY .....	18

## Section I – Program Information

The Prenatal Care Assistance Program (PCAP) is a preferred provider model within the New York State Medicaid Program. PCAP providers deliver quality, comprehensive prenatal care services to eligible low-income uninsured and underinsured women.

The comprehensive services that are included in the enhanced Medicaid clinic visit rate include the following:

- Screening for presumptive eligibility for Medicaid and assisting pregnant women complete the Medicaid application process;
- Outreach to improve early entry into prenatal care;
- Risk assessment;
- Care planning and coordination of care;
- Nutrition services including referral to the Women, Infants and Children (WIC) Program;
- Psychosocial services;
- HIV counseling and testing;
- Prenatal diagnostic and treatment services;
- Health education;
- Internal quality assurance; and
- Postpartum services.

### PCAP Providers

A PCAP provider is an Article 28 approved hospital outpatient department or free-standing diagnostic and treatment center (D&TC) that was approved by the New York State Department of Health (DOH) to provide prenatal care in accordance with Part 85.40 of Public Health Law at 10 NYCRR.

Standards can be found by conducting a search at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>.

Prenatal care must be listed on the facility's operating certificate for the site(s) where the services will be rendered.

If the application review process indicates the provider is qualified and the Department approves their enrollment, the provider is reimbursed at an enhanced Medicaid rate for the enriched package of services delivered.

To obtain a copy of the qualifications and an application to enroll as a PCAP provider, please go to the websites below:

<http://www.health.state.ny.us/nysdoh/perinatal/en/pcapapp.htm>  
(PCAP Application)

<http://www.health.state.ny.us/nysdoh/perinatal/en/pcapcover.htm>  
(Guidance for Submission of the PCAP Application).

Information can also be obtained by calling the Bureau of Women's Health at:

(518) 474-1911.

### Relevant Clinic Specialty Codes

A clinic must be authorized to provide service under one of the following specialty codes in order to seek enrollment as a PCAP.

Specialty Codes	Specialty Description
904	Obstetric
905	Gynecology
906	Family Planning
914	General Medicine

PCAP visits are exempt from Utilization Thresholds (UTs).

Payment for services rendered is based upon a discrete rate established by the DOH.

### PCAP Rate Codes

PCAPs are reimbursed at an enhanced Medicaid clinic rate using three (3) rate codes based on the type of obstetric visit:

Service Type	Hospital-Based Clinic Category of Service 0287 Rate Code	Free Standing D & TC Category of Service 0160 Rate Code
Initial Patient Visit	3101	1601
Follow-Up Visit	3102	1602
Postpartum Visit	3103	1603

## Section II – Medicaid Eligibility

For determining Medicaid eligibility, a pregnant woman counts as two. A current chart of the Medicaid annual and monthly income guidelines can be found at:

[http://www.nyhealth.gov/health\\_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/).

### Expanded Medicaid Eligibility

Expanded Medicaid Eligibility is Medicaid coverage for pregnant women with incomes at 0-200% of the federal poverty level (FPL) who would otherwise be ineligible for Medicaid.

Medicaid eligibility is guaranteed until the end of the month in which the 60<sup>th</sup> day postpartum occurs.

A Medicaid-eligible woman can receive care at PCAP sites throughout New York State, or from other Medicaid enrolled providers.

### Presumptive Eligibility

Presumptive Eligibility (PE) is the process whereby a preliminary financial screen for a pregnant woman is conducted at the PCAP site by a qualified provider (QP) to determine if the woman would be financially eligible for Medicaid (income at 0-200% of the FPL).

If the pregnant woman is found to be presumptively eligible for Medicaid by the QP, the PCAP is able to begin the woman's care, and is guaranteed to be paid for services rendered until the Medicaid application is processed and a full determination of Medicaid eligibility is made by the Local Department of Social Services (LDSS), even if the final determination is a denial.

The QP at the PCAP is *required* to assist the woman in assembling the necessary paperwork for a full Medicaid application and convey the information to the LDSS' Medicaid office. This process eliminates the need for the woman to make a separate trip to the LDSS to complete the Medicaid application.

The PE period lasts until the LDSS makes a full determination on the Medicaid application.

For any questions regarding Medicaid eligibility or Medicaid enrollment of the pregnant woman, contact the LDSS in the woman's county of residence. LDSS contact information can be found in the **Information for All Providers – Inquiry** manual, available online at:

<http://www.emedny.org/ProviderManuals/Prenatal/index.html>.

## PCAP and Presumptive Eligibility Screening

Appendix 1 of the **PCAP Comprehensive Agreement** stipulates that all PCAPs conduct presumptive eligibility screenings.

PCAP staff who will be designated as Qualified Providers (QP) must receive Presumptive Eligibility (PE) training prior to the submission of the application to DOH for QP enrollment status. The names of the staff trained must be listed on the QP application.

QP training is online and web-based at the Center for Development of Human Services at Buffalo State College.

For more information, please contact Ms. Sally Speed.

Email: [sallys@bsc-cdhs.org](mailto:sallys@bsc-cdhs.org)  
Telephone: (716) 876-7600.

To obtain a copy of the qualifications and application to become a QP, contact the DOH Office of Medicaid Management at (518) 486-6562 or access the DOH website:

[http://www.nyhealth.gov/health\\_care/medicaid/program/index.htm](http://www.nyhealth.gov/health_care/medicaid/program/index.htm).

## Section III – Billing Guidelines for PCAP Visits

### PCAP Initial Visit/Prenatal Evaluation

The initial prenatal evaluation or visit may be conducted in more than one encounter, but only one PCAP Initial Visit rate code may be billed to the Medicaid Program.

A PCAP initial visit can only be billed after all components, as stated in the **PCAP Agreement**, Appendix 2, have been completed *regardless of the number of encounters involved*. If all components of the PCAP Initial Visit cannot be scheduled on the same day, an intake visit may be conducted prior to the medical evaluation. This intake visit cannot be billed as a PCAP subsequent visit rate code.

All services associated with the initial visit must be completed within 60 days.

### Initial Visit: Included Services

This initial visit shall include:

- Medicaid presumptive eligibility determination;
- A complete history and physical examination, including a pelvic examination;
- Risk assessment, including medical and psychosocial factors;
- Laboratory screening;
- Patient history and symptoms to screen for possible genetic risks;
- Initiation of patient education;
- Initial development of a care plan;
- Screening for nutritional and psychosocial risk factors with appropriate referrals;
- HIV counseling and testing.

If a woman is enrolled in a Medicaid Managed Care Plan during the course of her prenatal care and the PCAP is not a provider in that network then only visits that took place **prior** to her enrollment in the Managed Care Plan will be paid fee for service.

PCAP staff should check a client's eligibility using the Medicaid Eligibility Verification System (MEVS) prior to **each** visit to ensure the woman's Medicaid eligibility and her status regarding Medicaid Managed Care Plans since her last visit.

All services provided to the patient should meet prenatal standards as defined in Section 85.40 of 10 NYCRR, regardless of the payer.

## PCAP Subsequent Visits/Prenatal Follow-Up Visits

These visits shall be for the purpose of providing ongoing prenatal care and shall include the following components:

- Ongoing risk assessments, including the review of such symptoms as:
  - headache;
  - changes in vision;
  - dizziness;
  - edema;
  - nausea and vomiting;
  - bleeding;
  - awareness of fetal movements;
  - occurrence of contractions or rupture of membranes;
  - review of laboratory data;
  - review of medical and psychosocial factors with appropriate documentation in the care plan; and
  - referral when indicated.
- Physical examination, including such items as:
  - maternal blood pressure;
  - weight;
  - presence of edema;
  - height of fundus;
  - fetal position; and
  - fetal heartbeat
- Recommended laboratory tests and other procedures, such as:
  - urine testing for glucose and albumin at each visit;
  - glucose challenge test at 28 weeks;

- repeat gonorrhea, chlamydia, syphilis and HIV screen during the third trimester, as clinically indicated;
  - repeat hematocrit or hemoglobin at 36 weeks;
  - urinalysis and urine culture as needed;
  - Group B streptococcus culture at 35-37 weeks, as indicated per the Centers for Disease Control and Prevention (CDC) guidelines;
  - obstetrical Ultrasound, as clinically indicated; and
  - Rh titre, as indicated.
- Health education, which shall be documented in the medical record and include the following topics:
- Orientation to facility procedures;
  - Rights/responsibilities of the pregnant woman;
  - Signs of complications of pregnancy;
  - Physical activity and exercise during the pregnancy;
  - Avoidance of harmful practices and substances including alcohol, drugs, non-prescribed medications, nicotine and any dangers in use of prescribed medications due to pregnancy;
  - Sexuality during pregnancy;
  - Occupational concerns;
  - Risks of HIV infection and risk reduction behaviors;
  - Signs of labor;
  - Labor and delivery process;
  - Relaxation techniques during labor;
  - Obstetrical anesthesia and analgesia;
  - Preparation for parenting including infant development, care and options for feeding;
  - The Newborn Screening Program with distribution of Newborn Screening educational literature; and

- Distribution of Medicaid information on the Child/Teen Health Program.
- Introduction of expanded Medicaid eligibility for infants up to one year of age;
- Family planning.

Additionally:

- There is no limit to the number of follow-up visits that may be billed.
- Follow-up visits must include an assessment by a licensed prenatal provider (physician, licensed midwife, nurse practitioner or physician's assistant) for a PCAP rate code to be billed.
- HIV post-test counseling should be provided for those clients who were HIV tested.
- Follow-up visits must not be billed with a service date after the date of delivery.
- Subsequent visits must be necessary and appropriate to the plan of care and must include a physical assessment and determination of ongoing risk by a medical practitioner as stated above. For example, if a PCAP client is seen by a nurse, nutritionist and/or a social worker and there is no medical provider encounter, a PCAP rate code cannot be billed.
- A telephone visit **does not** constitute a billable PCAP visit.
- A PCAP subsequent visit rate code can only be billed if all components of a PCAP subsequent visit are rendered. If a pregnant woman is seen in the office or clinic solely to treat a medical condition, such as strep throat, a PCAP visit cannot be billed. However, the visit can be billed through the facility's general medical clinic rate.
- If diagnostic and specialty counseling is indicated, the billing should be done using either the clinic, physician/laboratory or ambulatory surgery rates. Each agency's fiscal officer should determine which to use. The determination is based upon how the facility aggregated and reported costs of operating these generic services to the DOH.
- If costs have been incorporated into the clinic rate calculation, then clinic or ambulatory surgery rates should be billed. If not part of these rates, the Medicaid fee-for-service codes (physician/laboratory) are to be utilized.

### Level I, II and III Sonograms

- All sonograms (Levels I – III) are included in the PCAP clinic rate and cannot be billed separately. Medicaid should not be billed directly by the provider

(clinic, physician, licensed midwife, nurse practitioner) for either the technical or professional component of the procedure.

### Non-Stress Tests and Biophysical Profiles

A non-stress test (NST) and/or biophysical profile (BPP) performed on the same date of service as a prenatal follow-up visit is part of the PCAP follow-up visit rate and may not be billed separately.

This is true whether it is performed on the same date of service as a prenatal follow-up visit or it is performed on a subsequent day with no other service provided.

If a client has been referred from a PCAP for a NST or BPP the facility should bill the PCAP for the service.

### HIV Counseling and Testing Services

If the Article 28 PCAP has signed the **HIV Primary Care Provider Agreement**, the agency can bill for HIV services on the same date of services as a PCAP encounter using the appropriate HIV rate codes. Otherwise, no separate reimbursement is allowed.

### Required Services Provided by an Outside Vendor

- Routine labs and sonograms are part of the PCAP package of services, and are included in the all-inclusive, enhanced PCAP clinic rates.
- Each PCAP provider must establish procedures to ensure that ancillary services performed both inside the PCAP facility and by outside vendors are not billed directly to Medicaid if they are services that are routinely provided as part of prenatal care.
- A letter of agreement or subcontract should be developed with each outside vendor/contractor ensuring no duplicate billing of Medicaid will occur.
- The PCAP provider is responsible for compensating any outside vendors for routine prenatal care services they provide on referral from the PCAP. The PCAP should take measures to educate clients that they must go to service providers/vendors with whom the PCAP has a Memorandum of Understanding (MOU).
- The PCAP provider should anticipate that patients may not utilize the PCAP clinic's preferred vendors for ordered services. Some mechanism should be in place to instruct ANY vendor to bill the PCAP provider if providing routine prenatal services to a PCAP patient.

When ordering diagnostic services such as labs or ultrasounds, the PCAP must utilize a referral form that does not contain any information that would allow billing to Medicaid and clearly identifies the PCAP provider as the party responsible for making payment and states they should not bill Medicaid. In the event a patient goes to a non-participating provider, information on the referral form should indicate that the services should be billed to the PCAP provider and that billing the services directly to Medicaid will result in an audit *exception*.

The exception to this would be if a PCAP client needs to see a physician on a day when the physician is off-site at another PCAP. This is a core PCAP service that could be billed by the PCAP provider rendering the services, as long as all components of a subsequent visit are rendered. It is strongly recommended that a Letter or Memorandum of Agreement be in place to cover this type of visit.

### Referral for Specialty Prenatal Care Services Not Offered by the PCAP

A patient who needs up to three visits for high risk services from a specialist, such as a perinatologist, may be referred for these visits, and still continue as a PCAP patient.

The referral must be to a clinician who is **not** part of the PCAP staff in order to constitute a valid referral and not be part of the PCAP clinic rate.

Likewise, if the services for which the patient is being referred are available through current staff of the PCAP clinic, these services cannot be billed separately from the PCAP clinic rates.

If a patient needs more than three visits to a perinatologist or other specialist, the patient should be considered very high risk and should be managed by the specialist and disenrolled from PCAP. The visits should be billed by the perinatologist or other specialist according to their normal Medicaid billing procedure.

**A patient cannot be referred to a specialist solely for an ultrasound, NST, BPP or other procedure that is part of the PCAP rate, simply because these services are unavailable through the PCAP clinic.**

The services provided by the perinatologist or other specialist must include all components of a visit to treat a high risk patient. If it is for routine test procedures that the PCAP is unable to furnish then the perinatologist or other specialist must bill the PCAP for the procedures performed, not Medicaid.

### Referral for Non-Prenatal Services

Any services that are not part of routine prenatal care that are determined by the clinician to be needed for the health and well-being of the mother (i.e., chest X-ray, mammogram, dental services, etc.) that are **not** available at the PCAP clinic itself, should be referred to the nearest and most appropriate provider, in the same facility, if possible.

These referrals can be billed at the appropriate Medicaid visit rate for the receiving clinic or at the usual fee-for-service rate, as appropriate to the referral site.

## Postpartum Care Visit

A postpartum care visit:

- Can be billed only once per patient per pregnancy.
- Includes a two-week incision examination following a Cesarean section.
- A postpartum visit is for providing follow-up care after delivery. A postpartum visit should occur between 4-8 weeks after delivery, depending on the individual needs of the client.
- Following delivery, if additional visits are necessary due to medical complications, claims should be submitted using the clinic's general medicine rate codes.

The postpartum visit should include the following components:

- **Ongoing risk assessment**  
Review medical, psychosocial, nutritional, alcohol treatment, drug treatment and education needs of the mother, infant and family with appropriate referral when indicated.
- **Physical examination**  
Assessment of the breast, blood pressure, abdomen, external and internal genitalia and weight.
- **Laboratory studies**  
Complete blood count and other tests as indicated.
- **Health education**  
A combination of private interviews with health personnel, group discussions or classes, and printed material in the client's preferred language can be used. Health education should be documented in the medical record and should include the following topics:
  - Methods of family planning;
  - Preconception counseling needs;
  - Care of the infant, including infant feeding and pediatric follow-up;
  - Prevention of HIV and sexually transmitted diseases;
  - Physical activity and exercise;
  - Nutrition;

- Infant development; and
- Automatic one year Medicaid eligibility for infants born to Medicaid-eligible mothers.
- **Family planning**  
Assess family planning needs and provide advice and service or referral where indicated.
- **Preconception counseling**
- **Pediatric follow-up**

### Services Included in PCAP Rates

Clinic visit rates established for PCAP are considered reimbursement in full for the following:

- physician services, nursing services, technician services, nutrition services, health education services, psychosocial services, care coordination services and other related professional expenses directly incurred by the licensed facility;
- space occupancy and plant overhead costs;
- administrative personnel, business office, data processing, recordkeeping, housekeeping, and other related facility overhead expenses;
- all ancillary services including laboratory tests and diagnostic testing associated with routine prenatal care; and
- medical supplies, prenatal vitamins and iron supplements.

### Services Not Included in PCAP Rates

- Pharmaceuticals;
- Drug treatment and screening services;
- Genetic diagnostic services including Amniocentesis, chromosome analysis and physician/geneticist evaluation and counseling;
- Mental health services;
- Transportation services;
- Inpatient care;
- Specialty physician and clinic services;

- Labor and delivery services;
- Dental services;
- Emergency room services;
- Home care;
- HIV services (if the Article 28 PCAP has signed the **HIV Provider Agreement**, the clinic can bill for HIV services on the same date of service as a PCAP encounter using the appropriate HIV rate codes);
- Non prenatal and postpartum medical services.

**Note:** Routine Medicaid rates or fee-for-service procedure codes should be used to obtain reimbursement for services not included in the PCAP rate.

### Physicians Subcontracted with a PCAP

Deliveries (vaginal or C-section) can be billed by the physician or licensed midwife using appropriate Medicaid codes listed in the procedure code section of each Medicaid Provider Manual. Medicaid Provider Manuals are available online at:

<http://www.emedny.org/ProviderManuals/index.html>.

If a physician or licensed midwife is an approved clinical provider and enrolled in Medicaid, they may qualify to receive enhanced reimbursement for deliveries provided to PCAP clients by applying to become a Medicaid Obstetrical and Maternal Services (MOMS) provider. The MOMS Clinical application is available online at:

[http://www.health.state.ny.us/nysdoh/perinatal/docs/moms\\_application.pdf](http://www.health.state.ny.us/nysdoh/perinatal/docs/moms_application.pdf).

All antepartum and postpartum visits are included in the PCAP rate and cannot be billed to Medicaid by the physician, nurse practitioner or licensed midwife. “Global” delivery codes (vaginal or C-section) which include antepartum and postpartum care cannot be used for PCAP patients or be billed to Medicaid by the physician, nurse practitioner or licensed midwife. “Delivery only” codes are appropriate for the deliveries of PCAP clients.

### Fetal Monitoring

There is no separate reimbursement for fetal monitoring as that is considered to be part of the inpatient diagnosis related group (DRG) rate.

### Pay and Seek

In an effort to expedite access to primary care for pregnant women and timely provider reimbursement, an exception is made to the policy concerning pursuit of payment from

third part resources. Under the “Pay and Seek” guidelines, Article 28 clinics or fee-for-service physicians, nurse practitioners and licensed midwives are *not* required to seek reimbursement from third party insurers prior to billing the Medicaid Program.

Providers may bill Medicaid before billing other insurers for certain prenatal and pediatric services identified with an ICD-9-CM diagnosis code that falls within the range of the “Pay and Seek” guidelines.

Payment for “Pay and Seek” claims will be at the Article 28 clinic’s rate, or the lower of either the NYS maximum allowable fee-for-service or the practitioner’s usual and customary charge.

The DOH will collect any monies due from the responsible third party insurer.

“Pay and Seek” is optional. Providers may continue to bill a recipient’s third party insurer prior to billing the Medicaid Program.

**Prenatal Care Service ICD-9-CM Diagnosis Codes**

<b>ICD-9-CM Diagnosis Codes</b>	<b>Description</b>
V22.0 V22.1	Supervision of normal pregnancy
V23.0 - V23.9	Supervision of high risk pregnancy
V28.0 - V28.9	Antenatal Screening
* 640.0 - 648.9	Complications related to pregnancy
* 651.0 - 658.9 ** 671.0 - 671.9 ** 673.0 - 673.8 ** 675.0 - 676.9	Other conditions requiring care in pregnancy

\* Claims qualify for “Pay and Seek” reimbursement only if the fifth digit is a three (“3”).

\*\* Claims qualify for “Pay and Seek” reimbursement if there is a fifth digit.

## Section IV – PCAP Questions

Information on the following topics can be obtained on the Department of Health's website:

<http://www.health.state.ny.us/nysdoh/perinatal/en/pcap.htm>

- Prenatal Care Assistance Program (PCAP);
- Guidance for Prenatal Standards;
- PCAP Services Description;
- Guidance for Submission of an application as a designated PCAP provider;
- Application for comprehensive prenatal care service provider participation;
- Application for additional PCAP sites;
- PCAP annual report;
- Instructions for completing the PCAP annual report;
- Medicaid income levels for children and pregnant women;
- PCAP Billing Guidelines;
- Medicaid PCAP rates by trend factor;
- Find a PCAP provider near you.

### General Information Questions

New York State Department of Health  
Bureau of Women's Health  
Perinatal Health Unit  
Empire State Plaza  
Corning Tower, Room 1882  
Albany, New York 12237

(518) 474-1911

### Billing Procedures

Computer Sciences Corporation  
Institutional Helpline

(800) 343-9000

## Medicaid Policy

New York State Department of Health  
Office of Medicaid Management

(518) 486-6562

Growing Up Healthy Hotline

(800) 522-5006