



## Comprehensive Perinatal Services Program (CPSP)

CPSP Overview  
Day 1



## Trainers

- Paula Binner, MSW, LCSW
- Thelma Hayes, MA, RD
- Katie Balderas, MPH
- Christian Murillo, MPH
- Joanne Roberts, BSN, PHN



## Training Objectives

- Describe the 4 components of CPSP
- Explain the purpose of CPSP Orientation
- Explain how to use Provider Handbook, Steps to Take Guidelines, and Protocols
- Describe documentation guidelines
- Define Interconception Care



## Objectives (cont.)

- Report an increased understanding of mandated reporting laws
- Identify ways to effectively communicate with patients



### What does CPSP stand for?

- **C** Comprehensive
- **P** Perinatal
- **S** Services
- **P** Program



### Definition

“Comprehensive perinatal services” means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.”

(Title 22, CCR, 51179)



### CPSP Program Goals



- To decrease the incidence of low birth weight in infants
- To improve pregnancy outcome
- To give every baby a healthy start in life
- To lower health care costs by preventing catastrophic & chronic illness in infants & children



### CPSP Program History

- Developed from the OB Access Project
- A perinatal demonstration project for 7000 low income women that operated from 1979 to 1982 in 13 California counties



### CPSP Program

- Reduced low birth weight rate by 1/3 and saved about \$2 in short term NICU costs for every \$1 spent
- CPSP was legislated in 1984 and added to Medi-Cal program in 1987



### Medi-Cal Managed Care

- 1997: CPSP included in Medi-Cal managed care
- All Medi-Cal Managed Care health plans are required to ensure that their pregnant patients have access to CPSP services



### Title 22 Regulations

- Title 22, California Code of Regulations (CCR), defines the CPSP program requirements
- A copy of regulations are in the CPSP Provider Handbook



### Who Can Become A CPSP Provider?

- Physician (OB/GYN, FP, GP, Pediatrician)
- Medical Group, any of whose members is one of the above physicians
- Certified Nurse Midwife
- Nurse Practitioner (family or pediatric)
- Clinic (hospital, community or county)
- Alternative Birth Center



### CPSP Practitioners

- Physicians (MD, DO)
- Certified Nurse Midwives (CNM)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Registered Nurses (RN)
- Licensed Vocational Nurses (LVN)



### CPSP Practitioners (cont.)

- Social Workers (SW)
- Psychologists (PSY)
- Marriage and Family Therapist (MFT)
- Registered Dietitians (RD)
- Health Educators (HE)
- Certified Childbirth Educators (CCE)



### CPSP Practitioners (cont.)

- Comprehensive Perinatal Health Workers (CPHW)
  - \*At least 18 years old
  - \*High School Diploma or GED
  - \*Minimum one year full time paid perinatal experience



### CPSP in Los Angeles County (LAC)

- Statewide program: 58 counties + 3 cities
- All must follow Title 22 Regulations
- Some differences in different counties/cities
  - o Forms



### LAC CPSP Staff

- Public Health Nurses
  - Perinatal Services Coordinator (PSC)
  - 4 Assistant Coordinators



### LAC Staff (cont.)

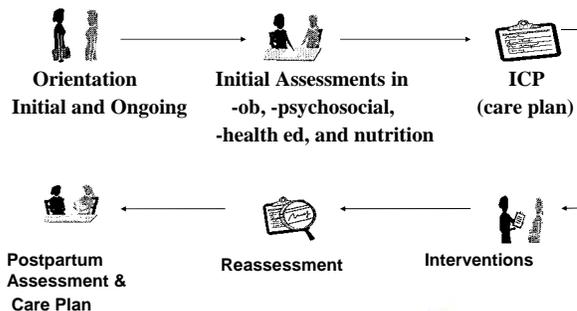
- Support Services Team:
  - Health Educator
  - Health Education Assistant
  - Registered Dietitian
  - Licensed Clinical Social Worker
- Staff Support



### CPSP Scope of Services



### CPSP Scope of Services



## Client Orientation

Keeping the client informed about her pregnancy care and available CPSP Services - *is necessary to best match services to the needs of the client and her family*



## Initial Client Orientation

- What OB, CPSP, and other services will be provided
- Who will provide services
- Where to obtain services
- Client rights and responsibilities
- Danger signs and symptoms
  - What to do /who to call



## Client Orientation

- Orientation to office policies
  - Office hours
  - Making and breaking appointments
- Opportunity to ask questions and express concerns about prenatal care, services, or information provided



## Client Orientation

- Informed consent to procedures
  - Genetic testing, hospital registration
- Information about referrals
  - WIC, dental care, pediatric
- Can be ongoing throughout pregnancy
- Maximum time 2 hours per pregnancy



**CPSP ORIENTATION CHECKLIST** 2

Provider: \_\_\_\_\_  
 Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ EDD: \_\_\_\_\_

Date Discussed	SUBJECT	Handout Completed	
		Yes	No
<input type="checkbox"/>	Perinatal services to be provided (including CPSP)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of provider (See Handout 012301-2)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Who will provide services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of nurse or RN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Where services will be provided	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Where signs of pregnancy start to do if they occur	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout 012301-2	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Patient Rights and Responsibilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout 012301-11	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HIV information/counseling given	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout 7 (see handout 012301-20)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Substances to avoid during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout or RN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Group Classes available	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Fetal movement monitoring (24-28 wks.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Integrated Prenatal Screening (IUI™) (optional lab, 10 week delays 13 weeks/late 15 and 16 weeks/late 17 week delays - 20 week/ delays	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Genetic Risk/Testing	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout or RN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Delivery Site Options	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout or RN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Financial Responsibility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Name of handout or RN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Other Subjects	<input type="checkbox"/>	<input type="checkbox"/>

The information checked above has been reviewed with me and I have had the opportunity to ask questions. I understand that as an active participant in my perinatal care, it is my responsibility to ask questions when I have a concern or problem.

State	Initial Client Signature	Client Signature	Provider/CPSPW Signature	Total Minutes

Revised/Revised/Revised  
August 16, 2011 iath

## Client Orientation

- No consent needed to participate in CPSP
- Patient has the right to decline
  - Document “patient declines” and reason
  - Re-offer at next trimester





## Initial Assessment

To gather baseline data and ask questions designed to identify issues affecting:

- The client’s health and pregnancy
- The client’s readiness to take action
- Resources needed to address the issues

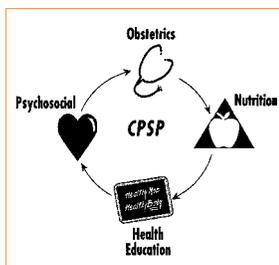


## Areas of Initial Assessment

- Personal Information
- Economic Resources and Housing
- Transportation
- Current Health Practices
- Pregnancy Care
- Educational Interests
- Nutrition
- Coping Skills



## CPSP Components



## Obstetrical (OB) Care

- Obstetrical Services
  - Prenatal care
  - Intrapartum (delivery) care
  - Postpartum Care



## OB Care

- Content of visits are in accordance with current American Congress of Obstetricians & Gynecologists (ACOG) Guidelines for Perinatal Care, and
- Clinic follows ACOG schedule for frequency of visits



## Initial OB Assessment

- Initial pregnancy-related exam is billed with code of (Z1032)
- Includes comprehensive history and physical exam



## Initial CPSP Assessment

- Health Education
- Nutrition
- Psychosocial
- Provide her with information that will help her make informed choices during her pregnancy.



**Prenatal Combined Assessment / Reassessment Tool**

Initial \_\_\_\_\_ 2nd Trimester \_\_\_\_\_ 3rd Trimester \_\_\_\_\_  
(1st 12 weeks) (13-27 weeks) (28 weeks-delivery)

This Prenatal Combined Assessment / Reassessment Tool has received California State Department of Health Services approval and **MAY NOT BE ALTERED**, except to be printed on your logo stationery.

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
 Health Plan: \_\_\_\_\_ Identification No.: \_\_\_\_\_  
 Provider: \_\_\_\_\_ Hospital: \_\_\_\_\_ Location: \_\_\_\_\_  
 Case Coordinator/Manager: \_\_\_\_\_ EDC: \_\_\_\_\_  
 Do:  Old High Risk Condition

**Personal Information**

1. Patient age:  Less than 12 years  12-17 years  18-34 years  35 years or older

2. Are you:  Married  Single  Divorced/Separated  Widowed  Other: \_\_\_\_\_

3. How long have you lived in this area? \_\_\_\_\_ yrs./mos. Place of birth: \_\_\_\_\_

4. Do you plan to stay in this area for the rest of your pregnancy?  Yes  No

5. Years of education completed:  0-8 years  9-11 years  12-16 years  16+ years

6. What language do you prefer to speak:  English  Spanish  Other: \_\_\_\_\_

7. What language do you prefer to read:  English  Spanish  Other: \_\_\_\_\_

8. Which of the following best describes how you read:  
 Like to read and read often  Can read, but read slowly or not very often  Do not read

9. Father of baby: (name) \_\_\_\_\_ His preferred language: \_\_\_\_\_ Education: \_\_\_\_\_ Age: \_\_\_\_\_

10. Was this a planned pregnancy?  Yes  No

11. How do you feel about being pregnant now?  
 Glad  Good  Troubled please explain: \_\_\_\_\_  
 Worried  Distressed please explain: \_\_\_\_\_

12. Are you considering (or) seeking abortion?  No  If Yes, Do you need information/counsel?  No  Yes

13. How does the father of the baby feel about this pregnancy?  
 Your family? \_\_\_\_\_  
 Your friends? \_\_\_\_\_

## Late Entry

- Initial assessment may occur in 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> trimester (*whenever client enters for care*)
- If client enters care in 2<sup>nd</sup> trimester (*wks of GA*), date initial assessment in the “**initial**” space and enter “**N/A**” in the 2<sup>nd</sup> trimester.
- Reassessment must occur in the following trimester.
- **All** questions must be asked (*unless N/A*) and recorded for the appropriate weeks.



## Initial CPSP Assessment

- Assessment information used to develop Individualized Care Plan
- ICP developed from identified problems/risks (shaded areas of assessment/reassessment)  
 > Problems/risks are prioritized with patient





## Initial Health Education

- Is used to identify the client's learning needs as they relate to her pregnancy
- Must contain the following required components




## Initial Health Education

- Current health practices
- Past experience with health care delivery systems
- Prior experience with and knowledge about pregnancy, prenatal care, delivery, postpartum self care, infant care & safety
- Client's expressed learning needs
- Formal education & reading level




## Initial Health Education

- Learning methods most effective for the client
- Educational needs related to diagnostic impressions, problems, and/or risk factors identified by staff
- Languages spoken & written
- Mental, emotional, or physical disabilities that may affect learning
- Mobility/residency




## Initial Health Education

- Religious/cultural influences that impact perinatal health should be identified
- Client and family or support person's motivation to participate in the educational plan should be determined and encouraged






### Initial Nutrition Assessment

- Encourage sound nutrition practices
- Identify women at risk for a poor pregnancy outcome
- Identify who can benefit from nutritional intervention
- Involve four (4) required components





### Frequently Asked Questions

---

- **What is healthy eating for me and my baby ?**  
*-Eating for two? - Food intake -Weight gain ?*
- **Will everything about my routine change ?**  
*-Exercise - Favorite foods -Morning coffee*
- **Why do I sometimes feel so bad?**  
*- Morning sickness - Swelling - Constipation*
- **The baby has arrived . Now what ?**  
*- Weight loss - Breastfeeding*





### Initial Nutrition Assessment

- Anthropometric (*height & weight*)
- Biochemical (*lab tests and values*)
- Clinical (*previous & current OB/Medical risks*)
- Dietary (*food intake*)





## Anthropometric

- Height and weight
- Weight history
- Pre-pregnant weight
- Record weights on grid at each OB visit
- Postpartum weight




## Weight Categories for Pre-pregnancy Weights

	Single	Twins
• Underweight	28 – 40 lbs.	N/A
• Normal weight	25 – 35 lbs	37-54 lbs
• Overweight	15 – 25 lbs	31-50 lbs
• Obese weight	11 – 20 lbs	25-42 lbs



## \*Recommended Rate of Weight Gain

	1 <sup>st</sup> Trimester	2 <sup>nd</sup> /3 <sup>rd</sup> Trimester
		(Per month)
Underweight	-----	4 lbs or more
Normal	-----	3-4 lbs
Overweight	-----	about 2 lbs
Obese	-----	Varies

\*IOM, 2009 Weight Gain During Pregnancy



State of California - Health and Human Services Agency - California Department of Public Health

Name: \_\_\_\_\_

### Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)\*

Weight (lbs)	Underweight	Normal	Overweight	Obese
110				
115				
120				
125				
130				
135				
140				
145				
150				
155				
160				
165				
170				
175				
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350				
355				
360				
365				
370				
375				
380				
385				
390				
395				
400				

Recommended Weight Gain†:

Underweight: 28-40 lbs.    High

Normal: 25-35 lbs.    37-54 lbs.

Overweight: 15-25 lbs.    31-50 lbs.

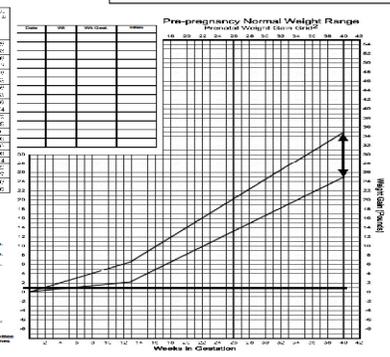
Obese: 11-20 lbs.    25-42 lbs.

Pre-pregnancy Weight: \_\_\_\_\_

Height: \_\_\_\_\_

#### Pre-pregnancy Normal Weight Range

\*Based on 2009 Institute of Medicine (IOM) Recommended Weight Gain During Pregnancy. †Based on 2009 Institute of Medicine (IOM) Recommended Weight Gain During Pregnancy. For more information, visit www.cdc.gov/pregnancy.



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## Biochemical

Review and record nutrition-related lab values

- ✓ Hgb/Hct
- ✓ Urine
- ✓ Glucose
- ✓ Proteins
- ✓ Ketones
- ✓ Mean Corpuscle Volume (MCV)





## Clinical

Assess and Record Nutrition Related Clinical Conditions

- ✓ Acute & Chronic Diseases
- ✓ High parity; Multiple Gestation
- ✓ Anemia ; Age <17
- ✓ Substance Use (alcohol, drugs, tobacco)
- ✓ Previous Low or High Birth Weight
- ✓ Others .....




## Dietary

### ASSESS

#### Discomforts / Cravings

- Food & Beverage
  - Eating Patterns / Allergies
  - Availability / Preparation
  - Safety / Storage / OTC Meds
- Eating Disorders / Vegetarian
- Infant Feeding Plan
- Food Intake: Quantity & Quality
- WIC Participation




### Daily Food Guide for Pregnant/Breastfeeding Women

Food Groups	Recommended Minimum Servings – Daily
Meat / Protein Foods	3
Milk Products	3
Breads, Cereals & Grains	7
Fruits and Vegetables : Vitamin C-rich	1
Fruits and Vegetables: Vitamin A-rich	1 (2-3 per week)
Fruits and Vegetables : Others	3
Unsaturated Fats	3



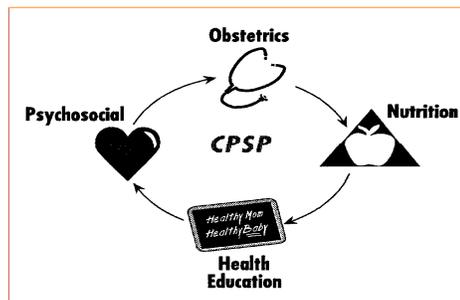


## CPSP Psychosocial Component

- What are some psychosocial issues that a woman may experience during her pregnancy?



## Components of CPSP



## Psychosocial Component



- Psychosocial services help patient understand and deal effectively with biological, emotional, and the social stressors of pregnancy
- Goal: Healthy moms and babies



## Psychosocial Component

### Assessment required to contain the following:

- Personal adjustment to pregnancy
- Wanted or unwanted pregnancy
- Acceptance of pregnancy



## Psychosocial Component

- Substance use, abuse or dependency
- Housing/household situation
- Current status including social support system



## Psychosocial Component

- Education
- Employment
- Financial and material resources



## Psychosocial Component

- History of previous pregnancies
- General emotional status and history
- Patient's goals for herself in this pregnancy



### Prenatal Combined Assessment / Reassessment Tool

Initial (1st Trimester) \_\_\_\_\_ 2nd Trimester (14-27 weeks) \_\_\_\_\_ 3rd Trimester (28 weeks-current) \_\_\_\_\_

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Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Health Plan: \_\_\_\_\_ Identification No: \_\_\_\_\_

Provider: \_\_\_\_\_ Hospital: \_\_\_\_\_ Location: \_\_\_\_\_

Case Coordinator/Manager: \_\_\_\_\_ EDC: \_\_\_\_\_

Dr. CD High Risk Condition: \_\_\_\_\_

**Personal Information**

1. Patient age:  Less than 12 years  12-17 years  18-34 years  35 years or older

2. Are you:  Married  Single  Divorced/Separated  Widowed  Other: \_\_\_\_\_

3. How long have you lived in this area? \_\_\_\_\_ yrs. min. Place of birth: \_\_\_\_\_

4. Do you plan to stay in this area for the rest of your pregnancy?  Yes  No

5. Years of education completed:  0-8 years  9-11 years  12-16 years  16+ years

6. What language do you prefer to speak:  English  Spanish  Other: \_\_\_\_\_

7. What language do you prefer to read:  English  Spanish  Other: \_\_\_\_\_

8. Which of the following best describes how you read:  
 Like to read and read often  (CD) Read, but read slowly or not very often  Do not read

9. Father of baby: (name) \_\_\_\_\_ His preferred language: \_\_\_\_\_ Education: \_\_\_\_\_ Age: \_\_\_\_\_

10. Was this a planned pregnancy?  Yes  No

11. How do you feel about being pregnant now?  
 Satisfied  Good  Troubled, please explain: \_\_\_\_\_  
 Not satisfied  Good  Troubled, please explain: \_\_\_\_\_  
 Not satisfied  Good  Troubled, please explain: \_\_\_\_\_

12. Are you considering (or) seeking abortion?  No  Yes Do you need information/referrals?  No  Yes

13. How does the father of the baby feel about this pregnancy?  
 Your family? \_\_\_\_\_  
 Your friends? \_\_\_\_\_

## Psychosocial Assessment

The psychosocial process assists the patient with:

- Community resources
- Emotional concerns
- Crisis intervention



## Psychosocial Component

- Let's discuss . . .
- What psychosocial issues listed are high risk, moderate risk and low risk ?



## Importance of Relationship

Let's discuss . . .

- Think about the first time you went to a new doctor for medical appointment. . .
- Was there anything provider did that made you comfortable to share personal information?



## Importance of Relationship

- She comes to trust you
- You can support her, and help her find her inner strengths
- She won't be judged, criticized, ignored, laughed at or labeled
- You can educate and inform her prenatal and postpartum care



## Importance of Relationship

- May need extra time to process what you are asking, may not be sure how much to share on first visit
- You are patient's partner in maximizing her care and cannot make her do anything



## Key Points for Interviewing

- Setting should assure confidentiality
- Keep all notes, lists, or charts involving the patient in a locked space when not in use
- Have a phone and resource list available



## Key Points for Interviewing

- Ask open-ended questions
- If asked in a sensitive, straightforward manner, most patients are willing to answer
- Many patients are relieved to discuss problems with a helpful, caring person



## Key Points for Interviewing

- Try to put the patient at ease by explaining the purpose of the assessment
- Adopt a non-judgmental, accepting, relaxed attitude
- Be aware of your own attitudes & ways your own personal history affects your ability to serve your patients



## Listening

- Verbal
- Non-verbal



## Non-Verbal Listening

- Accounts for 80% of communication
  - Communicate without words: heart rate, perspiration, labored breathing
  - Facial expressions and eye movements



## Listening Styles

- **Passive listening:** responsive listening, using nods, smiles, uhum, yes of course
- **Biased listening:** selective listening, not able to listen to the patient's views
- **Active listening:** gathering facts
- **Empathic listening:** understanding, checking facts and feelings, helping with patients needs
  - Listening Types by Allen Campbell



## Empathy

**The ability to put oneself in the shoes of another person and experience events and emotions the way that person experienced them**

- Batson



## Empathy

- Empathic listening aligns us with patient and crucial for effective understanding and communication
- Listen with full attention
- Consider cultural/ethnic aspects
- See and feel from patient's viewpoint
- Summarize to verify understanding



## High Risk Situations and Mandated Reporting



## Psychosocial High Risk Situations

- Seek help from supervisor, consultant, medical provider before patient leaves office
- Train all staff before crisis occurs
- Provider may designate you assist patient in accessing referrals



## Mandated Reporting

- May want to inform patient that you are a mandated reporter at beginning of assessment
- Clearly understand situations that must be reported to authorities



## Mandated Reporting

1. A minor patient reports to you that she is being abused, or a child is being harmed, or in danger of being abused or you suspect is being abused
2. You suspect a patient is suffering from physical injuries from a firearm, assault, or abusive conduct



## Mandated Reporting

3. You suspect an elder adult (age 65 and older) and/or a dependent adult (disabled, ages 18-64) who is unable to meet their own needs is a victim of abuse, neglect or exploitation



## Child Abuse

- Any act of commission/omission by adult that results in harm, potential for harm, or threat of harm to a child
- If suspect child being physically, sexually, emotionally abused and/or neglected (Penal code 11164-11174.3)
- Consult with Provider immediately
- Call Child Abuse Hot Line: 800-540-4000 or law enforcement immediately
- Complete "Suspected Child Abuse Report": SS8572



Print		SUSPECTED CHILD ABUSE REPORT		Reset Form		
To Be Completed by Mandated Child Abuse Reporters Pursuant to Penal Code Section 11166				CASE NAME: _____		
PLEASE PRINT OR TYPE				CASE NUMBER: _____		
A. REPORTING PARTY	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY	
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip			DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	REPORTER'S TELEPHONE (DAYTIME)	SIGNATURE		TODAY'S DATE		
B. REPORT NOTIFICATION	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION		AGENCY			
	<input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services)					
	ADDRESS Street City Zip			DATE/TIME OF PHONE CALL		
OFFICIAL CONTACTED - TITLE			TELEPHONE ( )			
C. VICTIM <i>One report per victim</i>	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY	
	ADDRESS Street City Zip		TELEPHONE ( )			
	PRESENT LOCATION OF VICTIM		SCHOOL	CLASS	GRADE	
	PHYSICALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME	
	IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME			TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)	
	RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THE VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		

D. INVOLVED PARTIES	
VICTIMS	1. NAME BIRTHDATE SEX ETHNICITY
	2. NAME (LAST, FIRST, MIDDLE) BIRTHDATE OR APPROX. AGE SEX ETHNICITY
	ADDRESS Street City Zip HOME PHONE BUSINESS PHONE
	3. NAME (LAST, FIRST, MIDDLE) BIRTHDATE OR APPROX. AGE SEX ETHNICITY
PARENT(S)/GUARDIAN(S)	ADDRESS Street City Zip HOME PHONE BUSINESS PHONE
	4. NAME (LAST, FIRST, MIDDLE) BIRTHDATE OR APPROX. AGE SEX ETHNICITY
	ADDRESS Street City Zip HOME PHONE BUSINESS PHONE
	SUSPECT'S NAME (LAST, FIRST, MIDDLE) BIRTHDATE OR APPROX. AGE SEX ETHNICITY
SUSPECT	ADDRESS Street City Zip TELEPHONE
	OTHER RELEVANT INFORMATION
E. INCIDENT INFORMATION	
# NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX [ ] # MULTIPLE VICTIMS, INDICATE NUMBER	
DATE / TIME OF INCIDENT	PLACE OF INCIDENT
NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)	

SS 8572 Rev. 12/03 DEFINITIONS AND INSTRUCTIONS ON REVERSE  
**DO NOT** submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.  
 WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY-District Attorney's Office; YELLOW COPY-Reporting Party

## Assault/ Intimate Partner Violence

- Any health practitioner, who provides medical services for a physical condition to a patient whom s/he knows, or reasonably suspects suffering from injuries of firearm or assaultive or abusive conduct, is required to make a report  
(Penal Code 11160-11163.6)
- Look in protocols, Steps to Take
- Consult with provider immediately



## Assault/ Intimate Partner Violence

- On CPSP Assessment, two or more “yes” answers to questions # 100-107 complete “Lethality Assessment”
  - Provider should complete this
  - Demonstrates the level of danger patient in currently and that she may need assistance immediately



## Assault/ Intimate Partner Violence

- |                          |                          |   |
|--------------------------|--------------------------|---|
| YES                      | NO                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has the physical violence increased in frequency over the past year?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has the physical violence increased in severity over the past year and/or has a weapon been used?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has s/he ever tried to choke you?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is there a gun in the house?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has s/he ever tried to force you into sex?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Does s/he use drugs? By drugs I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs, heroin, or mixtures.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Does s/he threaten to kill you, and/or do you believe s/he is capable of killing you?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is s/he drunk every day or almost everyday? (In terms of quantity of alcohol.)   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Does s/he control most of your daily activities? For instance, does s/he tell you who you can be friend with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him/her, check here <input type="checkbox"/> ) |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever been beaten by him when you were pregnant? (if never pregnant by him, check here <input type="checkbox"/> )   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Is s/he violently and constantly jealous of you? (For instance, does s/he say, "If I can have you, no one can")   |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever been threatened or tried to commit suicide?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Has s/he ever threatened or tried to commit suicide?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Is s/he violent outside of the home?  |

**DOMESTIC VIOLENCE**

DV Screen

DV - (Positive)

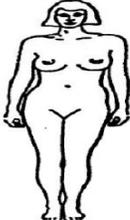
DV - (Disputed)

Date: \_\_\_\_\_ ID # \_\_\_\_\_

Time: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_




\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CALIFORNIA EMERGENCY MANAGEMENT AGENCY  
SUSPICIOUS INJURY REPORT**  
CaEMA 2-920 (4/10/09)

STATE OF CALIFORNIA

**INFORMATION DISCLOSURE**

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

**Part A: PATIENT WITH SUSPICIOUS INJURY**

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	4. SAFE PHONE NUMBER ( )
5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt. - NO P.O. Box)		City	State Zip
6. PATIENT SPEAKS ENGLISH <input type="checkbox"/> Y <input type="checkbox"/> N - Identify language spoken		7. DATE AND TIME OF INJURY Date Time <input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> Unknown	
8. LOCATION ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE - Check here if unknown: <input type="checkbox"/>			
9. PATIENT'S COMMENTS ABOUT THE INCIDENT - Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident.			<input type="checkbox"/> ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT - If identified by patient	11. RELATIONSHIP TO PATIENT, IF ANY
12. SUSPICIOUS INJURY DESCRIPTION - include a brief description of physical findings and the final diagnosis. <input type="checkbox"/> ADDITIONAL PAGES ATTACHED	
<b>Part B: REQUIRED - AGENCIES RECEIVING PHONE AND WRITTEN REPORTS</b>	
13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11163)	14. DATE AND TIME REPORTED Date Time <input type="checkbox"/> am <input type="checkbox"/> pm
15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE
17. PHONE NUMBER ( )	18. AGENCY INCIDENT NUMBER
<b>Part C: PERSON FILING REPORT</b>	
20. EMPLOYER'S NAME	21. PHONE NUMBER ( )
22. EMPLOYER'S ADDRESS (Number and Street)	City State Zip
23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE
25. HEALTH PRACTITIONER'S SIGNATURE	26. DATE SIGNED

## Assault/ Intimate Partner Violence

- Call Law Enforcement immediately
- Complete "Suspicious Injury Report", CaEMA 2-920
  - Report to be completed within 48 hours
- Mandated to report even if patient states different story or denies abuse
- Clinic does not have to inform patient that report being made, but suspicious injury/abuse must be reported




## Liability Issues for Reporting



- Reporting
  - Immunity with reporting as long as no evidence of bad faith reporting
- Not Reporting
  - Misdemeanor charges
  - \$1000 fine
  - Six months in jail
  - Subject to civil suit



## High Risk Situations

- Patient danger to self, others, or gravely disabled
  - Call PMRT (Psychiatric Mobile Response Team) or law enforcement
  - ACCESS LINE: 800.854.7771
  - LAPD Dispatch: 877.275.5273 (877.ASK.LAPD)
- Makes a serious threat to kill another person
- Seek help from supervisor
- Document what happened and authorities contacted
- Provider to see patient as soon as possible



## Was It Consensual Sex ?

- It is not: when coerced, or in any other way not voluntary
- Based on age difference between partners
  - Do I need to get the age of minor's sexual partner for reporting purposes ?
  - What if I'm not sure whether to report ?
- Let's Discuss . . .



### 2. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND PATIENT IN A FEW SITUATIONS

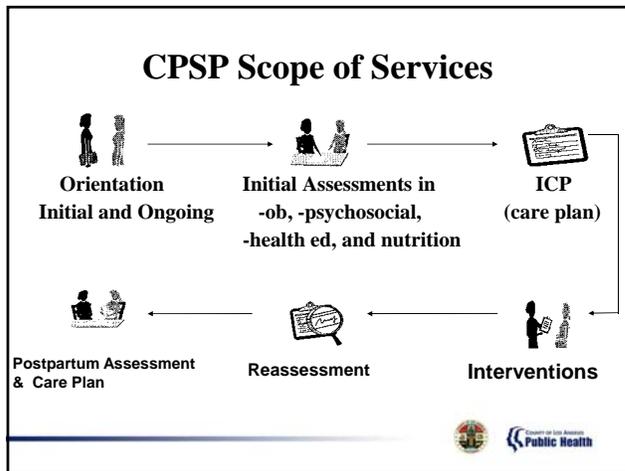
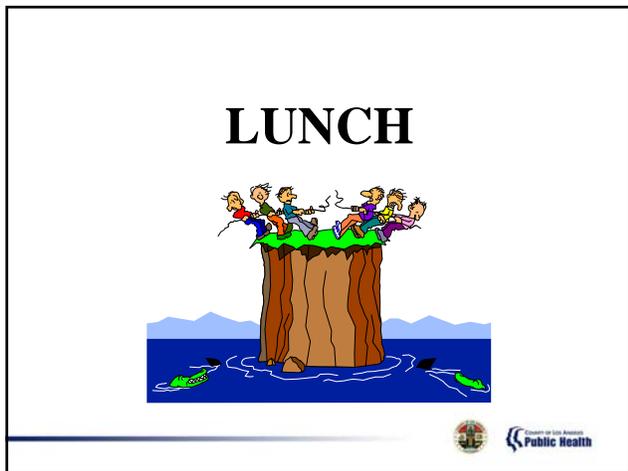
Mandated reporters also must report based on the age difference between the patient and his or her partner in a few circumstances, according to the following chart:

**Key:** M = Mandated. A report is mandated based solely on age difference between partner and patient.  
**CJ** = Clinical Judgment. A report is not mandated based solely on age; however, a reporter must use clinical judgment and must report if he or she has a reasonable suspicion that act was coerced, as described above.

Age of Partner ⇨	12	13	14	15	16	17	18	19	20	21	22 and older
Age of Partner ↓											
11	CJ	CJ	M	M	M	M	M	M	M	M	M ⇨
12	CJ	CJ	M	M	M	M	M	M	M	M	M ⇨
13	CJ	CJ	M	M	M	M	M	M	M	M	M ⇨
14	M	M	CJ	M	M ⇨						
15	M	M	CJ	M	M ⇨						
16	M	M	CJ								
17	M	M	CJ								
18	M	M	CJ	CJ	CJ	CJ					
19	M	M	CJ	CJ	CJ	CJ					
20	M	M	CJ	CJ	CJ	CJ					
21 and older	M	M	M	M	CJ	CJ					

Chart design by David Koepf, LCSW, UCSF.  
 (The legal source for this chart are as follows: Penal Code §§ 111651.1; 261.5; 261.259 Cal. Rptr. 762, 769 (1<sup>st</sup> Dist. Ct. App. 1989); 226 Cal. Rptr. 2d 361, 381 (1<sup>st</sup> Dist. Ct. App. 1986); 73 Cal. Rptr. 2d 331, 333 (1<sup>st</sup> Dist. Ct. App. 1998).)





### Resources

- Provider Handbook
- CPSP Prenatal Protocols and Postpartum Protocols
- Steps to Take Guidelines (STT)

County of Los Angeles  
Public Health

### Individualized Care Plan (ICP)

- Systematic way to prioritize problems, plan interventions, and track progress
- Coordinates care by all staff
- Serves as a self-management tool for the client

County of Los Angeles  
Public Health

## ICP Requirements

- Identification of risks
- Proposed interventions
- Outcome information
- Staff responsible
- Strengths
- Timeframe
- Developed in consultation with the patient



## Individualized Care Plan (ICP)

- Includes obstetrical, health education, nutrition, and psychosocial risks throughout pregnancy and postpartum



## Individualized Care Plan (ICP)

- All problems identified in assessments and reassessments should be addressed
- Staff & patient perceptions may differ
- Update ICP throughout pregnancy and postpartum



## Individualized Care Plan (ICP)

- Summary of the assessment process
- Must be done with the patient present
- Useful tool for case conferences
- All team members should review and ensure accuracy of plan and consistency of messages

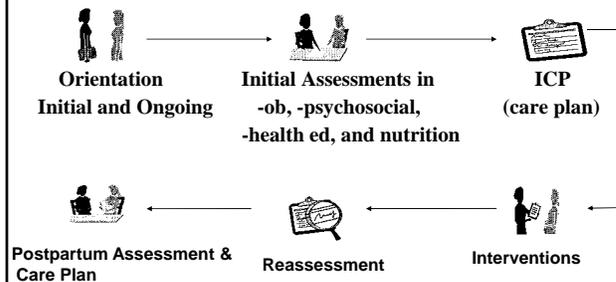


## Individualized Care Plan (ICP)

- The ICP:
  - **is not** a progress note
  - is a brief summary of patient problems and interventions
- For high risk patients, details of interventions and referrals should be described in a progress note



## CPSP Scope of Services



## Interventions

- Actions intended to reduce or eliminate risks
- Education, counseling, referrals, procedures
- Individual or group



## Reassessments

- Identify new risks
- Re-evaluate risks in previous trimesters
- Face-to-face with the client



## Reassessments

- Must be done each trimester and postpartum and must include:
- **Nutrition assessment**
  - Including Perinatal Food Frequency Questionnaire or 24 Hour Diet Intake
- **Health Education**
- **Psychosocial**



## Reassessments

- Document on CPSP Assessment/Reassessment form and/or in the progress note
- Update ICP at least each trimester and postpartum:
  - Progress on previous risks
  - New problems added



## Postpartum Assessment

- Review prenatal assessments, delivery record, and ICP
- Complete a postpartum assessment for:
  - Health Education
  - Nutrition
  - Psychosocial



**COMPREHENSIVE PERINATAL SERVICES PROGRAM  
COMBINED POSTPARTUM ASSESSMENT**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ I.D. No. \_\_\_\_\_  
 Health Plan: \_\_\_\_\_ Provider: \_\_\_\_\_ Delivery Facility: \_\_\_\_\_

**Anthropometric:**  
 1. Height \_\_\_\_\_ 2. Desirable Body Wt. \_\_\_\_\_ 3. Total Pregnancy Wt. Gain \_\_\_\_\_ 4. Wt. loss visit \_\_\_\_\_  
 5. Prepregnant wt. \_\_\_\_\_ 6. Postpartum Wt. \_\_\_\_\_ 7. Weeks Postpartum this visit \_\_\_\_\_

**Biochemical:**  
 8. Hemoglobin: (Hb) \_\_\_\_\_ 9. Hematocrit: (Hct) \_\_\_\_\_ Other: \_\_\_\_\_  
 10. Glucose: (G) \_\_\_\_\_ 11. Reticulocytes: (R) \_\_\_\_\_ 12. Protein: (P) \_\_\_\_\_ Other: \_\_\_\_\_  
 13. Blood Phosphorus: (P) \_\_\_\_\_ Comments: \_\_\_\_\_

**Clinical - Outcome of Pregnancy:**  
 14. Date of Birth: \_\_\_\_\_ 15. Gestational Age: \_\_\_\_\_ 16. Pregnancy/Delivery Complications: \_\_\_\_\_  
 17. Birth Weight (gms) \_\_\_\_\_ 18. Birth Length (cm) \_\_\_\_\_ 19. Apgar Scores: 1 min: \_\_\_\_\_ 5 min: \_\_\_\_\_  
 20. Current Weight (gms) \_\_\_\_\_ 20. Current Length (cm) \_\_\_\_\_  
 21. Type of Delivery: (mode) \_\_\_\_\_ (VAC) \_\_\_\_\_ (Forceps) \_\_\_\_\_ (C-section) (reason or reason) (NICU or Cesarean)

**Maternal** **Infant**  
 22. Have you had your postpartum check-up? (Yes) \_\_\_\_\_ (No) \_\_\_\_\_ when scheduled? \_\_\_\_\_  
 23. Any health problems since delivery? (Yes) \_\_\_\_\_ (No) \_\_\_\_\_ if Yes, any Problems? \_\_\_\_\_  
 If YES, please explain: \_\_\_\_\_ 24. Has infant had a newborn check-up? \_\_\_\_\_  
 25. Number of NICU Days: \_\_\_\_\_ 26. Infant exposure to: (smoke at all ages) \_\_\_\_\_  
 Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Drugs: \_\_\_\_\_

**Nutrition:**  
 27. Maternal Dietary Assessment: For \_\_\_\_\_  
 Dietary Goals: \_\_\_\_\_  
 Client agrees to: \_\_\_\_\_

Food Group	Serve/Portion	Suggested Change
Fruits	_____	_____
Milk Products	_____	_____
Breads/Cereals/Grains	_____	_____
Vegetables	_____	_____
Other	_____	_____

28. Infant: Diet adequate as assessed: (Yes) \_\_\_\_\_ (No) \_\_\_\_\_ Excessive: (Caffeine) \_\_\_\_\_  
 Method of Feeding: (Breast) \_\_\_\_\_ (Bottle) \_\_\_\_\_ (Bread & Butter) \_\_\_\_\_ # Wet diapers/day? \_\_\_\_\_  
 Type of Formula: (With Iron?) (Yes) \_\_\_\_\_ (No) \_\_\_\_\_ or \_\_\_\_\_ (Brand/Day)

CPSP Combined Postpartum Assessment 108

**Psycho-Social**

30. Do you feel comfortable in your relationship with your baby?  Yes  No

31. Any special concerns? \_\_\_\_\_

32. Are you experiencing postpartum blues?  Yes  No

33. Have your household members adjusted to your baby?  Yes  No

34. Has your relationship with the baby's father changed?  Yes  No

35. Do you have the resources to assist in maintaining the health of you and your baby?  Yes  No

36. If "No", indicate where needs exist:  Housing  Financial  Food  Family  Other \_\_\_\_\_

Outstanding Issues from Prenatal Assessment/Reassessment: \_\_\_\_\_

**Health Education**

37. If breast feeding:  
 Do you have enough milk?  Yes  No  
 Do you experience with formula?  Yes  No  
 Does your baby take the breast easily?  Yes  No  
 Are your nipples cracked and/or sore?  Yes  No

38. Do you have any questions about breast feeding?  Yes  No

39. Do you have any questions about timing or feeding formula?  Yes  No

40. Do you have any questions about your baby's health?  Yes  No

If "Yes", please explain: \_\_\_\_\_

41. Do you have any questions about your baby's safety?  Yes  No

If "Yes", please explain: \_\_\_\_\_

42. Are you using, or planning to use, any method of birth control?  Yes  No

If "Yes", which one? \_\_\_\_\_

If "No", would you like further information?  Yes  No

**Plan:**  
 Client goals, interventions and Timeline  
 Client agrees to: \_\_\_\_\_

**Referrals:**  
 Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_

**Materials Given:**  
 Birth Control  Infant Feeding  Infant Care  Infant Safety  \_\_\_\_\_  
 \_\_\_\_\_

**Summary:**  
 Date: \_\_\_\_\_ Interviewer: \_\_\_\_\_ Title: \_\_\_\_\_ Minutes Spent: \_\_\_\_\_

Copy of Individualized Care Plan sent to Patient's PCP on: (date) \_\_\_\_\_ by (name and title) \_\_\_\_\_

ICP/ Postpartum Assessment 108 

## Postpartum ICP

- Update existing ICP
- Note problems which have resolved since delivery
- Add new problems from postpartum assessment




## Interconception Care

- Interconception = between pregnancies
- The postpartum assessment and ICP are the first steps toward interconception care








## Interconception Care

- By helping the patient identify postpartum risks and ways to resolve them, you are helping her with “interconception care” (care between pregnancies)






### Case Coordination

- Implementation of a system for planning & ensuring the provision of comprehensive perinatal services to the patient
- The formal system of record keeping
- Communication among staff & other providers
- The involvement of all aspects of patient care & all practitioners



### STT Scavenger Hunt Activity



**BREAK !**



### CPSP Documentation and Billing



## Documentation and Billing Overview

- Only state-approved providers may bill
- Services must be provided by an approved CPSP practitioner
- Date of service must be between conception and end of the month in which the 60<sup>th</sup> postpartum day occurs



## Documentation and Billing Overview

- Billed using the appropriate procedure code
- Only services as specified in the CPSP regs
- If it's not documented the assumption is that no service was provided



## Documenting CPSP Services

### Forms in Chart:

- Client Orientation Checklist (optional)
- Initial Assessment/Reassessment Forms
- Individualized Care Plan (ICP)
- Perinatal Food Frequency Questionnaire (PFFQ)
  - one per trimester and postpartum



## Documenting CPSP Services

### Forms in Chart:

- Appropriate weight gain grid
  - Based on pre-pregnancy weight
- Postpartum assessment and postpartum ICP
- Progress Note
  - For documentation of services/education



## Reporting Application Changes

- Notify local CPSP office of any changes
  - Required forms
    - Initial assessments, reassessments, pp assessment
    - Individualized Care Plan
  - Staff
  - General Description of Practice
  - Agreements for delivery or CPSP support services



## Documenting CPSP Services

- A brief description of the service provided
- First initial, last name & CPSP title
- The date of service
- The length of time in minutes
- The service provided must be done with the client present (“face to face”)



## Group Education Documentation

- A group consists of two or more patients
- Group education is optional
- Must submit a lesson plan to local CPSP office
- Must have a sign in sheet for all classes



## Group Education Documentation

- Use of videos
  - Cannot be the entire class
  - Must be appropriate to content of class
  - Approved practitioner must be present throughout video



## Group Education Documentation

- Lesson plan on file in provider office
- Sign in sheets on file
  - Do not keep copies in patient charts
  - Title of class, date, name/title of instructor, total class time in minutes, signatures of attendees
- Document attendance in client chart: name of class, date, actual time client spent



## Billing Basics

- Only face-to-face service is billable
- Cannot bill services marketed as “free” to community
- Obstetrical services
  - By visit
  - Global – at least 4 ob visits and provided total ob care for patient
- CPSP support services – by visit billing only



## Billing Basics

- In accordance with the instructions in the Medi-Cal Billing Manual for Medi-Cal OB/CPSP
- [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)
- Submit claims within 6 months of service
- Contact Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555



## CPSP Billing

- Support services billed in 15-minute units
- Minimum 8 minutes
- Range for units



### CPSP Billing

UNITS	TIME (MIN.)	RANGE (Min.)*
1	15	8-22
2	30	23-37
3	45	38-52
4	60	53-67

\*Range = Time ± 7 minutes

Ex: 2 units = 30 minutes (30-7=23 and 30+7=37)



### CPSP Reimbursement\*^

- Individual services \$33.64/hr 23 hrs
- Group classes \$11.24/pt/hr 27 hrs
- Case Coordination \$85.34 in Z6500
- Prenatal vitamins \$30 300-day supply

\*TAR required for additional units of service

^Rates are for fee-for-service Medi-Cal only; do not apply to FQHC or Managed Care



#### COMPREHENSIVE PERINATAL SERVICES PROGRAM

##### Service Codes and Reimbursement Schedule

The following are the Comprehensive Perinatal Provider service codes effective August 1, 2009 for Nutrition, Health Education, and Psychosocial services.

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement <sup>1</sup>
Z6500 <sup>1</sup>	Initial Comprehensive Nutrition, Psychosocial, and Health Education Assessments and Development of Care Plan within 4 weeks of entry into care <sup>1</sup> , individual, first 30 minutes of each Assessment (60 minutes total), including ongoing coordination of care. Initial pregnancy-related exam (Z1022) must also be completed within this 4-week period.	Initial CPSP Assessment completed within 4 weeks of Initial Prenatal Exam (Z1032). This 90 minutes is for Health Educ., Nutrition, and Psychosocial initial assessment time only - does not include Client Orientation.	1	\$135.83	\$135.83
NUTRITION CODES					
Z6200	Initial Nutrition Assessment and Development of Care Plan, Individual, first 30 minutes.	For first 30 minutes of Initial Nutrition Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	\$16.83	\$16.83
Z6202	Initial Nutrition Assessment and development of Care Plan, Individual, each Subsequent 15 minutes (Maximum of 1.5 hours)	1) Time spent doing initial assessment exceeded 30 minutes in nutrition component (either Z6200 or Z6202 code) 2) A/Emergency new problem diagnosed later in pregnancy requiring a new nutrition assessment, e.g. gestational diabetes.	6	\$6.41	\$50.46
Z6204	Follow-up Antenatal Nutrition Assessment, Treatment, and/or Intervention, Individual, each 15 minutes	Trimester reassessments, appropriate counseling, such as by RD consultant.	8	\$6.41	\$67.28

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Z6206	Follow-up Antenatal Nutrition Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 3 hours)	Nutrition information provided in a group class.	12	\$2.81	\$33.72
Z6208	Postpartum Nutrition Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1 hour)	1) Postpartum nutrition assessment, 2) Postpartum nutrition intervention, e.g. assistance with breastfeeding.	4	\$6.41	\$33.64
50197	Prenatal Vitamins, 30 day supply	When provider dispenses prenatal vitamins.	10	\$3.00	\$30.00
PSYCHOSOCIAL CODES					
Z6300	Initial Psychosocial Assessment and Development of Care Plan, Individual, first 30 minutes	For first 30 minutes of Initial Psychosocial Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	\$16.83	\$16.83
Z6302	Initial Psychosocial Assessment and Development of Care Plan, Individual, each subsequent 15 minutes (Maximum of 1.5 hours)	1) Time spent doing initial assessment exceeded 30 minutes in psychosocial component (either Z6300 or Z6302 code) 2) A/Emergency new problem diagnosed later in pregnancy requiring a new psychosocial assessment, e.g. domestic violence.	6	\$6.41	\$50.46
Z6304	Follow-up Antenatal Psychosocial Assessment, Treatment, and/or Intervention, Individual, each 15 minutes (Maximum of 3 hours)	Trimester assessment, (antepartum) counseling or other intervention, such as by social work consultant.	12	\$6.41	\$100.92
Z6306	Follow-up Antenatal Psychosocial Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 4 hours)	Psychosocial information provided in a group class.	16	\$2.81	\$44.96
Z6308	Postpartum Psychosocial Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1.5 hours)	1) Postpartum psychosocial assessment, 2) Postpartum psychosocial intervention, e.g. postpartum depression.	6	\$6.41	\$50.46

2 of 4



HEALTH EDUCATION CODES					
26400	Client Orientation, Individual, each 15 minutes (Maximum of 2 hours)	Initial individual orientation (required, orientation required during pregnancy, e.g. when patient is referred to hospital for non-stress test.	8	\$8.41	\$67.28
26402	Initial Health Education Assessment and Development of Care Plan, Individual, first 30 minutes	For first 30 minutes of initial Health Education Assessment when Initial CPSP Assessment not completed within 4 weeks of initial Prenatal Exam (Z1032).	1	\$16.63	\$16.63
26404	Initial Health Education Assessment and Development of Care Plan, Individual, each subsequent 15 minutes (Maximum of 2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in health education component (either Z1030 or Z1032 used); 2) identify new problem diagnosed later in pregnancy requiring a new health education assessment.	8	\$8.41	\$67.28
26406	Follow up Antepartum Health Education Assessment, Treatment, and/or Intervention, Individual, each 15 minutes (Maximum of 2 hours)	Transverse assessment, additional counseling or other intervention, such as by health education consultant.	8	\$8.41	\$67.28
26408	Follow up Antepartum Health Education Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 2 hours)	Health education provided in a group class.	8	\$2.81	\$22.48
26414	Postpartum Health Education Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1 hour)	1) Postpartum health education assessment; 2) Postpartum health education intervention.	4	\$8.41	\$33.64

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PERINATAL EDUCATION CODES (Can be used antepartum or postpartum)					
26410	Perinatal Education, Individual, each 15 minutes (Maximum of 4 hours)	Individual education provided prenatally or postpartum.	16	\$8.41	\$134.56
26412	Perinatal Education, Group, per patient, each 15 minutes (Maximum 4 hours/day, 10 hours/pregnancy)	Group education, e.g. childbirth education (Lamaze)	72	\$2.81	\$202.32
CPSP OR BONUSSES					
Z1032-ZL	Initial Comprehensive Pregnancy-related office visit performed within 16 weeks of LMP	Initial prenatal exam done prior to 16 weeks LMP - if non-physician practitioner (NP, PA, CNM) does exam, see MFC Provider Manual for appropriate modifier.	1	\$56.63	\$56.63
Z1036	Tenth Antepartum Office Visit	One time only when 10 <sup>th</sup> antepartum visit performed.	1	\$113.26	\$113.26

<sup>1</sup> Additional reimbursement is subject to prior approval using a Medi-Cal Treatment Authorization Request (TAR).

<sup>2</sup> If Z1030 is used, codes Z1030, Z1030, and Z1042 cannot be used because the first 30 minutes of each assessment is already included in Z1030. However, additional initial assessment time can be billed under codes Z1032, Z1032, or Z1044.

<sup>3</sup> Entry into care is the time of the first billable pregnancy-related office visit or initial support service assessment.

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Rev. 5/16/11

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## Use of Billing Modifiers

- No modifiers required for CPSP support services
- Non-physician medical practitioners (CNM, NP, PA) must use correct modifier for medical services
- Multiple modifier (99) used when CNM, NP, PA do initial prenatal exam with early entry bonus (Z1032-ZL)



## Use of Billing Modifiers

- Billing ZL modifier when Z1032 done by non-MD
  - Bill as Z1032-99
  - CNM 99 = SB + ZL
  - NP 99 = SA + ZL
  - PA 99 = U7 + ZL



**Summary of CPSP Medi-Cal Billing**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ MR#: \_\_\_\_\_

CPSP Patient Billing	Billing Code	Number of Units Used (1 Unit = 15 Minutes) <i>Please Report and Check Each Unit Used per Visit</i>
Obstetrical (4 Visits)	21632	
Initial Pregnancy	21632	
2-3rd Trimester (3-6 weeks LMP)	21632	Modifier for use with 21632 only
4-6th Trimester	21632	
7th-9th Trimester	21632	After initial visit and 2 antepartum
Postpartum	21632	
Postnatal Visit (at 30c)	26210	
<b>CPSP Services</b>		
Initial Group Assess	26400	* All 3 completed within 4 weeks of Initial Prenatal Visit (21032)
1. Health Education - 30 Min - 15c	26400	
2. Nutrition - 30 Min - 15c	26400	
3. Psychosocial - 30 Min - 15c	26400	
<b>Nutrition</b>		
Initial Assessment - Indiv 30 min	26200	Don't use if 26200 billed
Subj Indiv Assess - Indiv 15 min	26202	
PAI Interview/Response - Indiv 2 hrs	26204	
PAI Interview - Group 2 hrs	26206	
Implementation - Indiv 1 hr	26208	
<b>Psychosocial</b>		
Initial Assessment - Indiv 30 min	26200	Don't use if 26200 billed
Subj Indiv Assess - Indiv 15 min	26202	
PAI Interview/Response - Indiv 2 hrs	26204	
PAI Interview - Group 2 hrs	26206	
<b>Health Education</b>		
Client Orientation - Indiv 2 hrs	26400	
Initial Assessment - Indiv 30 min	26200	Don't use if 26200 billed
Additional Indiv Assess - Indiv 2 hrs	26404	
PAI Interview/Response - Indiv 2 hrs	26406	
PAI Indiv Assessment - Group 2 hrs	26408	
Postpartum - Indiv 1 hr	26210	
<b>Perinatal Education - Indiv 4 hrs</b>		
Perinatal Education - Indiv 4 hrs	26410	
<b>Perinatal Education - Group 18 hrs</b>		
Perinatal Education - Group 18 hrs	26412	

## CPSP Billing

- Z1032 is billable separately, even with global
- Client Orientation (Z6400) is billed separately from Initial CPSP Assessment time
- Avoid “cookie cutter” documentation
  - Risk conditions
  - Minutes
- Make sure documentation justifies billing



Let's Practice!!



## Federally Qualified Health Centers (FQHC)

- Documentation the same as fee-for-service
- Do not spread out services on multiple days
- Bill using Code 01 for all services
- Group classes – bill for one patient only
- Same maximum service allowances as ffs



## FQHC Billing

- Treatment Authorization Request (TAR)
  - Do not submit to M/C
  - Document TAR requirements and keep in chart
  - Cannot provide additional prenatal visits
  - Use CPSP Billing Summary Form



## Medi-Cal Managed Care and CPSP

- Three different Managed Care Models in CA
  - Geographic Managed Care
  - County-Organized Health System
  - Two-Plan
- Los Angeles is a Two-Plan County
  - LA Care
  - Health Net



## Medi-Cal Managed Care

- LA Care and Health Net
  - Subcontract with other health plans (Blue Cross, Care 1<sup>st</sup>, Molina, etc.)
- IPAs and Medical Groups
- Providers



## Medi-Cal Managed Care

- **READ YOUR CONTRACT!**
- CPSP is a managed care benefit
- All managed care enrollees eligible
- Reimbursement method varies by contract
  - Capitation or separate fee-for-service rate
  - Do not bill Medi-Cal for managed care clients
  - May need prior authorization for high risk referrals



## Electronic Health Records

- CPSP should be part of any EHR
- Handouts
  - EHR Resource List
  - Functionality Basics



## Medi-Cal Fraud

Medi-Cal Fraud Reporting

1-800-822-6222



## Questions?

### Begin Post Test

