In-Home Postpartum Assessment Forms

Dear Provider:

The Postpartum Newborn Home Visit is a service for new moms and their babies. Vendors, like you, will visit our eligible members who gave birth in the past 21 to 56 days.

What should be completed at the appointment?

- *Conduct a postpartum visit with mom within 21 to 56 days ($130)*
  - Complete the Postpartum Assessment Form for mom (page 2-4)
    - Visits that qualify for an AWC visit and are billed using the E&M modifier code 25 will be billed at 100% of Medicaid
  - Complete the Edinburgh Postnatal Depression Scale (page 5-6)
  - Complete the Reproductive Life Plan - Safe Spacing (page 7-8) (OPTIONAL)
- *Conduct a newborn visit with baby ($35)*
  - Complete Newborn Assessment Form (page 9-10)
  - Complete Safe Sleep Assessment (page 11) (OPTIONAL)
- *Provide mom with "welcome baby kit" once visit is complete*

HEDIS® Quality and Billing Tips:	
Completed Care:	**Billing Code:**
Completed Postpartum In-Home Visits Use the following CPT code with the corresponding ICD-10 Diagnosis Code	
Care After Delivery	CPT **59430**
Routine Postpartum Follow-Up	ICD-10-CM diagnosis code **Z39.2**
Encounter for gynecological examination (general) (routine) with **abnormal findings**	ICD-10-CM diagnosis code **Z01.411**
Completed Adolescent Well-Care Visit (AWC) – Age 12 to 21 years All patients 12 to 21 should be identified by billing the correct diagnosis codes with modifier 25	
Initial comprehensive preventive medicine evaluation, new patient; adolescent **(age 12 to 17 years)**	CPT **99384**
Initial comprehensive preventive medicine evaluation, new patient; adolescent **(age 18 to 39 years)**	CPT **99385**
Encounter for routine child healthy examination **with abnormal findings**	ICD-10-CM diagnosis code **Z00.121**
Encounter for routine child healthy examination **without abnormal findings**	ICD-10-CM diagnosis code **Z00.129**
Completed Newborn Assessment Visit	
Initial comprehensive preventive medicine evaluation, new patient; infant **(age birth to 1 year)**	CPT **99381**
Initial comprehensive preventive medicine evaluation, new patient; infant **(1 year to 4 year)**	CPT **99382**
Health examination for newborn **8 to 28 days** old	ICD-10-CM diagnosis code **Z00.111**
Encounter for routine child health examination **with abnormal findings**	ICD-10-CM diagnosis code **Z00.121**
Encounter for routine child health examination **without abnormal findings**	ICD-10-CM diagnosis code **Z00.129**

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

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In-Home Postpartum Assessment Forms

Mom's Name:		Molina ID #:
Baby's Name:		Baby's DOB:
Address:		
Email:	Phone:	Baby's Gender: ☐ M ☐ F

Postpartum Visit Check

Date of Service:

Abdomen ☐ C/Section ☐ Incision Healing ☐ Distended ☐ Soft

Vital Signs:

Temp:	P:	R:	BP:	WT:

Allergies:	☐ None	☐ Yes If yes, what allergies?
Medications:	☐ None	

Name	Dose	Route	Frequency

Clinical Assessment:

	Normal	Abnormal	Comments (All abnormal require a comment)
Neuro	○	○	
Skin	○	○	
Lungs	○	○	
Abdomen	○	○	
Elimination	○	○	
Perineum	○	○	
Lochia	○	○	
Pain	1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○		Location:

Did you smoke in the last 3 months of your pregnancy?	○ Yes ○ No

Breastfeeding:

Are you currently breastfeeding?	○ Yes ○ No
Length of feedings:	Frequency of feedings:
Do you supplement with (sometimes use) formula?	○ Yes ○ No
Does your baby take your breast easily?	○ Yes ○ No
Are your nipples cracked and/or sore?	○ Yes ○ No

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

In-Home Postpartum Assessment Forms

Safe Spacing Plan			
Are you using, or planning to use, birth control? If so, what type?	◯ Yes	◯ No	Comment:
Was birth control administered (given) at today's visit?	◯ Yes	◯ No	If so, what type?
Psycho-Social Assessment:			
Do you feel comfortable in your relationship with your baby?	◯ Yes	◯ No	Comment:
Have your household members adjusted to your baby?	◯ Yes	◯ No	Comment:
Is the baby's father supportive and/or involved with the baby?	◯ Yes	◯ No	Comment:
How does your partner feel about the baby? (Check all that apply)	☐ Happy ☐ Angry ☐ Refused to be involved ☐ Not sure		
Do you feel safe at home, school and work?	◯ Yes	◯ No	Comment:
Are you in a relationship with someone who threatens you or hurts you?	◯ Yes	◯ No	Comment:
Do you have the resources to keep yourself and your baby healthy?	◯ Yes	◯ No	Comment:
If no, what needs exist?	☐ Housing ☐ Financial ☐ Food ☐ Family ☐ Other		

Educational Discussions/Material(s) Provided:			
Postpartum Depression Screening	☐ Education Provided	☐ Referred	☐ Declined
Contraception Methods	☐ Education Provided	☐ Referred	☐ Declined
Peripheral Blood Glucose	☐ Education Provided	☐ Referred	☐ Declined
Doctor Appointments	☐ Education Provided	☐ Referred	☐ Declined
Car Seat Safety	☐ Education Provided	☐ Referred	☐ Declined
Immunization Schedule	☐ Education Provided	☐ Referred	☐ Declined
Breast Feeding	☐ Education Provided	☐ Referred	☐ Declined
Infant Safety	☐ Education Provided	☐ Referred	☐ Declined
Family Planning	☐ Education Provided	☐ Referred	☐ Declined
Checkups	☐ Education Provided	☐ Referred	☐ Declined
Comments:			

Follow-Up Appointments		
Follow-Up Appointment Made:	◯ Yes ◯ No	Appointment Date:
Health Care Provider:		
Well-Child Visit Appointment Made:	◯ Yes ◯ No	Appointment Date:
Health Care Provider:		

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

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In-Home Postpartum Assessment Forms

Narration:

I received my Welcome Baby Kit.	Member Signature:	Date:

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) ______ Signature ______ Date ______

In-Home Postpartum Assessment Forms

EDINBURGH POSTPARTUM DEPRESSION SCALE[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis.

The scale indicates how the mother has felt ***during the previous week***. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. Ask the mother each question and record her response in terms of how she has been feeling in the past seven days. If she is unsure, ask her to decide on the answer that comes closest to how she has been feeling.
2. All areas must be completed by the vendor with the Molina Healthcare member.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others or gathering opinions from others (answers should come from the mother or pregnant woman).

Mothers with postpartum depression may find useful information online:

- National Women's Health Information Center: www.womenshealth.gov
- Postpartum Support International: www.postpartum.net
- Depression after Delivery: www.depressionafterdelivery.com

SCORING

QUESTIONS 1, 2 and 4 (without an *)

- Scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5 and 10 (marked with an *)

- Reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible depression: 10 or greater
**** Pay special attention to any marked 10 (suicidal thoughts)***

- Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

1 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786. 2 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

In-Home Postpartum Assessment Forms

Directions: Please indicate the answer that comes closest to how you have felt in the past seven days, not just how you feel today.

In the past seven days:

1. I have been able to laugh and see the funny side of things.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*6. I have felt overwhelmed.
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

2. I have looked forward to things with enjoyment.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*7. I have been so unhappy that I have had difficulty sleeping.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*3. I have blamed myself unnecessarily when things went wrong.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*8. I have felt sad or miserable.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

4. I have been anxious or worried for no reason.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*9. I have been so unhappy that I have been crying.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*5. I have felt scared or panicky for no reason.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

*10. The thought of harming myself has occurred to me.
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ None of the time

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

SAFE SPACING - REPRODUCTIVE LIFE PLAN

It is important to make a plan for birth control.

It is important patients wait 24 months, from baby's birth to conception of their next baby, in order to reduce the risk of low birth weight, preterm birth, small for gestational age, placental abruption and other poor birth outcomes and maternal morbidities.

Discuss birth control options with the member during the Reproductive Life Plan. The goal should be to guide the member down the path toward the most effective solution for the personal goals.

1. Educate member on the importance of safe spacing.
2. Provide every member with a pack of prophylactics.
3. Offer the member at least one immediate option for birth control for the next two months:
    a. The Depo-Provera birth control shot
    b. Two-month script for birth control
4. Offer to set an appointment with an OB/GYN for a Long Acting Reversible Contraceptive (LARC) appointment:
    a. Nexplanon® (three years)
    b. Intrauterine device (IUD) (five years)

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

In-Home Postpartum Assessment Forms

Choosing the Best Birth Control for You
Take this quiz to help you and your health care provider better understand what you are looking for in your contraception method:
I am concerned about preventing sexually transmitted diseases.
☐ True ☐ False
I would prefer to have a regular monthly period.
☐ True ☐ False ☐ No preference
I would prefer to take/use my birth control.
☐ Just before sex ☐ Daily ☐ Weekly ☐ Every few months ☐ Every few years or longer ☐ No preference
I am comfortable using a hormonal method for birth control.
☐ True ☐ False ☐ No preference
I would like to get pregnant in the next year.
☐ True ☐ False
When choosing my method of birth control, these are the most important things (check all that apply).
☐ Cost ☐ It protects me against pregnancy and sexually transmitted infections (STIs) ☐ I can keep it private ☐ I do not have to do anything before sex (it is ready when I am)
I am comfortable inserting vaginal birth control methods myself.
☐ True ☐ False

Recommended Birth Control Options			
Condoms	☐ Given at Appointment		☐ Refused
Birth Control Pills	☐ Given at Appointment	☐ Two-Month Prescription	☐ Refused
Depo-Provera Shot	☐ Given at Appointment	☐ Scheduled Appointment	☐ Refused
Nexplanon®		☐ Scheduled Appointment	☐ Refused
IUD		☐ Scheduled Appointment	☐ Refused

If Appointment Scheduled:
Health Care Provider:
Appointment Date:

Member Signature:	Date:

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

In-Home Postpartum Assessment Forms

Newborn Assessment:

Mom's Name:		Molina ID #:
Baby's Name:		Baby's DOB:
Gestational Age:	Birth Weight:	Gender: ☐ Male ☐ Female
Visit Date:	Family History of Sudden Infant Death Syndrome (SIDS): ☐ Yes ☐ No	

Instructions:

- Items with an asterisk (*) require further documentation to support the answer.

Vital Signs:

Temp:	P:	R:	WT:	Length:	Head Circ:

Clinical Assessment:

	Normal	Abnormal	Comments (All abnormal require a comment)
Head	☐	☐	
Skin	☐	☐	
Lungs	☐	☐	
Chest	☐	☐	
Abdomen	☐	☐	
Elimination	☐	☐	
Number of wet diapers per day:			Number of stools per day:
Adequate amount of diapers in home? ☐ Yes ☐ No*			
Genitalia	☐	☐	
Circumcised: ☐ Yes ☐ No*			
Extremities	☐	☐	

Mental Assessment:

	Normal	Abnormal	Comments (All abnormal require a comment)
Amount of Crying	☐	☐	
Makes Eye Contact	☐	☐	
Quiet When Picked Up	☐	☐	

Nutrition:

☐ Breast ☐ Bottle ☐ Breast and Bottle

Formula:	Amount/Frequency:
Adequate amount of formula in the home? ☐ Yes ☐ No*	
Is newborn enrolled in WIC? ☐ Yes ☐ No*	

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____

In-Home Postpartum Assessment Forms

If yes, which WIC clinic?
Immunizations:
Received initial Hepatitis B shot? ☐ Yes ☐ No*
If yes, where/when?
If no, has an appointment been scheduled? ☐ Yes ☐ No*
Date: Where:
Narration:

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) Signature Date

In-Home Postpartum Assessment Forms

Safe Sleep:			Observed	Parent Reported	Education Provided
1. What safe sleep surface is available?	☐ Crib ☐ Bassinet ☐ Pack 'n Play	☐ Other ☐ None	☐	☐	☐
2. Are there stuffed animals, toys, pillows, quilts, blankets, wedges, positioners, other loose bedding or bumpers in the infant's sleep environment?		☐ Yes ☐ No	☐	☐	☐
3. Where does baby usually sleep? ***Sleep environment should be placed away from any item that could burn, cut or become wrapped around your baby:*** • *Drapes or curtains* • *Window blinds or shutters* • *Electric cords* • *Furnace vent or radiator* • *Space heater or other heat sources* • *Baby monitor*	**FOR NAPS:** ☐ Crib ☐ Bassinet ☐ Pack 'n Play ☐ Couch ☐ Recliner ☐ Swing ☐ Car seat ☐ Bouncy seat ☐ Floor ☐ With an adult, child or pet ☐ Other	**AT NIGHT:** ☐ Crib ☐ Bassinet ☐ Pack 'n Play ☐ Couch ☐ Recliner ☐ Swing ☐ Car seat ☐ Bouncy seat ☐ Floor ☐ With an adult, child or pet ☐ Other	☐	☐	☐
4. Does baby ever share a sleep surface with a sibling, adult or pet?		☐ Yes ☐ No	☐	☐	☐
5. Does baby ever share a sleep surface in a bed, couch, recliner or other?		☐ Yes ☐ No	☐	☐	☐
6. What position do you place your baby to sleep?	**FOR NAPS:** ☐ Back ☐ Side ☐ Stomach	**AT NIGHT:** ☐ Back ☐ Side ☐ Stomach	☐	☐	☐
7. Are you and/or other caregivers smoking inside or outside the baby's home?	☐ Yes ☐ Inside ☐ Outside ☐ No		☐	☐	☐
8. If you smoke outside, do you change your clothes before holding your baby?		☐ Yes ☐ No	☐	☐	☐
9. Is the infant dressed appropriately for the temperature of the home?		☐ Yes ☐ No	☐	☐	☐
10. Is the infant breastfeeding? ☐ Yes ☐ No ☐ Exclusively breast milk ☐ Formula and breast milk			☐	☐	☐
11. Do you use a clean, dry pacifier that is not attached to a string or stuffed animal?		☐ Yes ☐ No	☐	☐	☐
12. Do you provide supervised tummy time while the baby is awake?		☐ Yes ☐ Not correctly ☐ No	☐	☐	☐

Member Name:	Molina ID #:

Family Nurse Practitioner Name (Print) _____ Signature _____ Date _____