



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

M

In-Home Postpartum Assessment Forms

Mom's Name:		Molina ID #:
Baby's Name:		Baby's DOB:
Address:		
Email:	Phone:	Baby's Gender: <input type="checkbox"/> M <input type="checkbox"/> F

Postpartum Visit Check

Date of Service:				
Abdomen	<input type="checkbox"/> C/Section	<input type="checkbox"/> Incision Healing	<input type="checkbox"/> Distended	<input type="checkbox"/> Soft
Vital Signs:				
Temp:	P:	R:	BP:	WT:
Allergies:	<input type="checkbox"/> None	<input type="checkbox"/> Yes If yes, what allergies?		
Medications:	<input type="checkbox"/> None			
<u>Name</u>	<u>Dose</u>	<u>Route</u>	<u>Frequency</u>	

Clinical Assessment:

	Normal	Abnormal	Comments (All abnormal require a comment)
Neuro	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Elimination	<input type="checkbox"/>	<input type="checkbox"/>	
Perineum	<input type="checkbox"/>	<input type="checkbox"/>	
Lochia	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	1 2 3 4 5 6 7 8 9 10		Location:
Did you smoke in the last 3 months of your pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Breastfeeding:

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

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M

In-Home Postpartum Assessment Forms

Safe Spacing Plan			
Are you using, or planning to use, birth control? If so, what type?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Was birth control administered (given) at today's visit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, what type?
Psycho-Social Assessment:			
Do you feel comfortable in your relationship with your baby?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Have your household members adjusted to your baby?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Is the baby's father supportive and/or involved with the baby?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
How does your partner feel about the baby? (Check all that apply)	<input type="checkbox"/> Happy <input type="checkbox"/> Angry <input type="checkbox"/> Refused to be involved <input type="checkbox"/> Not sure		
Do you feel safe at home, school and work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Are you in a relationship with someone who threatens you or hurts you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Do you have the resources to keep yourself and your baby healthy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
If no, what needs exist?	<input type="checkbox"/> Housing <input type="checkbox"/> Financial <input type="checkbox"/> Food <input type="checkbox"/> Family <input type="checkbox"/> Other		
Educational Discussions/Material(s) Provided:			
Postpartum Depression Screening	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Contraception Methods	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Peripheral Blood Glucose	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Doctor Appointments	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Car Seat Safety	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Immunization Schedule	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Breast Feeding	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Infant Safety	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Family Planning	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Checkups	<input type="checkbox"/> Education Provided	<input type="checkbox"/> Referred	<input type="checkbox"/> Declined
Comments:			
Follow-Up Appointments			
Follow-Up Appointment Made:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appointment Date:	
Health Care Provider:			
Well-Child Visit Appointment Made:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appointment Date:	
Health Care Provider:			

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EDINBURGH POSTPARTUM DEPRESSION SCALE¹ (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)**

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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

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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

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M

In-Home Postpartum Assessment Forms

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 #:
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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	<input type="checkbox"/> Given at Appointment		<input type="checkbox"/> Refused
Birth Control Pills	<input type="checkbox"/> Given at Appointment	<input type="checkbox"/> Two-Month Prescription	<input type="checkbox"/> Refused
Depo-Provera Shot	<input type="checkbox"/> Given at Appointment	<input type="checkbox"/> Scheduled Appointment	<input type="checkbox"/> Refused
Nexplanon®		<input type="checkbox"/> Scheduled Appointment	<input type="checkbox"/> Refused
IUD		<input type="checkbox"/> Scheduled Appointment	<input type="checkbox"/> Refused

If Appointment Scheduled:

Health Care Provider:

Appointment Date:

Member Signature:

Date:

Member Name:

Molina ID #:

M

In-Home Postpartum Assessment Forms

Newborn Assessment:

Mom's Name:		Molina ID #:	
Baby's Name:		Baby's DOB:	
Gestational Age:	Birth Weight:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Visit Date:	Family History of Sudden Infant Death Syndrome (SIDS): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Instructions:			
<ul style="list-style-type: none"> 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	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Elimination	<input type="checkbox"/>	<input type="checkbox"/>	
Number of wet diapers per day:		Number of stools per day:	
Adequate amount of diapers in home? <input type="checkbox"/> Yes <input type="checkbox"/> No*			
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	
Circumcised: <input type="checkbox"/> Yes <input type="checkbox"/> No*			
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Assessment:			
	Normal	Abnormal	Comments (All abnormal require a comment)
Amount of Crying			
Makes Eye Contact			
Quiet When Picked Up			
Nutrition:			
<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Breast and Bottle			
Formula:		Amount/Frequency:	
Adequate amount of formula in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No*			
Is newborn enrolled in WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No*			

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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:

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In-Home Postpartum Assessment Forms

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

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