

**Perinatal Risk Assessment Form (PRAF) and  
Report of Pregnancy (ROP)  
Fee for Service (FFS) Billing Guidelines**

Version 1.1

Last Updated 6/1/2026

Adapted from Ohio Administrative Code (OAC) [Rule 5160-21-04](#)

## Introduction

The Ohio Department of Medicaid (ODM) uses two complementary tools- the Perinatal Risk Assessment Form (PRAF) and the Report of Pregnancy (ROP)- to ensure early identification of pregnancy, continuous Medicaid eligibility, and timely care coordination for pregnant and postpartum members.

The PRAF is completed by obstetrical providers at the Medicaid member's first prenatal visit, the start of the postpartum period, and whenever there are changes in the members' medical or social determinant of health (SDOH) condition. The PRAF collects perinatal risk and health-related social needs to help support comprehensive maternal care.

The ROP is designed for use at the earliest confirmation of pregnancy by non-obstetrical Medicaid providers, Medicaid Managed Care Organizations (MCOs), and Community-Based Organizations (CBOs). It serves as an early notification mechanism when pregnancy is identified in settings such as primary care, emergency departments, or within a local health clinic. Submission of the ROP helps initiate care coordination, connects Medicaid members to obstetrical care and other services, and ensures Medicaid coverage throughout pregnancy and the postpartum.

Providers who are providing pregnancy care and who are eligible to submit the PRAF should submit the PRAF instead of the ROP when the pregnancy is first identified.

Please refer to the [NurtureOhio Provider User Guide](#) for instructions on submitting PRAFs and ROPs. Once the PRAF or ROP is submitted, the following billing guidance outlines how a provider can be reimbursed by Medicaid Fee for Service (FFS).

## Provider Enrollment

ODM is required to enroll and screen all providers who administer services to Ohio Medicaid members. The screening includes verification of good standing with federal and state agencies, National Provider Identifier verification, and appropriate licensure (if applicable). ODM also screens agency and practice owners during initial enrollment, monthly database checks, and revalidation. A provider must first go through this enrollment process, before performing services for a Medicaid member and seeking reimbursement for those covered services. All provider enrollment applications are submitted electronically in the Provider Network Management (PNM) module. An OH|ID is required for access to the PNM module. If you do not have an existing OH|ID, you will need to create one first. Once an OH|ID is obtained, Administrator and Agent roles for PNM must then be established. Once in the PNM module, a new provider application may be submitted. The provider application will then be processed by ODM. Once the provider application is approved, the provider may seek contracts with any applicable Managed Care Organization (MCO), which allows for reimbursement from those MCO's managed care members.

Resources to assist with gaining access to the PNM module can be found on ODM's Next Generation [PNM & Credentialing](#) webpage. There are many specific resources available to anyone, without needing to log into PNM, under the [PNM Learning tab](#). Trainings on how to use the PNM module can be accessed via the learning management system (LMS), Absorb. More details and steps on how to access Absorb can be found on ODM's Next Generation [Implementation Training and Resources](#) webpage.

## **A. Perinatal Risk Assessment Form (PRAF) Billing Guidance**

ODM provides coverage and reimbursement for PRAFs – a perinatal risk screen used to screen a woman for medical and social factors that may place a woman at risk for adverse pregnancy or postpartum outcomes and to substantiate the woman's need for enhanced pregnancy-related services and other support services during the perinatal period. The American College of Obstetricians and Gynecologists (ACOG) recommends that all pregnant patients receive a comprehensive medical, social, and structural risk assessment before 10 weeks' gestation, and Ohio's PRAF aligns directly with this expectation and contains key elements in alignment with ACOG.<sup>1</sup>

The PRAF is connected to ODM's Ohio Benefits eligibility system and submitted PRAFs ensure prospective and new mothers retain their Medicaid eligibility through pregnancy and postpartum care. The PRAF also notifies the Managed Care Organizations (MCOs) of the pregnancy and serves as a home visiting and WIC referral.

When completing the PRAF, providers must complete information on the perinatal screeners in the Risks and Referrals section of the form. In the event the member has no positive screening results, risk factors, or identified health-related social needs, providers must indicate this on the PRAF to verify those sections were completed for the member.

### **Eligible Rendering and Billing Providers**

The following rendering and billing providers may receive Medicaid payment for submitting a PRAF claim:

| <b>Provider Type/Specialty</b> | <b>Provider Description</b>  |
|--------------------------------|------------------------------|
| 20                             | Physician                    |
| 24                             | Physician Assistant          |
| 65                             | Clinical Nurse Specialist    |
| 71                             | Certified Nurse Midwife      |
| 72                             | Certified Nurse Practitioner |

<sup>1</sup> Tailored Prenatal Care Delivery for Pregnant Individuals: ACOG Clinical Consensus No. 8. Obstetrics and Gynecology e145(5):p 565-577, May 17, 2025 | DOI: 10.1097/ACOG.0000000000005889

|    |                                   |
|----|-----------------------------------|
| 50 | Clinics (*Includes FQHCs/RHCs)    |
| 84 | Community Mental Health Providers |
| 95 | Substance Use Treatment Providers |
| 01 | Outpatient Hospitals              |
| 11 | Free Standing Birth Center        |
| 21 | Professional Medical Group        |

### **Member Eligibility**

The PRAF may be billed for pregnant and postpartum members, up to twelve months postpartum. Claims must include an appropriate pregnancy or postpartum ICD-10 diagnosis code.

### **Fee for Service (FFS) PRAF Completion**

Under Medicaid FFS, PRAF may be completed at the member's first prenatal care appointment (including an RN/LPN intake assessment), at the start of the postpartum period, and whenever there are changes in the member's medical or social determinant of health (SDOH) condition. This could be defined as a significant change in one of the following:

Medical Conditions (not exhaustive):

- Hypertensive disorder of pregnancy
- Gestational/pregestational diabetes
- Sexually transmitted infection
- Substance use disorder (including tobacco)
- Fetal anomaly / aneuploidy
- Fetal growth restriction
- Multiple ED (OB or general)/ triage visits (3 or more)
- Prior antepartum admission
- Hospitalization for mental health diagnosis
- Placental accreta
- Placental abruption
- Any hospital admission
- Multiple (at least 2) emergency OB visits
- Depression, anxiety, or other mental health conditions
- Any non-pregnancy related surgical procedure

SDOH Needs (not exhaustive)

- Limited transportation
- Food insecurity
- Housing instability
- WIC referral
- Unemployment

- Underemployed (<40 hours per week)
- Payment less than livable wage
- Incarceration
- Domestic violence
- Suicide attempt

Completion of the PRAF during the RN/LPN intake assessment may be billed as a professional or institutional service and must have an eligible rendering provider on the claim.

**Fee for Service (FFS) Coverage and Payment:**

Medicaid Fee for Service (FFS) may reimburse eligible providers for up to six (6) PRAFs per member throughout the pregnancy and postpartum period. Providers should submit an initial PRAF and a subsequent PRAF in the postpartum period for each member; providers should submit an updated PRAF when there is a change in the member's medical or social determinant of health (SDOH) condition.

Medicaid Fee For Service (FFS) coverage and payment information can be found in the table below. MCOs may have different reimbursement amounts for the PRAF and each MCO has their own billing procedures. Refer to each MCO's billing manual for instructions on claims submission.

| Procedure Code Description                                                                                                                              | Procedure Code | FFS Reimbursement Rate                                                                         | Service Limitations                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <u>Initial</u> Web-based Perinatal Risk Assessment                                                                                                      | H1000 33*      | See <a href="#">Appendix DD</a> to OAC rule 5160-1-60 for applicable Medicaid rates            | One Initial PRAF submission allowed per provider per pregnant/postpartum member            |
| <u>Subsequent</u> Web-based Perinatal Risk Assessment                                                                                                   | H1000 TH*      | See <a href="#">Appendix DD</a> to OAC rule 5160-1-60 for applicable subsequent Medicaid rates | Up to five subsequent PRAF submissions allowed per provider per pregnant/postpartum member |
| <b>Telehealth:</b> Include the GT* modifier, along with the modifiers specified above, for H1000 when the PRAF is administered as a telehealth service. |                |                                                                                                |                                                                                            |

**Notes:**

\*HCPCS procedure code H1000 is used as a standalone procedure code. A PRAF may be billed with an E/M code on professional claims where appropriate.

\*For Outpatient Hospitals, the PRAF is reimbursed using EAPG methodology. This means it typically receives no additional payment when provided on the same day as a medical visit

(E/M) or a significant procedure (ex. surgery). However, the PRAF is usually separately payable when it's the only service billed on that date of service.

## **B. Report of Pregnancy (ROP)**

The ROP is used to report the initial identification of pregnancy and to assist members in maintaining Medicaid eligibility and care coordination. The ROP is connected to ODM's Ohio Benefits eligibility system and submitted ROPs ensure prospective and new mothers retain their Medicaid eligibility through pregnancy and postpartum care. The ROP also serves as a home visiting and WIC referral.

### **Eligible Billing and Rendering Providers**

The following rendering and billing providers may receive Medicaid payment for submitting a ROP claim:

| <b>Provider Type/Specialty</b> | <b>Provider Description</b>        |
|--------------------------------|------------------------------------|
| 20                             | Physician                          |
| 24                             | Physician Assistant                |
| 65                             | Clinical Nurse Specialist          |
| 71                             | Certified Nurse Midwife            |
| 72                             | Certified Nurse Practitioner       |
| 84                             | Community Mental Health Provider   |
| 37/370                         | Licensed Independent Social Worker |
| 47/474                         | Clinical Counseling                |
| 52/520                         | Marriage and Family Therapy        |
| 54/540                         | Chemical Dependency                |
| 39                             | Physical Therapists (PT)           |
| 41                             | Occupational Therapists (OT)       |
| 40                             | Speech Language Pathologists (SLP) |
| 30                             | Dentist                            |
| 43                             | Audiologist                        |
| 09                             | Doula                              |
| 01                             | Outpatient Hospital                |
| 21                             | Professional Medical Group (PMG)   |
| 50                             | Clinics (*Includes FQHCs/RHCs)     |

### **Fee for Service (FFS) Coverage and Payment:**

ODM may reimburse eligible providers for one ROP during pregnancy. Coverage and payment information may be found in the table below. MCOs may have different reimbursement

amounts for the ROP and each MCO has their own billing procedures. Refer to each MCO's billing manual for instructions on claims submission.

| Procedure Code Description                                                                        | Procedure Code | FFS Reimbursement Rate                                                                          | Service Limitations                    |
|---------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------|----------------------------------------|
| Report of Pregnancy (ROP)                                                                         | T1023          | See <a href="#">Appendix DD</a> to OAC rule 5160-1-60 for applicable subsequent Medicaid rates. | One ROP may be submitted per pregnancy |
| <b>Telehealth:</b> Include the GT* modifier when the ROP is administered as a telehealth service. |                |                                                                                                 |                                        |

### **Notes**

\*For Physicians, PAs, APRNs, Outpatient Hospitals, and Professional Medical Groups, the ROP must be billed in conjunction with an E/M service and will receive a separate payment. CPT codes such as 99202-99205 for new patients and 99211-99215 for established patients must be used. For non-practitioners of physician services, use the appropriate HCPCS/CPT code.

### **Documentation Detail**

Medical service documentation helps ODM understand who, what, why and how a service was delivered to a patient. All Medicaid providers are required to keep appropriate records to establish conditions for payment for all medical services. Some services require specific supporting documents to be attached to the claim. Additional detail on claim documentation requirements can be found in OAC rule [5160-1-27: Review of provider records](#).

### **Provider Compliance**

ODM reimburses providers for services that are medically necessary. Conditions of medical necessity include meeting generally accepted standards of medical practice and providing services that are clinically appropriate in the right place, for the right amount of time, at the right intensity of care. Services are expected to treat the condition the service is provided for and are expected to be provided in order to produce the anticipated, desired outcome. Additional detail on how ODM defines medical necessity can be found in OAC rule [5160-1-01: Medicaid medical necessity: definitions and principles](#).

ODM regularly reviews submitted claims for patterns of fraud, waste and abuse. When suspected fraudulent behavior is detected, providers will be subject to a review by ODM, and in instances of fraud the case will be referred to the Ohio Attorney General's (AG) Medicaid Fraud Control Unit (MFCU). If waste or abuse is suspected or apparent, ODM, the office of the AG, or both will take action to recoup inappropriate or excess payments. To ensure compliance and prevent audit findings, providers should understand Medicaid program requirements and ensure medical documentation supports all services billed and that the

services are truly medically necessary. Additional details can be found in OAC rule [5160-1-29: Medicaid fraud, waste, and abuse](#).

## **Billing and Claims Submission**

PRAF and ROP claims may be submitted via ODM Electronic Data Interchange (EDI) through a trading partner or using the ODM PNM provider portal. A trading partner is an entity that providers can contract with to take information from their Electronic Health Records system or other medical records to submit claims to ODM and the MCOs.

All PRAF and ROP claims should be submitted according to national accepted coding standards using the healthcare common procedure coding system (HCPCS) or current procedural terminology codebook (CPT) codes. FFS claims are expected to be received by ODM within 365 days of the actual date of service. Provider-reported underpaid claims should be adjusted within 365 days of the date of service. The MCOs may have a different contracted billing timeline. Exceptions to timely filing of claims and additional detail on claim submission requirements are outlined in OAC rule [5160-1-19: Submission of Medicaid claims](#).

The claims payment schedule is located in the PNM “Provider Financials and Remittance Advice” user manual accessible through the PNM [Provider Education & Training Resources](#) page. FFS claims are adjudicated daily, and payments are made weekly in accordance with established ODM policies. Each MCO has its own payment calendar. For a claim to be included in the current week’s payment cycle, the claim must be submitted by the appropriate deadline. Claims suspended for manual intervention are not guaranteed to be included in that week’s payment cycle. More detail on the electronic data interchange can be found on the [ODM website](#) and in the [ODM EDI FAQ](#).

## **FFS Coordination of Benefits**

Coordination of benefits is the process of determining which health insurance payer will pay first or determine the payment obligations of each payer covering the same benefits for a Medicaid covered member. Providers are responsible for reviewing the patient’s Ohio Medicaid card for evidence of third-party benefits and billing the other insurance company prior to billing ODM. Generally, Medicaid is the payer of last resort, with few exceptions. When a member has multiple insurance plans, the payment and adjudication information from the other payers is also taken into consideration when calculating Medicaid payment. Payment methodology used to calculate total reimbursement can vary depending on the claim type (i.e., institutional vs. professional) and payer type (i.e., Medicare vs. commercial). If a member does not have coverage from another plan the provider can submit a claim directly to ODM. Additional detail on ODM coordination of benefits and third-party liability can be found in OAC rule [5160-1-08: Coordination of benefits](#) (for FFS claims) and OAC rule [5160-26-09.1: Managed care third-party liability and recovery](#) (for managed care claims).

## Denied Claims

Common reasons for claim denials include coding errors, service limitations, lack of required prior authorizations, claim filing delays, and billing for non-covered services. Providers experiencing FFS denied claims can troubleshoot by reviewing claim denial reason codes in the PNM portal or in their electronic remittance advice (ERA). If the denial reason is still unclear, providers should reach out to the Integrated Helpdesk (IHD) for assistance. Representatives are available 8 a.m.- 4:30 p.m. ET, Monday-Friday and can be reached by calling 800-686-1516 or sending an email to [IHD@medicaid.ohio.gov](mailto:IHD@medicaid.ohio.gov). A representative will address the claim and provide instructions on how to update or correct the claim for resubmission. For questions regarding Managed Care claims, please contact the MCO directly. If you have already tried that route with no resolution, please use the online [managed care provider complaint form](#). ODM will review all concerns submitted along with MCO responses.

## Payment Questions

If there's a disagreement with the processing of a fee for service claim, please contact the Integrated Helpdesk (IHD). Representatives are available 8 a.m.- 4:30 p.m. ET, Monday-Friday and can be reached by calling 800-686-1516 or sending an email to [IHD@medicaid.ohio.gov](mailto:IHD@medicaid.ohio.gov). A representative will address the claim and provide instructions on how to update or correct the claim for resubmission. For questions regarding Managed Care claims, please contact the MCO directly. If you have already tried that route with no resolution, please use the online managed care provider complaint form located here: [Provider Complaint Form](#) ODM will review all concerns submitted along with MCO responses.

## Additional Resources:

- [Creating OH|ID for IOP PNM Login](#)
- [PNM Login/Access](#)
- [Identifying Your Role Within PNM](#)
- [New Provider Application](#)
- [Absorb LMS & Training Sign Up](#)
- [ODH Freestanding Birthing Centers Licensure](#)
- [ODM Submission of Medicaid Claims](#)
- [ODM Managed Care Claims and Prior Authorization](#)
- [ODM Provider Enrollment and Support](#)
- [ODM Provider Network Module](#)
- [ODM PNM Provider Education and Training Resources](#)
- [ODM Claim and Prior Authorization Submission FAQ](#)
- [ODM PNM Fee-For-Service Prior Authorization User Guide](#)
- [ODM Fee Schedule and Rates](#)
- [ODM Integrated Help Desk](#)
- [Anthem Provider Resource](#)
- [Amerihealth Caritas of Ohio Provider Resource](#)
- [Aetna OhioRISE Provider Resource](#)

- [Buckeye Provider Resource](#)
- [CareSource Provider Resource](#)
- [Humana Provider Resource](#)
- [Molina Provider Resource](#)
- [United Healthcare Provider Resource](#)

### **Questions?**

#### **General PRAF and ROP Questions:**

Email ODM at [MomsAndBabies@medicaid.ohio.gov](mailto:MomsAndBabies@medicaid.ohio.gov)

#### **Claims Submission:**

##### Fee-For-Service:

Please contact the ODM Integrated Helpdesk (IHD) at 800-686-1516 or [IHD@medicaid.ohio.gov](mailto:IHD@medicaid.ohio.gov). The IHD also provides 24/7 access to information regarding patient eligibility, claim and payment status, and provider information.

##### Managed Care:

If you are having issues with managed care claims, please contact the plan directly.