

Washington Apple Health (Medicaid)

Maternity Support Services and Infant Case Management Billing Guide

August 1, 2022

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an HCA rule arises, HCA rules apply.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **August 1, 2022**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in [WAC 182-533-0300](#) through [182-533-0386](#).

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's [ProviderOne billing and resource guide](#) for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's [provider alerts webpage](#).

To access provider documents, go to HCA's [provider billing guides and fee schedules webpage](#).

Where can I download HCA forms?

To download an HCA form, see HCA's [Forms & Publications](#) webpage. Type only the form number into the Search box (Example: 13-835).

* This publication is a billing instruction.

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Telemedicine and coronavirus (COVID-19)	<ul style="list-style-type: none"> Added a new section to consolidate the telehealth and telemedicine information and policy contained in this guide. The individual <i>Telemedicine</i> and <i>Telehealth</i> sections within the guide were removed. Revised the definition of telemedicine. Added a reference to the telehealth and telemedicine information and policy on HCA's website 	<ul style="list-style-type: none"> To reduce redundancy and improve usability To clarify what telemedicine is HCA clarified its telehealth and telemedicine policy and created audio-only procedure code lists, consolidating them on HCA's website.
Which place of service should I use when providing MSS or ICM services via telemedicine or audio-only telemedicine?	Added section	To incorporate in the guide new telemedicine and audio-only telemedicine policy effective July 1, 2022.

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Resources Available

Topic	Resource
Becoming a provider or submitting a change or address or ownership	HCA First Steps Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov
Obtaining prior authorization, limitation extension, or exception to rule	Fax all documents along with requests 1-866-668-1214
Policy or program oversight for Maternity Support Services	HCA First Steps Program Manager 360-725-1293 Fax: 360-725-1152 Email: FirstSteps@hca.wa.gov
Policy or program oversight for Infant Case Management	HCA First Steps Program Manager 360-725-5236 Fax: 360-725-1152 Email: FirstSteps@hca.wa.gov
General information, provider directory	View the First Steps web page
Additional Medicaid resources	See HCA's ProviderOne Resources web page.
Definitions	Refer to WAC 182-533-0315 and Chapter 182-500 WAC
Department of Health (DOH) credentialing requirements	Professional Credentialing Requirements
Health Benefit Exchange	wahealthplanfinder.org
Women, Infants, and Children (WIC) Nutrition program	WIC website and the Department of Health WIC web page
HCA billing guides and other publications	See HCA's provider billing guides and fee schedules web page .

Program Overview

What is First Steps?

Under the Maternity Care Access Act ([RCW 74.09.800](#)), HCA established First Steps to provide access to services for eligible clients and their infants. Maternity Support Services (MSS) and Infant Case Management (ICM) are two components of the First Steps program. Services include:

- **Medical Services**, including:
 - Full medical coverage (see [WAC 182-505-0115](#))
 - Prenatal care
 - Delivery
 - Post-pregnancy follow-up
 - One year of family planning services post-pregnancy for eligible clients
 - One year of full medical care for newborns (see [WAC 182-505-0210](#))
- **Enhanced Services**, including:
 - MSS
 - ICM
 - Childbirth Education (CBE)
- **Alcohol and drug assessment and treatment services**
- **Other (ancillary) services**, including but not limited to expedited medical eligibility determination

What is the Maternity Support Services program?

Maternity Support Services (MSS) delivers enhanced preventive health and education services and brief interventions to eligible pregnant clients. Services are provided as early in a pregnancy as possible, based on the client's individual risks and needs.

Goals of MSS include:

- Increasing:
 - Early access and ongoing use of prenatal and newborn care
 - Screening for Postpartum mood disorder
 - Initiation and duration of breastfeeding
 - Family planning knowledge

- Decreasing:
 - Maternal morbidity and mortality
 - Low birth-weight babies
 - Premature births
 - Infant morbidity and mortality rates
 - Health disparities
 - The number of unintended pregnancies
 - The number of repeat pregnancies within two years of delivery (Healthy birth spacing intervals)
 - Tobacco, nicotine, alcohol, marijuana, and drug use during pregnancy
 - Pediatric exposure to second-hand smoke

What is Infant Case Management?

Infant Case Management (ICM) improves the welfare of infants by providing their parent(s) with information and assistance for necessary medical, social, educational, and other services through the infant's first year.

Goals of ICM are to improve infant health outcomes by:

- Increasing referrals to well child visits and developmental screenings, as needed
- Screening for Postpartum mood disorder
- Reduce the number of repeat pregnancies within two years of delivery
- Reduce pediatric exposure to second-hand smoke

Telemedicine, telehealth, and coronavirus (COVID-19)

Telemedicine

- Telemedicine is the delivery of health care services using interactive audio and video technology, permitting real-time communication between the client at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine includes audio-only telemedicine, but does not include any of the following services:
 - Email and facsimile transmissions
 - Installation or maintenance of any telecommunication devices or systems
 - Purchase, rental, or repair of telemedicine equipment
 - Incidental services or communications that are not billed separately, such as communicating laboratory results
- Audio-only telemedicine is the delivery of health care services using audio-only technology, permitting real-time communication between the client at the originating site and the provider, for the purposes of diagnosis, consultation, or treatment.

Note:

- MSS clients may be eligible for telemedicine.
- ICM clients *and their parents* may be eligible for telemedicine.

Telehealth

Telehealth is the use of telecommunications technologies to support distant MSS/ICM covered services. HCA allows telehealth modalities to provide MSS/ICM services in lieu of an in-person visit, and the visits may be provided as audio-only (telephone calls).

Refer to HCA's [Provider billing guides and fee schedules webpage](#), under Telehealth, for more information on the following:

- Telehealth policy, under *Clinical policy and billing for COVID-19*
- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

See the Health Care Authority's [Information about novel coronavirus \(COVID-19\) webpage](#) for updated information regarding COVID-19.

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Apple Health. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's [Program Benefit Packages and Scope of Services](#) webpage.

Note: Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the [Washington Healthplanfinder's website](#).
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the [Washington Healthplanfinder's website](#) or call the Customer Support Center.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Clients enrolled in HCA-contracted managed care plans are eligible for MSS and ICM outside of their plan. HCA pays for MSS and ICM through its fee-for-service system. Providers must bill HCA directly. To verify eligibility when the client is enrolled in a Medicaid HCA-contracted managed care plan, view the managed care enrollment on the client benefit inquiry screen of ProviderOne.

Maternity Support Services

Purpose

The purpose of Maternity Support Services (MSS) is to:

- Improve and promote healthy birth outcomes. Services are delivered by an MSS interdisciplinary team to eligible pregnant and post-pregnant clients and their infants.
- Help clients to access:
 - Prenatal care as early in pregnancy as possible
 - Health care for eligible infants

Who is eligible for MSS?

To be eligible for MSS, a client must:

- Meet the definition of “Maternity Cycle” in [WAC 182-533-0315](#)
- Be covered under a categorically needy (CN), medically needy (MN), alternative benefit plan (ABP), or state-funded medical program with Washington Apple Health at the time services are provided.

If the client is pregnant, check ProviderOne to determine if the client is currently covered under a Benefit Package. If not, the client may submit an application for full coverage. See the note in [How can I verify a patient’s eligibility?](#)

For further information on verifying a client’s eligibility, see HCA’s [ProviderOne Billing and Resource Guide](#). See HCA’s [Program Benefit Packages and Scope of Services webpage](#) for a current listing of Benefit Packages.

Clients who do not agree with an eligibility decision by HCA have a right to an administrative hearing under [Chapter 182-526 WAC](#).

Note: Assisting a client in enrolling into Washington Apple Health is not an MSS-covered service.

Before seeing a client for the first time, providers must ask if the client is being seen by another MSS provider for the current pregnancy to determine if the client’s MSS benefit limit has been partially used or met. In addition, providers should contact HCA to find out if MSS claims have been paid for a client. Instructions for this process can be found under *Section 3* in the [ProviderOne Billing and Resource Guide](#).

Transfers

If a client received MSS from another provider, the client may not receive services from a new MSS provider unless the client voluntarily chooses to switch providers. For clients who choose to receive MSS from a new provider, the client must indicate the client's choice in writing, and it must be signed and dated. This information must be:

- Given to the MSS provider the client received services from
- Documented in the client's file

When a client chooses to receive services from a new provider, the previous provider must transfer the client's entire chart, including screening tools, care plans, and remaining units. This ensures continuity of care, reduce service duplication, and inform the new provider of the number of remaining MSS units.

New provider [limitation extension](#) requests will not be approved for additional units without the client's previous MSS chart.

Who is eligible to provide MSS?

MSS providers may include community clinics, federally qualified health centers (FQHCs), local health departments, hospitals, nonprofit organizations, and private clinics.

General requirements

MSS must be provided by a provider who is currently enrolled and approved as an eligible provider with HCA.

The approved provider must:

- Meet the requirements in [Chapter 182-502 WAC](#) and [WAC 182-533-0325](#).
- Comply with [Section 1902\(a\)\(23\) of the Social Security Act](#) regarding the client's freedom to choose a provider. By law, all clients are free to choose any approved MSS provider, regardless of where they receive prenatal, post-pregnancy, or pediatric medical care. Clients cannot be limited to MSS providers in a given county or clinic, even if the client receives all other HCA-covered services through that county or clinic.
- Comply with [Section 1915\(g\)\(1\) of the Social Security Act](#) regarding the client's voluntary receipt of services.

- Ensure that professional staff providing MSS:
 - Who are registered nurses, certified dietitians, and behavioral health specialists have an individual National Provider Identifier (NPI) and are enrolled in ProviderOne under the provider's billing NPI as a rendering provider with the MSS taxonomy 171M00000X
 - Meet [staff qualifications](#)
 - Complete an [orientation](#) to ensure the overall quality and continuity of client care
 - Follow the requirements under [Chapter 182-533 WAC](#) and this guide
- Appoint a designated person (usually a First Steps Coordinator) to view HCA's [First Steps Maternity Support Services and Infant Case Management Provider webpage](#) for updates and information regarding the program, at least quarterly and enroll in the [First Steps MSS GovDelivery list](#).
- Obtain approval of all MSS outreach related materials, including websites and publications, from the [MSS Program Manager](#), prior to making the materials available to clients. Requests for approval must be submitted via email or fax. The MSS Program Manager will review the submitted outreach-related materials to ensure they provide accurate information regarding the services a client may receive through MSS and will send a determination by email. The provider must keep the approval email and the outreach related materials on file for review as requested.
- Maintain and make available to HCA upon request: clinical supervision plans, consultation plans, staff training plans, current and historical personnel rosters, and clients' charts and records covering the last six years. (See [WAC 182-502-0020](#).)
- For each client, the provider must:
 - Screen each client for risk factors using the *MSS Prenatal Screening Tool* (HCA 13-874) form, and the *MSS Post-Pregnancy Screening Tool* (HCA 13-873) form. See [Where can I download HCA forms?](#) If using electronic health records (EHR), the screening tool language must match what is on these forms. If the system is limited and unable to use exact language, HCA approval is required; contact the [First Steps Program Manager](#) to obtain HCA approval.
 - Refer a client who may need a substance use disorder assessment to a provider who is contracted with the [Division of Behavioral Health and Recovery](#) (DBHR) through HCA.

Note: See [DBHR Substance Use Treatment Services](#) for information on treatment services and resources, including the Directory of Certified Treatment Agencies Services.

- Inform the eligible client of the *option* to receive MSS and *must not force* the client to receive MSS for which the client might be eligible.

- Screen client and infant for ICM eligibility and document screening results in the [client's chart](#).
- Conduct [case conferences](#) as described in this guide.
- Develop and implement an individualized [care plan](#) for each client.
- Initiate and participate in care coordination activities throughout the maternity cycle, with at least the MSS interdisciplinary team members, the client's prenatal care provider, and the Women, Infants, and Children (WIC) Nutrition office.
- Comply with documentation requirements.
- Create and maintain a system to track units used in service delivery. (See [First Steps Maternity Support Services and Infant Case Management Provider webpage](#))
- Deliver [MSS covered services](#) as described in [WAC 182-533-0330](#).

Note: MSS providers are mandatory reporters. If you are concerned that child abuse or neglect has occurred or is occurring, you must notify CPS by calling 1-800-363-4276.

Locations where services may be delivered

The provider and client together determine the most appropriate place for services to be delivered.

HCA pays for an MSS visit when the services are provided in any of the following settings:

- The provider's office or clinic
- The client's residence (not allowed for group services)
- An alternate site other than the client's residence. (The reason for using an alternate site for visitation instead of the home must be documented in the client's record.)

Can a member of the MSS interdisciplinary team be contracted out?

Yes. When the need for an interdisciplinary team member cannot be met by the MSS provider, it is allowable to contract out. The MSS provider must do all of the following:

- Have a written contract agreement with the qualified individual MSS Provider
- Keep a copy of the written subcontractor agreement on file. (See [staff-specific content](#) in documentation requirements)
- Ensure that an individual providing MSS services meets the minimum regulatory and educational qualifications required of an MSS provider

- Ensure that the subcontractor satisfies the requirements of [Chapter 182-533 WAC](#) and these billing instructions
- Maintain professional, financial, and administrative responsibility for the subcontractor
- Bill for services using the provider’s billing NPI, the individual rendering provider’s NPI, and the MSS taxonomy, as HCA will not reimburse the contractor directly (See [covered services](#).)

What are the staff requirements for MSS?

To ensure the overall quality and continuity of client care, each provider must fulfill orientation and staff requirements and provide required program services. (See [WAC 182-533-0327](#))

Orientation requirements

Providers must ensure that their staff follow the requirements [Chapter 182-533 WAC](#) and this provider guide. During orientation, professional staff must read:

- [Chapter 182-533 WAC](#)
- Maternity Support Services and Infant Case Management Billing Guide (this guide)
- [First Steps Maternity Support Services and Infant Case Management Provider webpage](#)
- [Prenatal and Post-Pregnancy Risk Factor Matrix](#) (Risk Factor definitions and outcome measures)
- [Prenatal and Post-Pregnancy Clarifications](#) (Clarification notes)

The date each employee completed the orientation must be [documented](#) and made available to HCA upon request.

The MSS interdisciplinary team

The provider's qualified staff must participate in an MSS interdisciplinary team consisting of at least a community health nurse, a certified dietitian, a behavioral health specialist, and, at the discretion of the provider, a community health representative/worker.

- The interdisciplinary team must work together to address risk factors identified in a client's care plan.
- Each qualified staff member must act within their area of expertise and address the client's needs identified during the maternity cycle. If the needs of the client are outside the staff member's scope of practice, the client must be referred to an appropriate team member. The referral must be documented along with the result of the referral.
- Team members must participate in a **case conference** at least once for clients who are entering MSS during pregnancy and are eligible for the maximum **level of service**. Using clinical judgment and the client's risk factors, the provider may decide which interdisciplinary team members to include in case conferencing.

Staff qualifications

MSS providers must use qualified professionals as specified in the table below. For more information about the Department of Health's (DOH's) qualifications for licensed and credentialed staff, including continuing education, see the online DOH [Health Care Professional Credentialing Requirements website](#).

Type of Professional Staff	Qualifications and Other Requirements
Behavioral Health Specialists	<p>Currently credentialed or licensed in the State of Washington by the DOH Chapters 246-809, 246-810, 246-811 and 246-924 WAC as one of the following:</p> <ul style="list-style-type: none"> • Licensed mental health counselor • Licensed independent clinical social worker • Licensed social worker • Licensed marriage and family therapist • Licensed psychologist • Associate mental health counselor • Associate independent clinical social worker • Associate social worker • Associate marriage and family therapist • Certified counselor • Substance use disorder professional
Certified Dietitians	<p>Currently registered with the Commission on Dietetic Registration and certified by the DOH under Chapter 246-822 WAC</p>
Community Health Nurses	<p>Currently licensed as registered nurses in the State of Washington by the DOH under Chapter 246-840 WAC</p>
Community Health Representatives/Workers	<ul style="list-style-type: none"> • Have a high school diploma or equivalent • Have a minimum of one year of health care or social services experience • Complete a training plan by their provider • Carry out all activities under the direction and supervision of a professional member or supervisor of the MSS interdisciplinary team

HCA will not pay for MSS provided by student interns. HCA considers claims for services provided by nonqualified staff as erroneous claims and will recover any resulting overpayment.

Requirements for Tribes, Indian Health Programs, and certain counties

All Tribes, Indian Health Programs, and any MSS provider within a county with fewer than 55 Medicaid births per year to county residents, according to the most recent [Characteristics of women who gave birth report](#), must meet all MSS program requirements in this guide, and are required to have at least one of the following interdisciplinary team members:

- A behavioral health specialist
- A certified dietitian
- A community health nurse

Clinical staff must meet the [staff qualifications](#) detailed within this guide, and must complete the [orientation requirements](#), whether delivering direct services or supervising MSS staff. When a client's needs are outside the scope of practice of the clinician, appropriate referrals and consultations must be attempted and documented.

All tribes, Indian Health Programs, and any MSS provider within a county with fewer than 55 Medicaid births per year may also have Community Health Representatives/Workers as additional team members.

What are the MSS program components?

Providers are required to manage the available units of service to meet the client's needs throughout the maternity cycle. See [levels of service](#) for details about minimum and maximum units of service available for clients.

Program components for MSS include screening, assessments, case conferences, care plans, case management, care coordination, and group services. These services must be [documented](#) in the client's records.

Screening

Screening is required for each client. The screening process is a method for systematically identifying and documenting risk factors and client need. Screening must be completed prior to billing.

Once a risk factor or need is identified, a behavioral health specialist, community health nurse, or certified dietitian may need to assess the client further to determine the client's [level of service](#). Screening is not an in-depth assessment for risk factors.

During the prenatal period of MSS, clients must be screened using HCA's *MSS Prenatal Screening Tool* (HCA 13-874).

During the postpartum period of MSS, clients must be screened using HCA's *MSS Postpartum Screening Tool* (HCA 13-873). During the postpartum period of MSS, the infant and client must be screened using HCA's *Infant Case Management (ICM) Screening Tool* (HCA 13-658). If the client is unable to be seen during the postpartum period, document in the discharge summary why the postpartum and ICM screenings were not completed during the MSS postpartum period.

Note: HCA approval is required for a provider to use an alternate screening tool. See [WAC 182-533-0325](#).

There are two screening guides, located on the [First Steps Maternity Support Services and Infant Case Management Provider webpage](#). Both the *MSS Prenatal Screening Guide* and the *MSS Post-Pregnancy Screening Guide* are reference documents where sample screening questions can be found.

Assessment

An assessment or evaluation beyond screening may be necessary. An assessment should expand beyond screening in the content area being evaluated. All types of assessments must be documented in the client's chart and include the date the assessment took place.

Case conference

Case conferences are a formal or informal consultation used by the members of the MSS interdisciplinary team to communicate and consult with each other and other health care providers, social services providers, and the client. The purpose of a case conference is to optimize the client's care by addressing risk factors that may lead to poor birth outcomes. Case conferences may be done in person, by phone, or through secure technological applications.

At least one prenatal MSS interdisciplinary team case conference is required for clients who are entering MSS during pregnancy and are eligible for the maximum level of service. The provider may decide, based on the client's risk factors, which interdisciplinary team members to include in the case conference. Documentation of the case conference must include the following: attendees, date, summary of discussion, and any updates or changes made to the care plan.

Care plan

A written statement developed for a person that continues throughout the eligibility period and outlines any medical, social, environmental, or other interventions to achieve an improved quality of life, including health and social outcomes. The care plan is to be based on the results of the MSS screening and assessment. The interdisciplinary team must develop and implement an individualized care plan for each client. The care plan contains information specific to the client's identified risk factors and is used to prioritize those risk factors and guide interventions.

An effective care plan includes:

- Screening results
- Planned interventions (any medical, social, environmental, or other interventions)
- Rationale for interventions (to achieve improved quality of life including health and social outcomes)

The care plan must be updated throughout the maternity cycle and reflect an overview of the client's identified risk factors and the planned interventions. For risk factors that are identified and not addressed, an explanation of why the risk factors were not addressed by the MSS provider must be included in the client's chart.

The community health nurse, behavioral health specialist, or certified dietitian must be involved in developing the care plan for clients eligible for expanded and maximum service levels. A list of the team members involved in developing the care plan must be kept in the client's file.

Case management

Case management is a collaborative process of assessment, care planning, facilitation, care coordination, evaluation, and advocacy for options and services that meet the health and social service needs of infants and pregnant clients.

A key aspect of case management is making referrals for MSS clients to:

- Medical care
- [Women, Infants, and Children \(WIC\) Nutrition program](#)
- [Childbirth Education \(CBE\) services](#)
- [Within-Reach](#)
- [ParentHelp123](#)
- [Quitline for tobacco and nicotine use](#)
- Family planning providers
- Treatment for substance use disorder, mental health problems, or domestic violence, as needed
- Other services and community resources, as needed

Care coordination

Care coordination is professional collaboration and communication between the client's MSS provider and medical or health and social services providers to address the individual client's needs as identified in the care plan. Providers must initiate and participate in care coordination throughout the maternity cycle to ensure that care is delivered in a logical, connected, and timely manner.

Care coordination must be documented in the client's file and may include any of the following:

- Face-to-face meetings
- Phone calls
- Secure emails

At minimum, care coordination must occur within the [MSS interdisciplinary team](#), with the client's prenatal care provider, and the WIC office. Communication with other community resources working with the client may be necessary to provide appropriate needed care. In addition, providers must coordinate with other MSS providers to reduce duplication and to ensure continuity of care.

Group services

Providers may offer group services to clients who are eligible for MSS. The group sessions must be voluntary and provide preventive health and education services.

Group classes may include, but are not limited to, the following subject areas:

- Alcohol and substance abuse or addiction
- Intimate partner violence
- Family violence
- Self-care and coping strategies
- Mental health (accessing mental health services, stress reduction techniques, depression and anxiety, etc.)
- Nicotine or marijuana reduction and cessation education
- Nutrition and diabetic education and awareness
- Breastfeeding
- Accessing community resources
- Parent education: when to access different kinds of medical help with baby, e.g., ER, urgent care, pediatrician, etc.

The goal of group services is to improve the outcome of pregnancy, birth, and parenting. Group activities may be used to address specific identified risk factors and should be described in each client's care plan.

The group must have a minimum of three and maximum of twelve MSS clients. Each group session must be provided for a minimum of one hour and a client is eligible for one group activity per day. Group services may not be provided by a community health representative/worker and are not allowed in a client's residence.

Each group session must be documented for each client. The client's chart must include the group facilitator's name, the topic, and the number of MSS attendees. If a provider chooses to use a presenter who specializes in the clients' risk factors, the presenter's name and contact information, and the name of the interdisciplinary team member who was in attendance must also be added to each client's chart.

The provider must maintain a list of all attendees for each session. Each list must be kept in the provider's file and made available to HCA as required in [WAC 182-502-0020](#).

What documentation is required for MSS?

All providers must satisfy the documentation requirements in [WAC 182-502-0020](#) and this guide, regardless of whether the provider creates the documents by hand or electronically. All documentation must be maintained for at least six years, must be submitted to HCA upon request, and made available during on-site visits and chart reviews.

Charting overview

Each provider must maintain a client record for each client that states the services provided and justifies how those services support the number of units billed. The client record must also clearly demonstrate the risk-factor progression from identification to final client outcome.

Client-specific records

Each client record must be stored in a single file that contains:

- Assessment records
- Case conference records
- Care coordination records
- Care plan records
- Client data, including:
 - Name
 - Date of birth
 - Estimated due date
 - Contact information (address and phone numbers)
 - Race (and if applicable, ethnicity or tribal affiliation)
 - Primary spoken language
 - ProviderOne Client ID and effective date

- Forms:
 - Required **MSS Prenatal and Post-Pregnancy screening tools**.
 - Consent to care document signed and dated must be done prior to billing for MSS covered services.
 - A *Freedom of Choice* document signed and dated. The declaration must inform the client:
 - That the client is not required to participate in MSS
 - That the client is free to choose any MSS provider to receive MSS regardless of where the client lives or where the client receives health care and **WIC services**.
 - Of all MSS providers in the county, and the surrounding area for those counties with less than two MSS providers, where the client resides
 - Transfer Form, if applicable which includes a written statement signed and dated by the client indicating the client's choice to receive services from a new provider
- Visit records for each MSS visit must include:
 - Date of the visit
 - Start time of MSS visit and End time of MSS visit
 - Specific location of the visit, such as home, office, etc. and any necessary notes
 - Any intervention(s) provided
 - Client progress related to identified risk factor(s) and addressed during the visit
 - The reason for not addressing a prioritized risk factor at the MSS visit
 - Any follow-up required from the previous visit
 - Next steps and/or plan for next visit
 - The signature of the person providing MSS

- Outcome and discharge data requirements:
 - The date and reason for the discharge from MSS
 - Outcomes related to identified MSS targeted risk factors
 - Weeks of gestation when prenatal care began
 - Family planning: date discussed and method selected
 - Infant weight at time of birth
 - Gestational weeks at time of birth
 - Breastfeeding: date started, was it exclusive or supplemented, and was client still breastfeeding at time of MSS discharge
 - Depression and anxiety screening: dates the client was screened and results of screening(s), if applicable
 - Results of an ICM screening: eligible, deferred, or denied
- Discharge Summary: a summary report capturing the client's final outcomes of their time in the MSS program.
- Contact log. Client records must have a chronology of contacts made with or regarding the client. Contact may be in person, in writing, or by phone. The contact log must include the following:
 - The date of the contact
 - A brief description of the nature of the contact
 - The name of the person making the contact
 - The name of the person or agency who was contacted

Staff-specific records

Providers must keep the following documentation for all people providing MSS:

- Training and supervision records for community health representatives/workers
- Continued education verification
- Current credentials for professional staff
- Date orientation completed
- Subcontracting documents, as specified under [WAC 182-533-0325](#)
- A signature log, which is a typed list that verifies a provider's identity by associating each provider's signature with their name, handwritten initials, and title

What services are covered under MSS?

HCA covers MSS provided by an [MSS interdisciplinary team member](#). Covered services include:

- In-person, [telemedicine](#), or [telehealth](#) screening of risk factors related to pregnancy and birth outcomes
- Brief assessment, when indicated
- Education related to improving outcomes of pregnancy and parenting
- Brief counseling
- Interventions for risk factors identified in the [care plan](#)
- Basic health messages
- [Case management](#)
- [Care coordination](#)
- Infant case management (ICM) screening

HCA pays for these services on a fee-for-service basis if MSS is:

- Provided to a client who meets the [eligibility requirements](#) in WAC 182-533-0320
 - Provided to a client in a face-to-face encounter, including [telemedicine](#) or through [telehealth](#)
 - Provided by a provider who meets the [MSS provider requirements](#)
 - Documented correctly in the client's chart (see [MSS documentation requirements](#))
 - Billed using:
 - The eligible client's ProviderOne Client ID
 - The correct procedure code and modifier identified in this guide. (See the [MSS coverage table](#))
 - The provider's billing NPI and taxonomy code 171M00000X
 - The NPI and taxonomy code 171M00000X of the individual rendering the service, if applicable.
- **Note:** Travel expenses, documentation time, phone calls, and mileage are built into the reimbursement rate for MSS and cannot be billed separately.

Levels of service

HCA may redetermine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium. (The maximum number of MSS units allowed per client is published in this guide.)

- Providers must bill for services delivered fee-for-service:
 - In 15-minute increments for individual services, or
 - For 1 hour for group services.
- If two or more of the MSS provider's staff meet with a client at the same time, only one of them can bill for a given unit spent with the client. For example:
 - Individual services: If a registered nurse and a certified dietitian visit a client together for 45 minutes, a maximum of three units is billable for this visit.
 - Group services: If a registered nurse and a behavioral health specialist provide a group session together, a maximum of one unit is billable for each eligible client.
- No more than six units per client may be billed for one date of service.
- Clients are eligible for only one MSS group service per day.
- If the client's level of service increases, the client is eligible for more units. For example, the client may move from basic to expanded services if additional qualifying risk factors are identified.
- Clients enrolled in MSS prenatally must be screened during post-pregnancy to assess whether an increase in level of service is needed due to new risk factors. If a provider is unable to screen during the post-pregnancy period, justification of why the client was not screened during the post-partum period must be documented.
- If all available units are used during the prenatal period, staff must document the following:
 - The client's circumstances and the reason that all units were used prenatally
 - Actions taken to link the client to other related services (such as medical care and WIC) that address post-pregnancy needs

Level of Service During the Entire Maternity Cycle	Units Allowed	Required Services
Client enrolled in MSS during prenatal period	Basic = 7 units	Screening, Care Coordination, Case Management, and Basic Health Messages
Client enrolled in MSS during prenatal period	Expanded = 14 units	Screening, Care Coordination, Case Management, and Basic Health Messages, and Interventions,
Client enrolled in MSS during prenatal period	Maximum = 30 units	Screening, Care Coordination, Case Management, and Basic Health Messages, Interventions, and Case Conference

Level of Service During the Post-Pregnancy Eligibility Period	Units Allowed	Required Services
Client enrolled in MSS post-pregnancy period only (client did not receive any MSS during the prenatal period)	Basic = 4 units	Screening, Care Coordination, Case Management, and Basic Health Messages
Client enrolled in MSS post-pregnancy period only (client did not receive any MSS during the prenatal period)	Expanded = 6 units	Screening, Care Coordination, Case Management, and Basic Health Messages, and Interventions,
Client enrolled in MSS post-pregnancy period only (client did not receive any MSS during the prenatal period)	Maximum = 9 units	Screening, Care Coordination, Case Management, and Basic Health Messages, and Interventions

Limitation extension requests

The provider may request a limitation extension to exceed the number of MSS units of service allowed under [WAC 182-501-0169](#).

Providers may submit a limitation extension request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's [prior authorization webpage](#) for details).

- A limitation extension request must be approved before additional units are used.
- Limitation extension requests must be:
 - Submitted with:
 - The *General Information for Authorization* (HCA 13-835) form, as the first page (DO NOT use a coversheet), see [Where can I download HCA forms?](#)
 - *The First Steps Maternity Support Services (MSS) Limitation Extension Request*, (HCA 13-884) form, as the second page
 - MSS client specific records showing progression, including the care plan and screening tools, as well as case conference notes, if applicable
 - Completed according to the directions on the forms
 - Faxed to 1-866-668-1214.

What services are not covered?

HCA covers only those services listed in [WAC 182-533-0330](#). Requests for noncovered services are evaluated under [WAC 182-501-0160](#).

Note: Federally Qualified Health Centers (FQHCs) and Tribal Health Programs must follow billing guidelines found on HCA's [Provider billing guides and fee schedules webpage](#)

MSS Coverage Table

Maternity support services coverage table

HCPCS Procedure Code	Diagnosis Code	Modifiers (bill in order as shown below)	Short Description	Comments
T1002	Use appropriate diagnosis code. See Diagnosis Code Table	HD	RN services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit
T1002	Use appropriate diagnosis code. See Diagnosis Code Table	HD TF	RN services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit for clients screening in with risk factors at expanded level
T1002	Use appropriate diagnosis code. See Diagnosis Code Table	HD TG	RN services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit for clients screening in with risk factors at maximum level (high risk)
S9470	Use appropriate diagnosis code. See Diagnosis Code Table	HD	Nutritional counseling, dietician visit	1 unit = 15 minutes during an MSS dietitian visit
S9470	Use appropriate diagnosis code. See Diagnosis Code Table	HD TF	Nutritional counseling, dietician visit	1 unit = 15 minutes during an MSS dietitian visit for clients screening in with risk factors at expanded level
S9470	Use appropriate diagnosis code. See Diagnosis Code Table	HD TG	Nutritional counseling, dietician visit	1 unit = 15 minutes during an MSS dietitian visit for clients screening in with risk factors at maximum level (high risk)
S9482	Use appropriate diagnosis code. See Diagnosis Code Table	HD	Behavioral health specialist	1 unit = 15 minutes during an MSS behavioral health visit

HCPCS Procedure Code	Diagnosis Code	Modifiers (bill in order as shown below)	Short Description	Comments
S9482	Use appropriate diagnosis code. See Diagnosis Code Table	HD TF	Behavioral health specialist	1 unit = 15 minutes during an MSS behavioral health visit for clients screening in with risk factors at expanded level
S9482	Use appropriate diagnosis code. See Diagnosis Code Table	HD TG	Behavioral health specialist	1 unit = 15 minutes during an MSS behavioral health visit for clients screening in with risk factors at maximum level (high risk)
T1027	Use appropriate diagnosis code. See Diagnosis Code Table	HD	Family training and counseling for child development (community health representative/worker)	1 unit = 15 minutes during an MSS community health representative /worker visit
T1027	Use appropriate diagnosis code. See Diagnosis Code Table	HD TF	Family training and counseling for child development (community health representative/worker)	1 unit = 15 minutes during an MSS community health representative /worker visit with risk factors at expanded level
T1027	Use appropriate diagnosis code. See Diagnosis Code Table	HD TG	Family training and counseling for child development (community health representative/worker)	1 unit = 15 minutes during an MSS community health representative /worker visit for clients screening with risk factors at maximum level (high risk)
S9446	Use appropriate diagnosis code. See Diagnosis Code Table	HD	Patient education group	1 unit = minimum 60 minutes during an MSS group session
S9446	Use appropriate diagnosis code. See Diagnosis Code Table	HD TF	Patient education group	1 unit = minimum 60 minutes during an MSS group session for clients screening in with risk factors at expanded level
S9446	Use appropriate diagnosis code. See Diagnosis Code Table	HD TG	Patient education group	1 unit = minimum 60 minutes during an MSS group session for clients screening in with risk factors at maximum level

Maternity support services diagnosis code table

Diagnosis Code	Diagnosis Description
Z34.00*	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80*	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90*	Encounter for supervision of other normal pregnancy, unspecified, unspecified trimester
Z34.91*	Encounter for supervision of other normal pregnancy, unspecified, first trimester
Z34.92*	Encounter for supervision of other normal pregnancy, unspecified, second trimester
Z34.93*	Encounter for supervision of other normal pregnancy, unspecified, third trimester
Z39.2	Encounter for routine postpartum follow-up

* Codes with a greater degree of specificity should be considered first.

Coverage for Tribal programs

To receive reimbursement, Tribal programs must use the procedure code and modifier(s) above and one of these additional modifiers based on the client's demographic information:

Client demographics	Additional modifiers
American Indian or Alaska Native	UA
Nonnative person	SE

Infant Case Management

Purpose

The purpose of Infant Case Management (ICM) is to improve the welfare of infants by providing their parents with information and assistance to access medical, social, educational, and environmental services. Families that meet criteria for ICM will be offered services focused on referrals and linkage to community resources.

For the purposes of ICM, a parent is any person who resides with an infant, provides the infant's day-to-day care, and is one or more of the following:

- The infant's natural or adoptive parent
- A person other than a foster parent who has been granted legal custody of the infant
- A person who is legally obligated to support the infant

Who is eligible for ICM?

To be eligible for ICM, the infant must:

- Be covered under categorically needy (CN), medically needy (MN), or state-funded medical programs with Washington Apple Health
- Meet the age requirement for ICM, which is the day after the maternity cycle ends, through the last day of the month of the infant's first birthday
- Reside with at least one parent who needs assistance accessing medical, social, educational, or other services to meet the infant's basic health and safety needs
- Not be receiving any case management services funded through Title XIX Medicaid that duplicate ICM services

For instructions on how to verify a client's eligibility, see HCA's [ProviderOne Billing and Resource Guide](#). See HCA's [Program Benefit Packages and Scope of Services](#) for a current listing of benefit packages. Clients who disagree with an eligibility decision by HCA have a right to a fair hearing under [Chapter 182-526 WAC](#).

Eligibility when the infant is placed outside the home

If the infant does not live with a parent, the infant is not eligible for ICM services. If the infant is returned to a parent during the ICM eligibility period, the provider may determine eligibility for ICM.

Examples:

- A child is placed outside the home in foster care. Children's Administration (CA) provides Targeted Case Management (TCM) and is the legal custodian of the child. This child is no longer eligible for ICM.
- A child has an open Child Protective Services (CPS) case and is still in the parents' home. ICM could be delivered to the family in the home without the concern of duplicate billing.
- Grandparents have legal custody of the infant. The infant may be eligible for ICM, provided that the infant meets the eligibility criteria to receive services.

Transfers

Providers must coordinate with other ICM providers. Providers must ask if the client is being seen by another ICM provider and determine if the client's ICM benefit limit has been partially used or met. In addition, providers should contact HCA to determine if a client has paid ICM claims. Instructions for this process can be found under Section 3 in the [ProviderOne Billing and Resource Guide](#). Communication with other community resources working with the family may also be necessary to provide the appropriate needed care.

When a client's parent chooses to receive services from a new provider, the previous provider must transfer the client's entire chart, including screening tools, care plans, and remaining units to the new ICM provider. This will ensure continuity of care, reduce service duplication, and inform the new provider of the number of remaining ICM units.

For clients' parents who choose to receive ICM from a new provider, the client's parent must indicate the new choice in writing and it must be signed and dated. This information must be:

- Given to the ICM provider the client was receiving services from

AND

- Documented in the client's file.

New provider limitation extension requests will not be approved for additional units without the client's previous MSS chart.

Who is eligible to provide ICM?

General requirements

ICM services must be provided by a provider who is currently enrolled as an eligible ICM provider by HCA.

The approved ICM provider must:

- Meet the requirements in [Chapter 182-502 WAC](#) and [WAC 182-533-0325](#).
- Comply with [Section 1902\(a\)\(23\) of the Social Security Act](#), which requires that all clients must be free to choose any approved ICM provider regardless of where they receive pediatric medical care or received MSS. Clients cannot be limited ICM providers in a given county or clinic, even if the client receives all other HCA-covered services through that county or clinic.
- Comply with [Section 1915\(g\)\(1\) of the Social Security Act](#), which requires that an approved provider must inform the eligible client's parent of the option to receive ICM and must not force the client and parent to receive ICM services for which the client or the client might be eligible.
- Ensure that professional staff providing ICM:
 - Who are Registered Nurses, Certified Dietitians, and Behavioral Health Specialists have an individual National Provider Identifier (NPI) and are enrolled in ProviderOne under the provider's billing NPI as a rendering provider with the ICM taxonomy 171M00000X
 - Meet [staff qualifications](#)
 - Complete an [orientation](#) to ensure the overall quality and continuity of client care
 - Follow the requirements under [Chapter 182-533 WAC](#) and this guide
- Appoint a designated person (usually a First Steps Coordinator) to view the [First Steps Maternity Support Services and Infant Case Management Provider webpage](#) for updates and information regarding the program, at least quarterly and enroll in the [First Steps ICM GovDelivery list](#).
- Obtain approval of all ICM outreach-related materials, including websites and publications, from the [ICM Program Manager](#), prior to making the materials available to clients. Requests for approval must be submitted via email or fax. The ICM Program Manager will review the submitted outreach-related materials to ensure they provide accurate information regarding the services a client may receive through ICM and will send a determination by email. The provider must keep the approval email and the outreach related materials on file for review as requested.
- Maintain and make available to HCA upon request: clinical supervision plans, consultation plans, staff training plans, current and historical personnel rosters, and clients' charts and records covering the last six years. (See [WAC 182-502-0020](#).)

For each client, the ICM provider must:

- Screen client for ICM eligibility using the ICM Screening Tool (HCA 13-658) form. See [Where can I download HCA forms?](#) If using electronic health records (EHR), the screening tool language must match what is on this form. If the system is limited and unable to use exact language, HCA approval is required; contact the First Steps Program Manager to obtain HCA approval.
- Create and maintain a system to track units used in service delivery. (See [First Steps Maternity Support Services and Infant Case Management Provider webpage](#))
 - Screen clients for ICM eligibility and document screening results in the [client's chart](#).
 - Employ staff who meet [staff qualifications](#) and complete a required orientation to ensure the overall quality and continuity of client care.
 - Comply with all [documentation requirements](#).
 - Deliver [ICM covered services](#) as described in [WAC 182-533-0380](#).

Note: ICM providers are mandatory reporters. If you are concerned that child abuse or neglect has occurred, or is occurring, you must notify CPS by calling 1-800-363-4276.

What are the staff requirements for ICM?

To ensure the overall quality and continuity of client care, each provider must fulfill orientation and staff requirements and provide required program services.

Orientation requirements

Providers must ensure that their staff follow the requirements under [Chapter 182-533 WAC](#) and this provider guide. During orientation, professional staff must read:

- [Chapter 182-533 WAC](#)
- Maternity Support Services and Infant Case Management Billing Guide (this guide)
- [First Steps Maternity Support Services and Infant Case Management Provider webpage](#)

The date each employee completed the orientation must be [documented](#) and made available to HCA upon request.

Staff qualifications

ICM services must be provided by an infant case manager who is employed by an [approved provider](#). The infant case manager must meet at least one of the following sets of qualifications.

Qualifications for an infant case manager

Education		Other requirements
<p>1. Be a current member of the MSS interdisciplinary team who qualifies as a behavioral health specialist, certified dietitian, or community health nurse.</p>	<p>AND</p>	<p>Meet MSS staff requirements and WAC 182-533-0327.</p>
<p>2. Have a bachelor's or higher degree in a social service-related field, such as social work, behavioral sciences, psychology, child development, or mental health.</p>	<p>AND</p>	<p>Have at least one year of full-time experience working in one or more of the following areas:</p> <ul style="list-style-type: none"> • Community services • Social services • Public health services • Crisis intervention • Outreach and referral programs • Other related fields
<p>3. Have an associate of arts degree or associate degree in a social service-related field, such as social work, behavioral sciences, psychology, child development, or mental health.</p>	<p>AND</p>	<p>Have at least two years of full-time experience working in one or more of the following areas:</p> <ul style="list-style-type: none"> • Community services • Social services • Public health services • Crisis intervention • Outreach and referral programs • Other related fields <p>And be supervised by a clinical staff person who meets the requirements under #1 or #2 in this table. Clinical supervision may include face-to-face meetings and/or chart reviews.</p>

Note: HCA considers claims for services provided by nonqualified staff as erroneous claims and will recover any resulting overpayment.

Locations where services may be delivered

HCA pays for an ICM visit when the services are provided in:

- The provider's office or clinic
- The client's residence
- An alternate site that is not the client's residence. (The reason for using an alternate site for services instead of the home or office must be documented in the client's record.)

What are the ICM program components?

Note: Providers are required to manage the available units of service to meet the client and parent's needs throughout the ICM eligibility period. See [levels of service](#) for the range of service units available to clients.

Program services for ICM include screening, assessment, care plans, case management, and care coordination. These services must be **documented** in the client's records.

Screening

A brief in-person, [telemedicine](#), or [telehealth](#) evaluation provided by a qualified person, under [WAC 182-533-0375](#), to determine whether an infant and the infant's parent(s) have a specific risk factor(s). Screening is required for each client. The infant case manager must systematically identify and document the client's needs and risk factors to determine the appropriate [level of service](#). Screening is not an in-depth assessment of risk factors. No more than two units may be billed to complete the ICM screening.

Assessment

An assessment or evaluation beyond screening may be necessary but is not required. An assessment should expand beyond screening in the content area being evaluated. All types of assessments must be documented in the client's chart and include the date the assessment took place.

Care plan

A care plan is a written statement developed for the client and parent(s) that outlines identified medical, social, educational, and environmental risk factors to be addressed through referrals, linkages, and case management services. The care plan must be based on results of the ICM screening, and the provider must develop and implement an individualized care plan that contains information specific to identified risk factors and is used to prioritize risk factors and guide linkage, referrals, and case management and care coordination services.

An effective care plan includes:

- Screening results
- Planned interventions (to include only referrals, linkages, advocacy, case management and care coordination)
- Rationale for interventions (to achieve improved quality of life including health and social outcomes)

The care plan must be updated as needed throughout the ICM eligibility period and reflect an overview of the client's identified risk factors and planned interventions. For risk factors identified and not addressed, an explanation of why the ICM provider did not address the risk factors must be included in the chart.

Case management

Case management is a collaborative process of assessment, facilitation, care planning, care coordination, evaluation, and advocacy for options and services that meet the medical, social, educational, and environmental needs of the client and parent(s).

A key aspect of case management is referrals for infants and families to:

- Pediatric care
- Specialized and general medical care
- [Women, Infants, and Children \(WIC\) Nutrition program](#)
- [Within-Reach](#)
- [ParentHelp123](#)
- [Quitline for tobacco/nicotine use](#)
- Family planning providers
- [ABCD Dental](#)
- [Children with Special Health Care Needs](#)
- Local food banks
- [Infant See program](#)
- Treatment for substance use disorder, mental health problems, or domestic violence, as needed
- Other services and community resources

Care coordination

Care coordination is professional collaboration and communication between the client's ICM provider and medical or health and social service providers to address the needs as identified in the care plan. This approach seeks to ensure that care is delivered in a logical, connected, and timely manner so that the medical, social, educational, and environmental needs of the client and parent(s) are met.

Care coordination must be documented in the client's file and may include any of the following:

- Face-to-face meetings
- Phone calls
- Secure emails

What documentation is required for ICM?

All providers must satisfy the documentation requirements in WAC 182-502-0020 and this guide, regardless of whether the provider creates the documents by hand or electronically. All documentation must be maintained for at least 6 years, submitted to HCA upon request, and made available during on-site visits and chart reviews.

Charting overview

Each provider must maintain a client record for each client that states the services provided and justifies how those services support the number of units billed. The client record must also clearly demonstrate the risk-factor progression from identification to final client outcome.

Client-specific records

Each client record must be stored in a single file that contains:

- All notes by the infant case manager
- Assessment records, if applicable
- Care coordination records
- Care plan records

- Client data, including:
 - The client's name
 - The date of birth
 - Race (and if applicable, ethnicity, and tribal affiliation)
 - The client's ProviderOne Client ID number and effective date
 - Contact information (address and phone numbers)
 - Parent data, including:
 - Name
 - Primary language spoken
- Required forms:
 - Consent to care document signed and dated by the client's **parent**, indicating whether the parent consented or refused care

A *Freedom of Choice* document provided for each client's **parent** to read and sign. The declaration must inform the parent:

- The client and parent are not required to participate in ICM.
- The client and parent are free to choose any ICM approved agency to receive ICM regardless of where the client lives or receives health care and/or **WIC services**.
- Of all ICM providers in the county where the infant resides and the surrounding areas for those counties with less than two ICM providers.
- The ICM Screening Tool (HCA 13-658) form. See [Where can I download HCA forms?](#)
- Transfer Form, if applicable, that includes a written statement signed and dated by the client indicating the client's choice to receive services from a new provider.
- Visit records and notes for each ICM visit that include:
 - Date of visit
 - Start time of ICM visit and end time of ICM visit
 - Specific location of the visit such as home, office, etc., and any necessary notes
 - Any referrals and linkages provided
 - Client progress related to identified risk factors and addressed during the visit
 - Reason for not addressing a prioritized risk factor at visit
 - Any follow-up required from the previous visit
 - Next steps and/or plan for next visit
 - Signature of the person providing ICM services

- Client outcome and discharge data:
 - The date and reason for the discharge from ICM
 - Results of ICM screening with ICM services are documented as:
 - Provided
 - Deferred, because the client/family is receiving case management services as part of another program
 - Declined by the client's parent
- Discharge summary: a summary report capturing the client's outcomes of his or her time in the ICM program.
- Contact log. Client records must have a chronology of contacts made with or regarding the client and must include the following:
 - The date of the contact
 - A brief description of the nature of the contact
 - The name of the person making the contact
 - The name of the person or agency who was contacted

Staff-specific records

Providers must keep the following documentation for all professional staff:

- Supervision records for infant case managers
- Continued education verification, if applicable
- Current credentials for professional staff
- A signature log, which is a typed list that verifies a provider's identity by associating each provider's signature with their name, handwritten initials, and title

What services are covered under ICM?

HCA covers ICM provided by an Infant Case Manager or qualified MSS interdisciplinary team member. Covered services include:

- An initial in-person, [telemedicine](#), or [telehealth](#) screening, which includes an assessment of risk factors and the development of an individualized care plan
- Case management services and care coordination
- Referring and linking the client and parent(s) to other services or resources
- Advocacy for the client and parent(s)
- Follow-up contact with the parents to ensure the care plan continues to meet the medical, social, educational, and environmental needs of the client and parent(s)

HCA pays for these services on a fee-for-service basis if ICM is:

- Provided to a client who meets the eligibility requirements in [WAC 182-533-0370](#)
- Provided to a client in a face-to-face encounter, including [telemedicine](#) or through [telehealth](#)
- Provided by a person who meets the ICM [provider requirements](#) listed in this guide
- Documented in a manner that satisfies the ICM [documentation requirements](#)
- Billed using:
 - The client's ProviderOne Client ID
 - The correct procedure code and modifier identified in this provider guide
 - The provider's billing NPI and taxonomy code 171M00000X
 - The NPI of the person rendering the service and taxonomy code 171M00000X, if applicable

Note: Travel expenses, documentation time, telephone calls, and mileage are built into the reimbursement rate for ICM and cannot be billed separately.

Levels of service

HCA may redetermine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium. The maximum number of ICM units allowed per client is published in this guide.

The client and parent(s) must be screened to determine if there is a need to help access medical, social, educational, or environmental services. The number of units an infant may receive is based on the amount of assistance the parent needs to address identified risks.

Other considerations include:

- Providers must bill in 15-minute increments for services delivered fee-for-service.
- All services must be delivered face-to-face, including [telemedicine](#) or through [telehealth](#), with client and parent present.
- If the infant's circumstances cause a change to a higher level of service, the appropriate number of units may be added. Total units may not exceed 20.

Level of service and allowable units during the entire ICM eligibility period:	Definition of service level	Required services
No Risk Factors = 2 units*	Client and parent(s) found to have no risk factors based on ICM screening.	ICM screening
Low level = 6 units*	Client and parent(s) are able to access services with minimal assistance from an infant case manager.	ICM screening and care plan
High level = 20 units*	Client and parent(s) demonstrate a greater need for assistance accessing services.	ICM screening and care plan

*Units used to screen client and parent(s) are included in the maximum allowed in each level.

Limitation extension requests

The provider may request authorization for a limitation extension to exceed the number of allowed ICM units of service under [WAC 182-501-0169](#).

Providers may submit a limitation extension request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's [prior authorization webpage](#) for details).

- A limitation extension request must be approved before additional units are used.
- Limitation extension requests must be:
 - Submitted with:
 - The General Information for Authorization (HCA 13-835) form as the first page (DO NOT use a coversheet), see [Where can I download HCA forms?](#)
 - *The First Steps Infant Case Management (ICM) Limitation Extension Request* (HCA 13-0018) form as the second page
 - ICM [client-specific records](#) showing progression, including the care plan and screening tools
 - Completed according to the directions on the forms
 - Faxed to 1-866-668-1214

What services are not covered under ICM?

HCA covers only those services that are listed in [WAC 182-533-0380](#). Requests for noncovered services are evaluated under [WAC 182-501-0160](#). Group services are not covered under ICM.

Note: The client is the infant. The parent-infant dyad must be seen together and the care plan developed must benefit the welfare of the infant.

ICM Coverage Table

Infant case management

Procedure Code	Diagnosis Code	Modifier*	Short Description	Policy/Comments
T1017	Z76.2	HD	Targeted case management, each 15 minutes	1 unit = 15 minutes

* To receive reimbursement, tribal programs must use the procedure code and modifier above and one of these *additional* modifiers based on the client's demographic information.

Client Demographic	Additional Modifier
American Indian or Alaska Native	UA
Nonnative person	SE

What is expedited prior authorization (EPA)?

The expedited prior authorization (EPA) process is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

HCA denies claims submitted without the appropriate diagnosis code, procedure code, or service as indicated by the last four digits of the EPA number. The billing provider must document in the client's file how the EPA criteria were met and make this information available to HCA upon request.

Note: When billing electronically, enter the EPA number in the Prior Authorization section.

When is EPA required for ICM?

EPA is required when an infant's ICM eligibility occurs before age three months.

Use EPA# **870001418** only when the infant meets all the following criteria:

- Infant meets all ICM eligibility as listed in this guide.
- An infant's eligibility for ICM begins during the 2nd month of life (see [ICM Newborn Calendar](#)).
- ICM services are provided during an infant's 2nd month of life.

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see [Paperless Billing at HCA](#). For providers approved to bill paper claims, see HCA's [Paper Claim Billing Resource](#).

What are the general billing requirements?

Providers must follow the billing requirements listed in HCA's [ProviderOne Billing and Resource Guide](#). The guide explains how to complete claims. The following table includes information specific to MSS and ICM services.

Name	Code	Enter/Use for
Claim note for MSS only		Enter the client's current estimated due date for those who become pregnant again before the ICM eligibility period ends. This is necessary to "reset" the clock for the new pregnancy in the claims system.
Prior Authorization		The authorization reference number for approved limitation extension and the Expedited Prior Authorization (EPA) number for ICM claims that meet the criteria.
Place of Service	02*	Telehealth provided other than in the client's home
Place of Service	03*	School
Place of Service	05*	Indian Health Service free-standing facility
Place of Service	06*	Indian Health Service provider-based facility
Place of Service	07*	Tribal 638 free-standing facility

Name	Code	Enter/Use for
Place of Service	08*	Tribal 638 provider-based facility
Place of Service	10*	Telehealth provided in the client's home
Place of Service	11*	Office
Place of Service	12*	Home (client's residence)
Place of Service	19*	Off-campus – outpatient hospital
Place of Service	21*	Inpatient hospital
Place of Service	22*	Outpatient hospital
Place of Service	50*	Federally qualified health center
Place of Service	72*	Rural health clinic
Place of Service	99*	Other
Service Date (From and To)		Enter one date of service per billed line. Multiple units will be billed regularly using the allowed codes

* This is an example of an appropriate code for MSS and ICM.

Use taxonomy code 171M00000X for all MSS and ICM covered services.

See the Maternity Support Services and Infant Case Management fee schedule on HCA's [Professional Rates and Billing Guides webpage](#).

Which place of service should I use when providing MSS or ICM services via telephone or telemedicine?

Effective July 1, 2022, HCA changed the place of services (POS) providers must use when billing for MSS and ICM services provided via telephone (audio-only) or telemedicine.

When billing for MSS- and ICM-covered services provided via telephone (audio-only) or telemedicine, use the appropriate MSS or ICM procedure code and one of the following places of service (POS):

Place of service	Description	Comments
02	Telehealth provided other than in the patient's home	The client is not in their home when receiving MSS or ICM through telecommunication technology.
10	Telehealth provided in the patient's home	The client is in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving MSS or ICM through telecommunication technology.

When billing for MSS or ICM services provided via telephone (audio-only), you **must** include **modifier 93** (synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system) on the claim. Modifier 93 indicates that the services were provided using an audio-only system and were not provided as telemedicine. Claims for services provided via telemedicine do not require an additional modifier to indicate services were provided via HIPAA-compliant, real-time video and audio technology.

Reminder: You **must** bill using **modifier HD** as the primary modifier on all MSS and ICM claims. Modifier 93 may be listed as the secondary or tertiary modifier on MSS claims.

Refer to HCA's [Provider billing guides and fee schedules webpage](#), under Telehealth, for more information on the following:

- Telehealth policy, under *Clinical policy and billing for COVID-19*
- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

How do I resolve issues with gender indicators when billing for transgender clients?

For a transgender client, providers must include a secondary diagnosis on the claim indicating that the client is transgender. Information on HCA billing practices for transgender clients can be found in the [Physician-Related Professional Services Billing Guide](#).