Washington State Health Care Authority

Medicaid Provider Guide

Maternity Support Services / Infant Case Management

[WAC 182-533-0300 through 182-533-0386]

April 1, 2013

A Billing Instruction

About this guide

This guide supersedes all previous *Maternity Support Services/Infant Case Management Medicaid Provider Guides* published by the Health Care Authority (Medicaid agency).

What has changed?

Reason for Change	Effective Date	Page No.	Subject	Change
Better understanding and accuracy by providers (PN 13-19)	April 1, 2013	All	All	Clarified, streamlined, and reordered information, corrected cross-references, and removed outdated information, as needed.

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's Provider Publications website.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	HCA Family Services Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov
Prior authorization, limitation extensions, or exception to rule	Fax all documents along with requests attn: First Steps Program Manager
Policy or program oversight for Maternity Support Services	HCA Family Services Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov
Policy or program oversight for Infant Case Management	HCA Family Services Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov
General information, including a provider directory	View the First Steps website.
Additional Medicaid resources	See the agency's online list of Resources Available.
Definitions	Refer to Chapter 182-533-0315 and the Medicaid agency's Medical Assistance Glossary.

About the Program

What is First Steps?

Under the Maternity Care Access Act (Chapter 74.09 RCW), the Medicaid agency established First Steps to provide access to services for eligible women and their infants.). Maternity Support Services (MSS) and Infant Case Management (ICM) are two components of the First Steps program

First Steps includes:

- **Medical Services**, including:

  - ✓ Full medical coverage (per WAC 182-505-0115)
  - ✓ Prenatal care
  - ✓ Delivery
  - ✓ Postpregnancy follow-up
  - ✓ One year of family planning services postpregnancy for eligible women
  - ✓ One year of full medical care for newborns (per WAC 182-505-0210)

- **Enhanced Services**, including**:**

  - ✓ Maternity Support Services (MSS)
  - ✓ Infant Case Management (ICM)
  - ✓ Childbirth Education (CBE)

- **Alcohol and Drug Assessment and Treatment Services** for eligible pregnant women available statewide and administered by the Division of Behavioral Health and Recovery with the Department of Social and Health Services. (See WAC 182-533-0701 and the Chemical-Using Pregnant (CUP) Women Program Medicaid Provider Guide.)

- **Other (ancillary) services** including but not limited to:

  - ✓ Expedited medical eligibility determination

  - ✓ Nonemergency medical transportation services, such as to or from medical appointments

  - ✓ Interpretive services

What are Maternity Support Services and Infant Case Management?

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

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

Goals of MSS/ICM include:

- Increase in:
  - ✓ Early access and ongoing use of prenatal and newborn care
  - ✓ Initiation and duration of breastfeeding
- Decrease in:
  - ✓ Maternal morbidity and mortality
  - ✓ Low birth-weight babies
  - ✓ Premature births
  - ✓ Infant morbidity and mortality rates health disparities
- Reduction of:
  - ✓ The number of unintended pregnancies
  - ✓ The number of repeat pregnancies within two years of delivery
  - ✓ Tobacco use during pregnancy and pediatric exposure to second-hand smoke

Are clients eligible when enrolled in a Medicaid agency-contracted managed care plan?

[Refer to WACs 182-538-060 and -095 or WAC 182-538-063]

YES! However, the Medicaid agency reimburses for MSS/ICM through its fee-for-service system. Bill the Medicaid agency directly. Clients enrolled in these managed care plans are eligible for MSS/ICM outside of their plan.

Note: To verify eligibility when the client is enrolled in a Medicaid agency-contracted managed care plan, view the managed care enrollment on the client benefit inquiry screen of ProviderOne.

Maternity Support Services

What is the purpose of Maternity Support Services (MSS)?

[Refer to WAC 182-533-0310]

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

- Improve and promote healthy birth outcomes.
- Facilitate access to:
  - ✓ Prenatal care as early in pregnancy as possible.
  - ✓ Health care for eligible infants.

How can I verify a patient's eligibility for MSS?

[Refer to WAC 182-533-0320]

Patients must be pregnant or within 60 days of postpregnancy to be eligible. In addition, 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 the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
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 www.wahealthplanfinder.org or call the Customer Support Center.

What are the provider requirements for MSS?

[Refer to WAC 182-533-0325]

General requirements

MSS/ICM services may be provided only by an agency or entity that is currently enrolled as an eligible provider with the Medicaid agency (WAC 182-533-0325).

The approved agency or entity must also:

- 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.

  Notes: All clients (fee-for-service and managed care) must be free to choose any approved MSS/ICM agency regardless of where she/he receives prenatal, postpregnancy or pediatric medical care. Clients cannot be limited to MSS/ICM providers in a given county or clinic, even if the client receives all other Medicaid agency-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.

  An approved agency or entity must inform the eligible client of the *option* to receive MSS/ICM and *must not force* the client to receive MSS/ICM services for which the client and/or the client's infant might be eligible.

- Deliver MSS covered services as described in WAC 182-533-0330.

- Screen clients for ICM eligibility and document screening results in the client's chart.
- Refer a client who may need chemical dependency assessment to a provider who is contracted with the Division of Behavioral Health and Recovery (DBHR) through the Department of Social and Health Services (DSHS).

  Note: See the directory of DSHS-certified chemical dependency service providers. Contracted providers are designated with an asterisk (*) next to the service type.

- Employ staff who meet staff qualifications and complete a required orientation to assure the overall quality and continuity of client care.
- Maintain and make available to the Medicaid agency 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.
- Comply with documentation requirements.
- Create and maintain a system to track units used in service delivery.
- Appoint a designated person (usually a First Steps Coordinator) to periodically view the First Steps website for updates and information regarding the program.

Note: MSS providers are mandatory reporters. If there is reasonable cause or concern that child abuse or neglect has or is occurring, a referral to CPS must be made by calling 1-800-363-4276.

Places services may be delivered

The provider and client together determine whether services are to be delivered in the home or in the agency's office or clinic.

The Medicaid agency pays for a MSS visit when the services are provided in any of the following places:

- An agency's office or clinic
- The client's residence
- An alternate site that is not the client's residence in the case of an unsafe place of residence or a potential problem with client confidentiality

  (The reason for using an alternate site for visitation instead of the home must be documented in the client's record.)

See billing for place of service (POS) codes.

What are the program requirements for MSS?

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

Orientation requirements

- All individuals providing a MSS/ICM service must read the following:

  ✓ Chapter 182-533 WAC
  ✓ MSS/ICM Medicaid Provider Guide
  ✓ First Steps Resource Guide found on the First Steps website

- Employees must fulfill this orientation requirement before their agency can bill for a covered service provided by them.

- The date each employee completed the orientation must be documented and made available to the Medicaid agency upon request.

Staff requirements

Interdisciplinary team

The interdisciplinary team is a group of providers consisting of at least a community health nurse, a certified registered dietitian, a behavioral health specialist, and, at the discretion of the First Steps provider, a community health worker. The team is available for clients at expanded and maximum risk levels.

The team works together and communicates frequently to share specialized knowledge, skills, and experience to address risk factors identified in a client's care plan. Each qualified staff member acting within her/his area of expertise addresses the variety of client needs during the maternity cycle.

Staff qualifications

Type of staff	Degree/Experience Requirements	Credentials	Other Requirements	Notes
Behavioral health specialist	A master's degree in counseling, social work, marriage and family therapy **-OR-** A bachelor's degree in counseling, social work or marriage and family therapy ***and*** 2 years post-graduate experience not including internships or practicum	Is currently credentialed and has active status in the State of Washington by the Department of Health as one of the following: • 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		Documentation of any continuing education required by DOH must be placed in the individual's personnel file.

Type of staff	Degree/Experience Requirements	Credentials	Other Requirements	Notes
Certified and registered dietitian	Baccalaureate degree or higher in major course of study in human nutrition, foods, and nutrition, dietetics, or food management	• Registered with the Commission on Dietetic Registration • Certified by the Washington State Department of Health	Evidence of completion of a continuous preprofessional experience of coordinated undergraduate program in dietetics under the supervision of a qualified supervisor	Documentation of any continuing education required by DOH must be placed in the individual's personnel file.
Community health nurse	A bachelor's degree in nursing ***and*** A recent graduate or no experience in the nursing field for the past three years.	Currently licensed with the Washington State Department of Health as a registered nurse.	Completion of a six-month training/clinical supervision and mentoring plan provided by the provider agency	Documentation of any continuing education required by DOH must be placed in the individual's personnel file.
Alternative set of qualifications for community health nurse	A two-year associate's degree or three-year diploma in nursing ***and*** Two years' experience in community maternal health nursing	Currently licensed with the Washington State Department of Health as a registered nurse.	Completion of continuing education in community-based maternal child health nursing topics (such as, lactation, parent infant interaction, domestic violence, motivational interviewing, chemical dependency, family planning)	Documentation of any continuing education required by DOH must be placed in the individual's personnel file.

Type of staff	Degree/Experience Requirements	Credentials	Other Requirements	Notes
Community health nurse (cont.) Alternative set of qualifications	A two year associate's degree or three year diploma in nursing ***and*** Two-year maternal child nursing experience but limited nursing experience in the community health setting.	Currently licensed with the Washington State Department of Health as a registered nurse	Completion of a 12- month training/clinical supervision and mentoring plan provided by the provider agency	Documentation of any continuing education required by DOH must be placed in the individual's personnel file.
Community health worker (CHW)	A high school diploma or the equivalent ***and*** A minimum of one year of health care and/or social services experience		Successfully complete a training plan developed by the provider agency, including observation of client service delivery and accuracy of health education messages provided to the client Carries out all activities under the direction and supervision of a professional member or supervisor of the MSS interdisciplinary team	Supervision must occur at least monthly and will include face-to-face or group meetings, and a review of CHW documentation in client records. Documentation of the supervision received must be maintained by the provider agency and made available to the Medicaid agency upon request.

Note: The Medicaid agency will not pay for maternity support services provided by student interns. The Medicaid agency considers claims for services provided by nonqualified staff as erroneous claims and will recoup any resulting overpayment.

Requirements for certain counties and all tribes

Any county with less than 55 Medicaid births per year and all tribes must meet all MSS program requirements in this chapter, with the exception of providing services by a MSS interdisciplinary team. Instead of needing to have an interdisciplinary team, the tribe or county is required to have at least one of the following:

- A community health nurse
- Behavioral health specialist
- Registered dietitian

All these clinical staff must meet the staff qualifications detailed within this Medicaid provider guide, and must complete the orientation requirements, whether delivering direct services or supervising MSS/ICM staff. When the needs of a client are outside the scope of practice of the clinician, appropriate referrals/consultations must be attempted and documented.

MSS program services

Screening

Screening is required for each client. The screening process is a method for systematically identifying and documenting risk factors and client need.

Once a risk factor or need is identified, a clinician (behavioral health specialist, community health nurse, or registered 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.

There are two screening guides. Both the MSS Prenatal screening guide and the MSS Postpregnancy screening guide are reference documents in which sample screening questions can be found. Both screening guides may be found on the First Steps website.

Assessment

Assessment or evaluation beyond screening may be necessary. Assessment should expand beyond screening in the content area being evaluated. All types of assessment (standardized and nonstandardized) must be documented and/or filed in the client chart including dates.

Case conference

A MSS interdisciplinary team case conference is required at least once prenatally for clients entering MSS during pregnancy and eligible for expanded or maximum levels of service. Each team member must be present for the conference.

Case conferencing is used by members of the MSS interdisciplinary team to communicate and consult with each other, and, when possible, with other health care, social services providers, and/or the client to optimize client's care. Case conferences may be formal or informal consultations.

> **Note:** All MSS interdisciplinary team members must be involved in developing the care plan for clients eligible for expanded or maximum service levels.

Care plan

Based on results of a MSS screening and assessment, the provider 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:

- Assessment
- Planning
- Intervention
- Rationale
- Evaluation

The care plan should be updated throughout the maternity cycle.

MSS interdisciplinary team members must be involved in developing the care plan for clients eligible for expanded or maximum service levels.

Case management

Case management includes basic referrals to:

- Medical care
- Women Infant and Child (WIC) food program
- Childbirth Education(CBE) services
- Within Reach
- Family planning providers
- Treatment for chemical dependency, mental health problems and domestic violence, as needed.

Care coordination

Providers are required to initiate and participate in care coordination activities throughout the maternity cycle. Care coordination is a comprehensive approach to achieving continuity of care for clients. This approach seeks to ensure that care is delivered in a logical, connected and timely manner so that the medical and personal needs of the client are met.

At a minimum, care coordination must occur within the MSS interdisciplinary team, with the client's prenatal care provider and the WIC office. Coordinated communication with other community resources working with the client may be necessary to provide the appropriate care.

Providers must coordinate with other MSS/ICM providers. When seeing a client for the first time, providers must ask if the client is being seen by another MSS/ICM agency. If so, screening must not occur until the agencies coordinate to decide who is following the client.

If an agency transfers a client to another agency, the client screening and chart information must also be transferred. This will ensure continuity of care and reduce service duplication.

Care coordination may include any of the following:

- Conducting face-to-face meetings
- Making phone calls
- Transferring a client's screening tools and care plans

Alert! Providers are required to manage the available units of service to meet the client needs/risks throughout the maternity cycle. See levels of service for details about minimum and maximum units of service available for clients.

What are the documentation requirements?

[Refer to WACs 182-502-0020 and 182-533-0345]

Charting system

All MSS/ICM agencies must maintain a charting system that reflects accurate and complete documentation of all Maternity Support Services (MSS). Each MSS interdisciplinary team member must have access to all documentation recorded by the community health nurse (CHN), behavioral health specialist (BHS), registered dietitian (RD), and community health worker (CHW), including subcontractors and/or consultants.

MSS screening tools

Required forms

MSS forms must be completed by a qualified member of the MSS team. These forms may include:

- MSS Prenatal Screening Tool form 13-874
- MSS Postpregnancy Screening Tool form 13-873

Agencies also may use their own documentation forms/format, if approved by the Medicaid agency. Forms will be reviewed by the Medicaid agency at the time of a site visit or chart review.

Screening guides

The Medicaid agency's MSS prenatal and postpregnancy screening guides contain sample screening questions to assist with:

- Accurate completion of the MSS screening tool forms.
- Determination of client level of service.

Note: Providers may view the MSS screening guides through the First Steps website under the Provider Page.

Providers may elect to use their own version of these state screening guides, as long as the questions asked enable accurate completion of the MSS screening forms and determination of client level of service.

Required client record content

A complete MSS client record must be available to the Medicaid agency upon request, and must:

- Reflect services provided in a concise, efficient format and support the number of units billed.

- Clearly show risk factor progression: identification, inclusion in the care plan, intervention(s), client progress, provider follow up, and final client outcomes.

Note: Agencies using electronic documentation must adhere to the same standards outlined for paper documentation. They must be able to generate reports, as requested by the Medicaid agency. If you do not have electronic signature capability, you must have a way to fulfill the any signature requirement.

All documentation must include the following client record content:

- **Assessment** if conducted beyond the screening process

- **Case conference,** which must include dates and team members involved, and whether or not the care plan was updated based on the case conferences

- **Care coordination**

- **Care plan**

  The care plan must reflect an overview of the client's identified risk factors and anticipated interventions. For risk factors that are identified and not addressed, an explanation of why the risk factors were not addressed must be included in the chart. The care plan must identify all the individuals who participated in the plan.

- **Client data** (demographic and contact information)

  - ✓ Client name
  - ✓ Date of birth
  - ✓ Contact information (address and phone number(s)
  - ✓ Race (and if applicable, ethnicity and/or tribal affiliation)
  - ✓ Client's primary spoken language
  - ✓ Client's ProviderOne Client ID and effective date

- **Client outcome and discharge data**

  Providers are required to determine and record all of the following client data:

  - ✓ Date and reason for discharge from MSS
  - ✓ Outcomes related to any identified MSS targeted risk factors
  - ✓ Weeks of gestation when prenatal care began
  - ✓ Date family planning was discussed, and if a birth control method was initiated
  - ✓ Infant weight and gestational weeks at time of birth
  - ✓ Client-initiated breastfeeding, if applicable:
    - ➢ Was it exclusive?
    - ➢ Was the client still breastfeeding at discharge?
  - ✓ Date the client was screened for depression and results of screening, if applicable

- ✓ Results of ICM screening, if completed during the MSS eligibility period, with ICM services documented as:
  - ➢ Provided
  - ➢ Deferred, because the client/family is receiving case management services as part of another program
  - ➢ Declined by the client
- ✓ Final client outcomes must be recorded in a one summary report/document

- **Consent to care**, an agency-specific "consent to care" document signed and dated by the client indicating whether the client consented or refused

- **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:

  - ✓ 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

- **"Freedom of choice" document**

  The agency must provide a "freedom of choice declaration" for each client to read and sign. The declaration must inform the client that she is:

  - ✓ Not required to participate in MSS/
  - ✓ Free to choose any MSS/ICM provider to receive MSS regardless of where she lives or receives health care and/or WIC services.

- **"Release of information" form**

  MSS services are considered health care services and are covered under HIPAA regulations. The agency-specific "release of information" form is a provider form that must be signed by the client. The form must comply with RCW 70.02.030.

- **Signature log and copies of staff's legal signatures**

  All client charts must contain a signature log, with printed names and titles of all agency staff providing care in addition to a copy of their legal signatures. If staff initials are used in the chart, a legible sample must be included on the signature log.

- **Screening forms** (13-874 and 13-873)

- **Visit record/notes** (for each MSS visit)

  - ✓ Date of visit
  - ✓ Time the visit started and ended
  - ✓ Location of visit – home, office, hospital
  - ✓ Any intervention(s) provided
  - ✓ Client progress related to risk factors documented on the care plan and addressed during the visit
  - ✓ Reason for not addressing prioritized risk factor at visit
  - ✓ Any follow-up required from the previous visit
  - ✓ Next steps
  - ✓ Signature of the person providing MSS services

What MSS services are covered?

[Refer to WAC 182-533-0330]

The Medicaid agency covers maternity support services (MSS) provided by a MSS interdisciplinary team member. Covered services include:

- In-person screening and assessment of risk factors related to pregnancy and birth outcomes
- Education that relates to improving pregnancy and parenting outcomes
- Brief counseling
- Interventions for risk factors identified on the care plan
- Basic health messages
- Case management
- Care coordination
- Family planning screening and referral
- Screening, education and referral(s) for tobacco usage and second-hand smoke exposure
- Infant case management (ICM) screening.

The Medicaid agency pays for these covered maternity support services on a fee-for-service basis as long as MSS is:

- Provided to a client who meets the eligibility requirements in WAC 182-533-0320.
- Provided to a client on an individual basis in a face-to-face encounter.
- 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.
- Billed using the correct procedure codes and modifiers identified in this chapter. (See the MSS coverage table.)
- Billed using the provider's NPI and taxonomy code 171M00000X.

Notes: Travel expenses, charting time/documentation, phone calls and mileage are built into the reimbursement rate for MSS. If the client becomes pregnant within 12 months from the end of the previous pregnancy, enter the new "Due Date" in field 19 on the CMS-1500 claim form for new MSS services.

Levels of service

- Providers must bill in units service with one unit of service equaling 15 minutes, delivered face-to-face. (See WAC 182-533-0345.)
- If two or more of the MSS provider's staff meet with a client at the same time, only one discipline can bill for each 15 minute unit of time spent with the client.

  For example, if a registered nurse and registered dietitian visit a client together for 45 minutes, a maximum of three units is billable for this visit—not six units.
- No more than six units per client may be billed for one date of service.
- If the client's level of service increases, she is eligible for more units. For example, she may move from basic to expanded.
- If the client's level of service moves to a lower level during the pregnancy or postpregnancy periods, the units of service available do not decrease.
- Clients enrolled in MSS prenatally must be screened in postpregnancy to determine any increase in level of service.

- If all available units are used during the prenatal period, staff must document the following:

  - ✓ The client's circumstances with an 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 postpregnancy needs.

See the table on the next page for more specific information about basic, expanded, and maximum levels of service with allowable units for clients.

Number of Units per Level of Service

Level of Service and Allowable Units *(for the entire maternity cycle)*		**Required Services**
Client Enrolled in MSS During Prenatal Period	**Basic = 7 units**	Screening, Care Coordination, Case Management, BasicHealth Messages and Other Messages based upon client need
	Expanded = 14 units	Screening, Care Coordination, Case Management, BasicHealth Messages, Clinical Assessment and Interventions, Case Conference
	Maximum = 30 units	Screening, Care Coordination, Case Management, BasicHealth Messages, Clinical Assessment and Interventions, Case Conference
Level of Service and Allowable Units *(for the postpregnancy eligibility period)*		**Required Services**
Client Enrolled in MSS Postpregnancy Period Only (client did not receive any MSS during the prenatal period)	**Postpregnancy Basic = 4 units**	Screening, Care Coordination, Case Management BasicHealth Messages and Other Messages based upon client need
	Postpregnancy Expanded = 6 units	Screening, Care Coordination, Case Management, BasicHealth Messages Clinical Assessment and Interventions, Case Conference
	Postpregnancy Maximum = 9 units	Screening, Care Coordination, Case Management, BasicHealth Messages, Clinical Assessment and Interventions, Case Conference

Limitation extension requests

Limitation extension requests for units exceeding the number of allowed MSS units of service may be requested by providers.

- A limitation extension request must be preauthorized.

- Limitation extension requests:
  - ✓ Must be submitted using Limitation Extension Request (Maternity Support Services and/or Infant Case Management) form, 13-884.

  - ✓ Must be completed according to the directions on the form.

  - ✓ Must be submitted with:

    - ➢ General Information for Authorization form, 13-835
    - ➢ The complete MSS chart, which includes the care plan

Note: Federally Qualified Health Centers (FQHCs) must follow billing guidelines found in the Medicaid agency's Federally Qualified Health Center (FQHC) Medicaid Provider Guide.

What MSS services are not covered?

[Refer to WAC 182-533-0340]

The agency evaluates requests for any noncovered service following the requirements and process in WAC 182-501-0160.

MSS Coverage Table

Procedure Code	Diagnosis Code	Modifiers*	Short Description	Policy/ Comments
Maternity Support Services				
T1002	V22.2	HD	RN services, up to 15 minutes	**1 unit = 15 minutes** during a MSS community health nursing visit
T1002	V22.2	HD TF	RN services, up to 15 minutes	**1 unit = 15 minutes** during a MSS community health nursing visit for clients screening in with risk factors at expanded level
T1002	V22.2	HD TG	RN services, up to 15 minutes	**1 unit = 15 minutes** during a MSS community health nursing visit for clients screening in with risk factors at maximum level (high risk)
S9470	V22.2	HD	Nutritional counseling, dietitian visit	**1 unit = 15 minutes** during a MSS dietitian visit
S9470	V22.2	HD TF	Nutritional counseling, dietitian visit	**1 unit = 15 minutes** during a MSS dietitian visit for clients screening in with risk factors at expanded level
S9470	V22.2	HD TG	Nutritional counseling, dietitian visit	**1 unit = 15 minutes** during a MSS dietitian visit for clients screening in with risk factors at maximum level (high risk)
96152	V22.2	HD	Behavioral health specialist	**1 unit = 15 minutes during a** MSS behavioral health visit
96152	V22.2	HD TF	Behavioral health specialist	**1 unit = 15 minutes during a** MSS behavioral health visit for clients screening in with risk factors at expanded level

Procedure Code	Diagnosis Code	Modifiers*	Short Description	Policy/ Comments
Maternity Support Services				
96152	V22.2	HD TG	Behavioral health specialist	**1 unit = 15 minutes during a** MSS behavioral health visit for clients screening in with risk factors at maximum level (high risk)
T1027	V22.2	HD	Family training and counseling for child development (community health worker)	**1 unit = 15 minutes** during a MSS community health worker visit
T1027	V22.2	HD TF	Family training and counseling for child development	**1 unit = 15 minutes** during a MSS community health worker visit for clients screening in with risk factors at expanded level
T1027	V22.2	HD TG	Family training and counseling for child development (community health worker)	**1 unit = 15 minutes** during a MSS community health worker visit for clients screening in with risk factors at maximum level (high risk)

*For tribal programs to receive reimbursement, use the procedure codes and modifiers above with these *additional* modifiers on claims:

American Indian/Alaska Native (AI/AN) client	Use additional modifier UA
Nonnative client	Use additional modifier SE

Fee schedule

You can view the Medicaid agency's Maternity Support Services/Infant Case Management Fee Schedule online.

Infant Case Management

What is the purpose of Infant Case Management?

[Refer to WAC 182-533-0360]

The purpose of Infant Case Management (ICM) is to improve the welfare of infants by providing their parents with information and assistance to access needed medical, social, educational, and other services. Families meeting criteria for ICM will be offered services that focus on referrals and linkage to community resources and client advocacy. Families who did not receive Maternity Support Services (MSS) may be eligible for ICM services.

How can I verify a patient's eligibility for ICM?

[Refer to WAC 182-533-0370]

To be eligible for ICM, the infant must:

- Be within the ICM eligibility period, which is the day after the mother's maternity cycle ends and continues through the last day of the month of the infant's first birthday.
- Reside with at least one parent.
- Not be receiving any case management services funded through Title XIX Medicaid that duplicate ICM services.

In addition to the above, 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 the agency will not pay for.

Verifying eligibility is a two-step process:

Step 3. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

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

Step 4. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

4. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
5. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
6. 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 www.wahealthplanfinder.org or call the Customer Support Center.

How "parent" is defined

[Refer to WAC 182-533-0315]

For ICM, a parent(s) is a person that resides with an infant and provides the infant's day-to-day care, and is one of the following:

- The infant's natural or adoptive parent(s)
- 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

When the infant's mother becomes pregnant during the ICM eligibility period

If the infant's mother becomes pregnant during the ICM eligibility period and she is eligible for MSS, ICM services are closed. The MSS eligibility period would begin upon learning of the pregnancy. Maternity Support Services for the new pregnancy begin and are billed using MSS procedure codes.

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 his/her 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 CPS case and is still in his/her parents' home. No other Title XIX case management is being provided (like Early Intervention Program services). ICM could be delivered to the family in the home without the concern of duplicate billing.
- If more than one Title XIX funded service is involved with an ICM family, ICM must be closed in order to prevent duplicate payments.
- Grandparents have legal custody of the infant. The infant may be eligible for ICM, provided that the infant meets the eligibility criteria to receive ICM.

What are the provider requirements for ICM?

[Refer to WAC 182-533-0325]

General requirements

MSS/ICM services may only be provided by an agency or entity that is currently enrolled as an eligible provider with the Medicaid agency (WAC 182-533-0325).

The approved agency or entity also 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.

  Notes: All clients (fee-for-service and managed care) must be free to choose any approved MSS/ICM agency regardless of where she/he receives prenatal, postpregnancy or pediatric medical care. Clients cannot be limited to MSS/ICM providers in a given county or clinic, even if the client receives all other Medicaid agency-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.

  An approved agency or entity must inform the eligible client of the *option* to receive MSS/ICM and *must not force* the client to receive MSS/ICM services for which the client and/or the client's infant might be eligible.
- Deliver ICM covered services as described in WAC 182-533-0330.
- 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 assure the overall quality and continuity of client care.
- Maintain and make available to the Medicaid agency upon request: clinical supervision plans, consultation plans, staff training plans, and current and historical personnel rosters, clients charts and records covering the last six years.
- Comply with documentation requirements.
- Create and maintain a system to track units used in service delivery.

- Appoint a designated person (usually First Steps Coordinator) to periodically view the First Steps website for updates and information regarding the program.

Note: MSS/ICM providers are mandatory reporters. If there is reasonable cause or concern that child abuse or neglect has or is occurring, a referral to CPS must be made by calling 1-800-363-4276.

Qualifications for a person to deliver ICM

ICM services must be provided only by a qualified person who is employed by an agency or entity that meets the requirements outlined within this Medicaid provider guide. To qualify as an ICM provider, the person must meet at least one of the following:

- Is a current member of the MSS interdisciplinary team who qualifies as a community health nurse, behavioral health specialist, or registered dietitian. (See MSS staff requirements.)

-or-

- Has a bachelor's or master's degree in a social service-related field, **plus** at least one year of full-time experience working in one or more of the following areas:

  - ✓ Community services
  - ✓ Social services
  - ✓ Public health services
  - ✓ Crisis intervention
  - ✓ Outreach and referral programs
  - ✓ Other social service-related fields

-or-

- Has a two-year associate of arts degree in a closely allied field, **plus** at least two years of full-time experience in an area listed above **and** ongoing monthly supervision by a member of the MSS interdisciplinary team. (Supervision may include face-to-face meetings, chart reviews, or both.)

Note: The Medicaid agency considers claims for services provided by nonqualified staff as erroneous claims and will recoup any resulting overpayment.

Places services may be delivered

The Medicaid agency pays for an ICM visit when the services are provided in:

- An agency's office or clinic
- The infant's home (client's residence)
- An alternate site that is not the client's residence in the case of an unsafe place of residence or a potential problem with client confidentiality

  (The reason for using an alternate site for visitation instead of the home must be documented in the client's record.)

What are documentation requirements for ICM?

[Refer to WACs 182-502-0020 and 182-533-0386]

Charting system

A complete client record must be available to the Medicaid agency upon request, and must:

- Reflect services provided in a concise, efficient format and support the number of units billed.
- Clearly show risk factor progression: identification, inclusion in the care plan, intervention(s), client progress, provider follow up, and final client outcomes.

ICM Screening Tools

The ICM Screening Tool form, 13-658, is a screening tool and must be completed by a qualified member of the MSS/ICM team. Agencies also may use their own documentation forms/format, if approved by the Medicaid agency. Forms will be reviewed by the Medicaid agency at the time of a site visit or chart review.

Required ICM client record content

Each client must have one client record (central file) that includes all chart notes by the Infant Case Manager including subcontractors or consultants. All documentation must support the services provided regardless of documentation system used.

Note: Agencies using electronic documentation must adhere to the same standards outlined for paper documentation. They must be able to generate reports, as requested by the Medicaid agency. If you do not have electronic signature capability, you must have a way to fulfill the any signature requirement.

The required record content for ICM clients must include:

- **Screening tool,** the ICM Screening Tool form, 13-658
- **Care coordination**, including all care coordination activities for the client
- **Care plan**, reflecting an overview of the client's identified risk factors and anticipated actions the provider will take to address those risks
- **Consent to care**, which is an agency-specific "consent to care" document signed and dated by the client, whether the client consented or refused
- **Contact log**, which is a chronological record of all contacts made with, or regarding a client, including telephone contacts
- **Demographic and contact information** - Legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  ✓ Client's name
  ✓ Date of birth
  ✓ Contact information
  ✓ Race (and if applicable, ethnicity and tribal affiliation)
  ✓ Primary language spoken
  ✓ Infant's ProviderOne ID number
  ✓ Infant's parent or guardian information

- **"Freedom of Choice" document,** a declaration signed by the client, informing the client that:

  ✓ Participation in ICM is optional

  ✓ Services may be received through any MSS/ICM approved agency no matter where the client lives or receives health care and/or WIC services

- **"Release of information" form**

  ICM services are considered health care services and are covered under HIPAA regulations. The agency-specific "release of information" form is a provider form that must signed by the client. The form must comply with RCW 70.02.030.

- **Signature log and copies of staff's legal signature**

  All client charts must contain a signature log, with printed names and titles of all agency staff providing care in addition to a copy of their legal signatures. If staff initials are used in the chart, a legible sample must be included on the signature log.

- **Client outcome and discharge,** including the date and reason for discharge from ICM

  - ✓ Final client outcomes recorded in one summary report/document for each client
  - ✓ Results of ICM screening with ICM services documented as:
    - ➢ Provided
    - ➢ Deferred, because the client/family is receiving case management services as part of another program
    - ➢ Declined by the client

Visit record/notes (for each ICM visit)

- ✓ Date of visit
- ✓ Time the visit started and ended
- ✓ Location of visit—home, office, hospital
- ✓ Any other nonICM risk factor that may impact the infant's welfare (even if the risk factor is not addressed)
- ✓ Any intervention(s) provided, such as referrals and linkages
- ✓ Client progress related to risk factors documented on the care plan and addressed during visit
- ✓ Reason for not addressing prioritized risk factor at visit
- ✓ Any follow-up required from the previous visit
- ✓ Next steps
- ✓ Signature of the person providing ICM services

What services are covered under ICM?

[Refer to WACs 182-533-0380 and -0386]

The Medicaid agency covers eligible infants on a fee-for-service basis for case management under the ICM program, including:

- An initial in-person screening, which includes an assessment of risk factors and developing an individualized care plan.

- Providing case management services and care coordination.

- Referring and linking the infant and parent(s) to other services or resources.
- Advocating for the infant and parent(s).
- Following up with infants and their parent(s) to ensure that the care plan continues to meet the needs of the infant and parent(s).

The Medicaid agency pays for these covered ICM services on a fee-for-service basis when:

- Provided by a provider meeting the ICM provider requirements listed in this Medicaid provider guide.
- Provided to a client meeting the eligibility requirements in WAC 182-533-0370.
- Documented in the infant's and/or parent's chart/record (see the ICM documentation requirements).
- Billed using the infant's ProviderOne Client ID.
- Billed using the correct procedure codes and modifiers identified in this provider guide. (See the ICM coverage table.)
- Billed using the provider's NPI and taxonomy code 171M00000X.

Note: Infant Case Management Services must be billed using the Infant's ProviderOne Client ID. **Do not** use the mother's ProviderOne Client ID.

Levels of service

All infants/parents must be screened to determine if there is a need to assist the family in accessing medical, social, educational or other services. The number of units an infant may receive is based on the amount of assistance the parent(s) needs in accessing services to address identified risk(s).

Providers screening infants and parents must use the ICM Screening Tool form, 13-658.
If no risk factor is identified (in Column A of the form), the amount of services is limited to two units for the eligibility period, unless there is a change in circumstances. Units used to screen clients are included in the maximum allowed in each level.

All services must be delivered face-to-face with the infant present.

Lower level case management allows an infant up to six units of ICM services during the ICM eligibility period. This means that the parent(s) is able to access services with minimal assistance from an infant case manager.

Higher level case management allows a client up to 20 units of service throughout the eligibility period. For higher level services, the parent demonstrates a greater need for assistance in accessing available services. The case manager may provide these additional services that are appropriate for the client, based on a family's identified needs.

Examples of parents needing more assistance include:

- A parent not showing for scheduled appointments.
- A parent requesting extra services due to circumstances that prevent access, such as suffering from depression.
- An adolescent parent with little understanding of infant and child development.
- A parent with a premature infant who has complex medical needs.

Note: The units used to do the screening during the ICM eligibility period must be deducted from the maximum number of units allowed for whatever level the infant/parent qualifies.

Number of units for levels of service

Providers must bill in units of service with one unit of service equaling 15 minutes delivered face-to-face. Other considerations for billing ICM units are:

- No more than two units may be billed to complete the ICM Screening Tool form, 13-658.
- Infants qualifying for **lower level** may receive a maximum of six units of service throughout the ICM eligibility period, as documented using the ICM Screening Tool form, 13-658.
- Infants qualifying for **higher level** may receive a maximum of 20 units of service throughout the ICM eligibility period as documented using the ICM Screening Tool form, 13-658.
- If the infant's circumstances causes a change to a higher level of service, the appropriate number of units may be added. Total units may not exceed 20.
- If the infant's circumstances cause a change to a lower level of service, the units of service available do not change. However, the client must demonstrate need for remaining units to be used.

Limitation extension requests

Limitation extension requests for units exceeding the number of allowed ICM units of service may be requested by providers.

- A limitation extension request must be preauthorized.
- Limitation extension requests:
  - ✓ Must be submitted using Limitation Extension Request (Maternity Support Services and/or Infant Case Management) form, 13-884.
  - ✓ Must be completed according to the directions on the form.
  - ✓ Must be submitted with:
    - ➢ The General Information for Authorization form, 13-835.
    - ➢ The complete ICM chart, which includes the care plan.

What services are not covered under ICM?

[Refer to WAC 182-533-0385]

The agency evaluates requests for any noncovered service following the requirements and process in WAC 182-501-0160.

ICM Coverage Table

Procedure Code	Diagnosis Code	Modifier*	Short Description	Policy/ Comments
Infant Case Management				
T1017	V20.1	HD	Targeted case management, each 15 minutes	1 unit = 15 minutes

*For tribal programs to receive reimbursement, use the procedure code and modifier above with these *additional* modifiers on claims:

American Indian/Alaska Native (AI/AN)	Use additional modifier UA
Nonnative client	Use additional modifier SE

Fee schedule

You can view the Medicaid agency's Maternity Support Services/Infant Case Management Fee Schedule online.

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the Medicaid agency's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill the Medicaid agency for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

How is the CMS-1500 claim form completed?

Note: Refer to the Medicaid agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

The following CMS-1500 claim form instructions relate to the MSS/ICM providers:

Field No.	Name	Entry
19.	**Reserved for Local Use**	Enter the estimated due date for clients who become pregnant again before ICM ends. This is necessary in order to "Reset" the clock for the new pregnancy in the claims system.
24B.	**Place of Service**	**Code** — **To Be Used For** 07 — Tribal 638 free standing facility 08 — Tribal 638 provider based facility 11 — Office 12 — Client's residence (home visit)
24G.	**Days or Units**	One date of service per billed line. Multiple units will be billed regularly using the 15-minute codes.

The Medicaid agency recognizes taxonomy code 171M00000X as appropriate for MSS/ICM Services.