



**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAID PURCHASING ADMINISTRATION**

and

**Department of Health
Office of Maternal and Child Health**



**Maternity Support Services/
Infant Case Management
Billing Instructions**

[WAC 388-533-0300 and 388-533-0386]

About This Publication

This publication supersedes all previous Department/MPA *Maternity Support Services/Infant Case Management Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **June 27, 2010.**

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Document	Subject	Issue Date	Pages Affected
Billing Instructions	Definitions and Abbreviations	June 27, 2010	1-5
Billing Instructions	About the Program	June 27, 2010	A.1-A.2
Billing Instructions	Maternity Support Services	June 27, 2010	B.1-B.20
Billing Instructions	Infant Case Management	June 27, 2010	C.1-C.10
Billing Instructions	Billing and Claim Forms	June 27, 2010	D.1

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How Can I Get the Department/MPA Provider Documents?

To download and print the Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at <http://hrsa.dshs.wa.gov> (click the *Billing Instructions and Numbered Memorandum* link).

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Important Contacts

Note: This section contains important contact information relevant to MSS/ICM. For more contact information, see the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	Department of Health MSS Coordinator 360-236-3967
Finding out about payments, denials, claims processing, or Department managed care organizations	See the Department/MPA <i>Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
Prior authorization, limitation extensions, or exception to rule	
Policy or program oversight for Maternity Support Services	Department of Health MSS Coordinator 360-236-3967
Policy or program oversight for Infant Case Management	Department-MPA ICM Program Manager 360-725-1293

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Applicant – A person who has applied for medical assistance.

Assessment – The collection of information beyond screening to identify client strengths and needs to develop an individualized care plan with interventions, and document client progress and outcomes.

Basic Health Messages – For the purposes of this program, means preventive health education messages designed to promote healthy pregnancies, healthy newborns, and healthy parenting.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Care Coordination - Professional collaboration and communication between the client’s MSS provider and other medical and/or health and social service providers to address the individual client’s needs as identified in the care plan.

Care Plan – A written plan that must be developed and maintained throughout the eligibility period for each client in MSS and ICM.

Case Conference – Communication and consultation between members of the MSS interdisciplinary team, and when possible, health care and social service providers and/or the client to optimize client care.

Case Management – Services to assist individuals who are eligible to gain access to needed medical, social, educational, and other services.

Chemical Dependency – A condition characterized by reliance on psychoactive chemicals. These chemicals include alcohol, marijuana, stimulants such as cocaine and methamphetamine, heroin, and/or other narcotics. Dependency characteristics include: loss of control over the amount and circumstances of use, symptoms of tolerance, physiologic and psychologic withdrawal when use is reduced or discontinued, and substantial impairment or endangerment of health, social and economic function.

Childbirth Education (CBE) – A component of the First Steps program that provides enhanced services to women during pregnancy. CBE includes a series of educational sessions offered in a group setting and led by an approved instructor that prepares a pregnant woman and her support person(s) for an upcoming childbirth. See the Department/MPA *Childbirth Education Billing Instructions*.

Child Protective Services (CPS) - The program within the Division of Child and Family Services authorized by statute (RCW 26.44) to receive and investigate referrals of child abuse, neglect, and exploitation.

Children's Health Program - A state-funded full-scope health program for children 17 years of age and younger who are not eligible for a federal health program

Clinical Supervision – A formal process of professional support and learning that enables an individual to develop additional knowledge and competence in their professional discipline. Clinical supervision focuses on matters related to client safety and best practice for the identified professional discipline. Supervisors of BHS staff must meet qualifications as described in WACs 246-810-025, 246-809-134, 246-809-234, and 246-809-334.

Community Services Office (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level.

Core Provider Agreement - The basic contract between the Department and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs.

Department of Health (DOH) – The Washington state agency whose mission is to protect and improve the health of people in Washington State.

Enhanced Services - For the purpose of the First Steps Program means:

- Childbirth education (CBE)
- Infant case management (ICM)
- Maternity support services (MSS)

EPSDT Provider - (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; *or* (2) a dentist, dental hygienist, audiologist, optometrist or ophthalmologist who is an enrolled Medical Assistance provider and performs all or one component of the ESPDT screening.

First Steps - The program created under the 1989 Maternity Care Access Act (RCW 74.09)

Home Visit – Services delivered in the client's place of residence or other setting if a visit in the client's home is not possible due to an unsafe place of residence or a potential problem with client confidentiality.

Infant Case Management (ICM) – Established as a component of the First Steps program to provide a parent(s) with information and assistance in accessing needed medical, social, educational, and other services to improve the welfare of infants.

Intervention – An action or effort that addresses client risk factors and needs, focused on improving the health status of women and infants.

Linking – Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.

Managed Care - A comprehensive system of medical and health care delivery that includes preventive, primary specialty, and ancillary health services. These services are provided through a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-538-050]

Maternity Cycle – Eligibility period for maternity support services that begins during pregnancy and continues to the end of the month in which the sixtieth-day post pregnancy occurs.

Maternity Support Services (MSS) – A component of the First Steps program that provides enhanced services to women during the maternity cycle and their newborn infants. MSS includes screening, assessment, basic health messages, education, counseling, case management, care coordination and other interventions delivered by an MSS interdisciplinary team.

Maternity Support Services (MSS) Interdisciplinary Team – A team consisting of at least a community health nurse, a certified registered dietitian, a behavioral health specialist and at the discretion of the MSS/ICM agency, a community health worker. The team works together and communicates frequently to share specialized knowledge, skills and experience in order to address risk factors identified in the client’s care plan. Based on individual client needs, each team member must be available to provide maternity support services and consultation.

Maternity Support Services (MSS)/Infant Case Management (ICM)/ Childbirth Education (CBE) Management Team – Employees from the Department of Social and Health Services (the Department) and Department of Health (DOH) who are responsible for collaboratively managing the First Steps program. This team provides technical assistance to First Steps MSS/ICM and CBE providers and their staff. Members of this team develop program policy, protocols, and guidelines for service delivery; monitor data related to services delivery and monitor providers.

Maximum allowable - The maximum dollar amount the Department will reimburse a provider for a specific service, supply, or piece of equipment.

Medical Identification Card(s) – See *Services Card*.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Office Visit – Services delivered in an office (or an alternate) formal setting at the agency or an off-campus site (for example: WIC clinic, satellite office, clinic site, mobile office.).

Parent(s) – For the purpose of ICM, a parent is a person who resides with an infant and provides the infant’s day-to-day care, and is:

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

Performance measure - An indicator used to measure the results of a focused intervention or initiative.

Post-pregnancy period – The portion of the maternity cycle that starts when a pregnancy ends and continues through the end of the month in which the sixtieth day of the end of the pregnancy occurs. (CFR 435.70)

Provider – For the purpose of MSS/ICM, any person or organization that is approved by the DOH, enrolled as an eligible provider with the Department and has a signed contract or Core Provider Agreement with the Department.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system assigned number that uniquely identifies a single Client within the ProviderOne system; the number consists of nine numeric characters followed by WA.

For example: 123456789WA.

Psychoactive Chemicals - Chemicals, including alcoholic beverages, controlled substances, prescription drugs, and over-the-counter (OTC) drugs, which affect mood and/or behavior. Nicotine and food are not considered psychoactive chemicals.

Referral – Providing information and support to clients that will assist them in accessing medical, social, educational, or other services.

Risk factors – Biopsychosocial factors that could lead to poor birth outcomes, and infant morbidity, and/or infant mortality.

Screening – A brief, in person evaluation to detect the presence of a specific risk factor(s).

Services Card – A plastic “swipe” card that the Department issues to each client on a “one- time basis.” Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client’s name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Subcontractor - An individual or agency that has contracted with an approved MSS/ICM provider to provide services to MSS/ICM clients. This individual or agency must be informed of, and comply with, all regulations contained in the Core Provider Agreement and these billing instructions as they pertain to service delivery to the MSS/ICM the client.

Taxonomy Code - A unique, 10-digit, alphanumeric code that allows a provider to identify their specialty category. Providers applying for their NPI will be required to submit their taxonomy information. Providers may have one or more than one taxonomy associated to them. Taxonomy Codes can be found at <http://www.wpc-edi.com/codes/Codes.asp>.

Unit of service – Fifteen minutes of one-to-one service delivered face-to-face.

Usual and customary charge – The fee that the provider typically charges the general public for the product or service.

WithinReach – An organization that connects families to essential health resources through four statewide hotlines and ParentHelp123.org, an interactive website that helps families find and apply for programs and local services available to them.

Women, Infant, and Children (WIC) Nutrition Program - A nutrition program that helps pregnant/post-pregnant women, new mothers, and young children eat well, learn about nutrition and stay healthy.

About the Program

What is First Steps?

First Steps is the term used to describe the program created under the 1989 Maternity Care Access Act (RCW 74.09). This program includes:

- **Medical Services**, including prenatal care, delivery, post pregnancy follow-up, dental care, vision care and one year of family planning services post pregnancy for eligible women. Newborns receive one year of full medical care.
- **Enhanced Services, including:**
 - ✓ Maternity Support Services (MSS),
 - ✓ Infant Case Management (ICM), and
 - ✓ Childbirth Education (CBE) (link to CBE BI's here)
- **Expedited alcohol and drug assessment and treatment services** for eligible pregnant women and their infants. This is offered through the Omnibus Drug Act, which encompasses residential treatment, outpatient treatment and transitional housing (WAC 388-533-0701).
- **Ancillary services** including expedited eligibility determination, case finding, outreach, transportation and interpreter services.

What are Maternity Support Services and Infant Case Management?

MSS and ICM are two components of First Steps.

First Steps MSS and ICM are managed by the Department of Social and Health Services (the Department) Medicaid Purchasing Administration (MPA) with assistance from the Department of Health.

Maternity Support Services (MSS) are designed to provide enhanced preventive health and education services and brief interventions to eligible pregnant women as early in a pregnancy as possible based on the client's individual risks and needs. Infant Case Management (ICM) is to improve the welfare of infants by providing their parent(s) with information and assistance in order to access needed medical, social, educational, and other services through the infant's first year of life.

Goals of MSS/ICM include:

- Increased in early access and ongoing use of prenatal and newborn care;
- Decrease in maternal morbidity and mortality;
- Decrease in low birth-weight babies;
- Decrease in premature births; (Continued on next page)

(Continued from previous page)

- Decrease in infant morbidity and mortality rates;
- Decrease in health disparities;
- Reduction in the number of unintended pregnancies;
- Reduction in the number of repeat pregnancies within two years of delivery;
- Increase initiation and duration of breastfeeding; and
- Reduction of tobacco use during pregnancy and pediatric exposure to second-hand smoke.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES! However, the Department reimburses for MSS/ICM through its fee-for-service system. **Bill the Department directly.** Clients enrolled in a Department managed care plan are eligible for MSS/ICM outside of their plan. When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen.

Maternity Support Services

What Is the Purpose of Maternity Support Services?

The purpose of maternity support services (MSS) is to:

- Improve and promote healthy birth outcomes; and
- Facilitate access to:
 - ✓ Prenatal care as early in pregnancy as possible; and
 - ✓ Healthcare for infants of eligible clients (WAC 388-533-0310).

Who Is Eligible for MSS?

To be eligible for MSS, a client must:

- Be pregnant or within 60 days post pregnancy; and
- Be covered by a benefit service package that covers MSS.

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Coverage Chart* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Note: If the client is pregnant but her services card does not identify one of the covered benefit service packages, please refer her to the local community services office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

How Long Is a Woman Eligible for MSS?

Medicaid eligible women may receive MSS during pregnancy and through the post pregnancy period (the last day of the month from the 60th day after the pregnancy ends).

What Are the Provider Requirements for MSS?

MSS/ICM services can only be provided by an agency or entity that is currently approved by the Department of Health and enrolled as an eligible provider with the Department (WAC 388-533-0325).

The approved agency or entity must also:

- Meet the requirements in chapter 388-502 WAC Administration of Medical Programs – Provider Rules;
- Comply with Section 1902(a)(23) of the Social Security Act regarding freedom to choose a provider: “...any individual eligible for medical assistance may obtain assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required.”

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, post pregnancy or pediatric medical care.

Note: Clients cannot be limited to MSS/ICM providers in a given county or clinic, even if the client receives all other Department-covered services through that county or clinic.

- Comply with Section 1915(g)(1) of the Social Security Act regarding 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 covered services as described in WAC 388-533-0330 and;
- Provide both MSS and ICM services. All clients who have received MSS must be screened for ICM eligibility, and screening results must be documented in the client’s chart. If eligible for ICM, services are either:
 - ✓ Provided; or
 - ✓ Deferred, because the client/family is receiving case management services as part of another program; or
 - ✓ Declined by the client.

Refer a client who may need chemical dependency assessment to a provider who is contracted with the Division of Behavioral Health and Recovery (DBHR). To see a directory of Department certified chemical dependency service providers visit the Department online at: <http://www.dshs.wa.gov/dasa/services/certification/directory/directory.shtml>

- Staff that deliver covered services must meet staff qualifications described within these billing instructions.

Maternity Support Services/Infant Case Management

- All employees that an agency could submit a bill for providing an MSS/ICM service must complete the following orientation requirements:
 - ✓ Before the agency can bill for a covered service provided by the employee, the employee must read the following:
 - Chapter 388-533 WAC;
 - MSS/ICM Billing Instructions; and
 - First Steps Manual;
 - ✓ Within 30 days of the first date of providing a covered service, the employee must complete:
 - The “First Steps Family Planning Performance Measure (Link)” online training;
 - Registration for the “ABC’s of First Steps training.

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

- Maintain and make available to the Department upon request or MSS/ICM/CBE Management Team upon request, clinical supervision plans, consultation plans, staff training plans, and current and historical personnel rosters covering the last six years;
- Comply with documentation requirements;
- Maintain a system to track units used in service delivery;
- Appoint a designated person (usually First Steps Coordinator) to receive communications from the First Steps Messages Mailbox; and
- Follow all other requirements as described in WAC 388-533-0325.

What are the Required Program Elements for MSS?

To assure the overall quality and continuity of client care, each agency must include the following elements within its program model:

- **Interdisciplinary Team** – MSS must be delivered by an interdisciplinary team; each qualified staff acting within her/his area of expertise to address the variety of client needs during the maternity cycle.
- **Staff qualifications** – MSS must be delivered by a qualified person. A qualified person includes:

✓ Behavioral Health Specialist(s) that:

- Has a master's degree in counseling, social work, marriage and family therapy; or
- Has a bachelor's degree in counseling, social work or marriage and family therapy; and
- 2 years post graduate experience not including internships. or practicum; and
- Is currently credentialed 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; and
- Abide by the terms and conditions described in the credential and operate within the scope of the behavioral health specialist job description in the First Steps Manual.

To download and print the First Steps Manual, go to the Department/MPA website at: <http://hrsa.dshs.wa.gov/firststeps/Provider%20Page/First%20Steps%20Manual.1.pdf>

Note: Any behavioral health specialist that holds credentials, but is not listed above is not eligible to bill for MSS services provided to an eligible client.

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✓ Certified and registered dietitian(s) who is currently:

- Registered with the Commission on Dietetic Registration, and
- Certified by the Washington State Department of Health, and
- Operating within the scope of the certified registered dietitian job description in the First Steps Manual.

To download and print the First Steps Manual, go to the Department/MPA website at: <http://hrsa.dshs.wa.gov/firststeps/Provider%20Page/First%20Steps%20Manual.1.pdf>.

✓ Community health nurse(s) who is currently licensed with the Washington State Department of Health as a registered nurse and:

- Has a bachelor's degree in nursing and;
- Is a recent graduate or has not worked in the nursing field for the past three years. This person is **required to complete a six-month training/clinical supervision and mentoring plan** provided by the agency. The plan will document progress and experience that enhances knowledge and skills in community maternal child health nursing. The plan must be submitted for approval to the First Steps state nurse consultant within 60 days of hire;

OR

- Has a two year associate's degree or three year diploma in nursing; and
- Has two years experience in community maternal health nursing, plus documented continuing education in community-based maternal child health nursing topics (i.e. lactation, parent infant interaction, domestic violence, motivational interviewing, chemical dependency, family planning);

OR

- Has a two year associate's degree or three year diploma in nursing; and

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- Has at least two years maternal child nursing experience, but limited nursing experience in the community health setting. This person is required to complete a twelve (12) month **training/clinical supervision and mentoring plan provided by the agency**. The plan to document progress and experience that enhances knowledge and skills in community maternal child health nursing. The plan must be submitted for approval to the First Steps state nurse consultant within 60 days of hire.

AND

- Operates within the scope of the community health nurse job description in the First Steps Manual.

Note: The Department will not pay for maternity support services provided by student interns.

✓ Community health worker (CHW)

Each MSS/ICM agency has discretion to add staff to the MSS/ICM interdisciplinary team. MSS/ICM agencies must ensure that the following requirements for CHW are met:

- Have a high school diploma or the equivalent; and
- Have one year of health and/or social services experience; and
- Operate within the scope of the community health worker job description in the First Steps Manual;
- Completes the CHW-specific orientation/observation requirements; and
- Carries out all activities under the direction and supervision of a professional member or supervisor of the MSS interdisciplinary team;

AND

Before providing services and making a claim, the CHW must complete both the standard required staff orientation; (as described within these billing instructions) and the supervisor must confirm that the CHW has met the following requirements by documenting in the CHW's personnel record that the CHW demonstrates:

- A clear understanding of what her/his role and responsibilities will be in carrying out assigned activities with clients.
- A clear understanding of, and agreement to, carry out her/his assigned responsibilities in a client's care plan.
- The skills and ability to interact with clients on a one-on-one basis.
- The skills and ability to document provision of covered MSS services.

CHW Orientation: In addition to registering for the ABCs of First Steps training within 30 days of hire, the CHW must also successfully complete the specific orientation with the supervisor, using the CHW Orientation Checklist form, DSHS 15-415 which must be documented in the CHW's personnel file.

CHW Observation: Within 30 days of hire, the CHW is required to **observe** one visit made by each professional member of the MSS team. (At least two visits are required to be home visits) (The professional team consists of the community health nurse, the behavioral health specialist, and the registered dietitian). In addition, the CHW must **be observed** by a professional member of the MSS team for at least three hours interacting successfully with clients in at least two home visits and two office visits which must be documented in the CHW's personnel file.

CHW Supervision: At least once per calendar month, the Department requires a CHW to be under the supervision of a clinical staff person who meets the criteria as a professional member of the MSS team. Supervision may include face-to-face meetings or chart review or both which must be documented in the CHW's personnel file.

Note: The Department considers claims for services provided by non-qualified staff as erroneous claims and will recoup any resulting overpayment.

- **Screening** – A requirement for each client. One time prenatally, and once again post pregnancy. Screening provides a method for systematically reviewing and documenting risk factors and client need. Screening is not intended to be an in-depth assessment for each risk factor. Once a risk factor or need is identified, a clinician (CHN, BHS, RD) may need to assess the client further to determine the client's level of service. The MSS Prenatal Screening Guide ([LINK](#)) is a reference document where sample screening questions can be found.
- **Case Conference** - The method used by members of the MSS interdisciplinary team to communicate and consult with each other, and when possible, with other healthcare, social services providers, and/or the client to optimize client care. Case conferences may be formal meetings or informal consultations. The MSS interdisciplinary team should hold a case conference based on client or provider need for those clients eligible for the basic level of service (i.e. BHS consulting with RD on client weight gain). An MSS interdisciplinary team case conference is required at least once prenatally (for clients entering MSS during pregnancy) and once post pregnancy for clients eligible for expanded or maximum levels of service.
- **Care Plan** - Based on results of MSS screening and assessment, the provider must develop and implement an individualized care plan for each client. The care plan

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contains information specific to the client’s identified risk factors. It is used to prioritize risk factors and guide interventions and is updated throughout the maternity cycle.

Note: All MSS interdisciplinary team members must be involved in developing the care plan for clients eligible for expanded or maximum service levels, even if all team members are not providing direct care to the client.

- **Interventions** – The following table describes interventions provided to clients based on level of service:

MSS Level of Service	Number of Units	Intervention(s)
Basic	Eight (8) units - includes both <ul style="list-style-type: none"> • Prenatal; and • Post pregnancy periods. 	<ul style="list-style-type: none"> • Screen - MSS targeted risk factors and client need (15-30 minutes maximum) • Care Coordination – Medical care and WIC, MSS team members, if applicable. • Case Management – Referral & link according to the instructions within these billing instructions. • Basic Health Messages – At a minimum, warning signs of pre-term labor, infant safety, family planning, tobacco cessation/second hand smoke and post-partum depression. • Other messages based on client need or time.

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<p align="center">Expanded</p>	<p>Eighteen (18) units, includes both</p> <ul style="list-style-type: none"> • Prenatal; and • Post pregnancy periods. 	<ul style="list-style-type: none"> • Screen - MSS target risk factors and client need (15 – 30 minutes maximum). • Care Coordination – Medical provider, WIC, and MSS interdisciplinary team. Others as indicated by client risk (mental health, CPS, etc.). • Case Management – referral and linkage per BI's. • Basic Health Messages – At a minimum, warning signs of pre-term labor, infant safety, family planning, tobacco cessation/second hand smoke, post-partum depression and others based on client need/risk factors. • Clinical assessment and interventions – counseling and education based on risk. • Case Conferencing – MSS interdisciplinary team (CHN, BHS, RD and as appropriate, CHW)
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Maximum	<p>40 units, units, includes both</p> <ul style="list-style-type: none"> • Prenatal; and • Post pregnancy periods 	<ul style="list-style-type: none"> • Screen - MSS targeted risk factors & client need (15-30 minutes maximum). • Care Coordination – Medical provider, WIC and MSS team. Others as indicated by client risk (mental health, CPS, etc.). • Case management – referral and linkage per BI’s. • Basic health messages – At a minimum, warning signs of pre-term labor, infant safety, family planning, tobacco cessation/second hand smoke, post-partum depression and others, based on client need/risk factors. • Clinical Assessment and Interventions – counseling and education based on risk. • Case Conferencing – MSS interdisciplinary team (CHN, BHS, RD and as appropriate, CHW).
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Note: Providers are required to manage the available units of service to meet the client needs/risks throughout the maternity cycle.

- **Case Management** - Basic referrals to medical care, WIC, CBE, WithinReach, family planning and as needed, treatment for chemical dependency, mental health problems and domestic violence. See MSS/ICM Manual for additional clarification.

To download and print the Department/MPA MSS/ICM Manual, go to the Department/MPA website at: <http://hrsa.dshs.wa.gov/firststeps/Provider%20Page/First%20Steps%20Manual.1.pdf>.

- **Care Coordination** – Providers are required to initiate and participate in care coordination activities throughout the maternity cycle. At a minimum, care coordination must occur within the MSS team, with the client’s prenatal care provider and the WIC office. Coordinated communication with other community resources that may be working with the client may be necessary in order to provide the appropriate care. Some

mechanisms of care coordination activities include face-to-face meetings, phone calls, or sending of screening tools and care plans.

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.

- **Collect and Report Client Outcome and Discharge Data** – Providers are required to determine, and record 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 was initiated;
 - ✓ Date when family planning was discussed, and if a method was initiated;
 - ✓ Date(s) of assessment and interventions related to tobacco cessation, relapse prevention and second-hand smoke exposure, and initiation of a relapse prevention plan (if applicable);
 - ✓ Infant weight and gestational weeks at time of birth;
 - ✓ Whether or not the client initiated breastfeeding;
 - Was it exclusive?
 - Was the client still breastfeeding at discharge?
 - ✓ Date client was screened for depression, record results of screening, if applicable; and
 - ✓ Results of ICM screening, if completed during the MSS eligibility period.
- **Documentation** – All MSS/ICM agencies must maintain a charting system that reflects accurate and complete documentation of all Maternity Support Services (MSS). Each MSS 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. A complete client record must be available to the Department upon request; and must:
 - Reflect services were provided in a concise, efficient format and support the number of units billed; and
 - Clearly show risk factor progression: identification, inclusion in the care plan, intervention, client progress, provider follow up, and final client outcomes.

Maternity Support Services/Infant Case Management

The following documentation is required for Maternity Support Services (MSS);

- **Required DSHS Numbered MSS Forms** – Maternity Support Services Screening Tools. The following forms must be completed by a qualified person from the MSS team:
 - ✓ **MSS Prenatal Screening Tool form, DSHS 13-874;**
 - ✓ **MSS Post Pregnancy Screening Tool form, DSHS 13-873.**

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

- **Required MSS Client Record Content** – Agencies may use their own documentation forms/format, in addition to the required forms (listed above). This information will be reviewed by the MSS/ICM Management Team at the time of a site visit or chart review.

All documentation must include the required client record content as follows:

- **Assessment** - Assessment or evaluation beyond screening may be necessary. Assessment should not duplicate the screening, but expand the content area being evaluated. All types of assessment (standardized and non-standardized) should be documented and/or filed in the client record.
- **Case Conference** - Agencies must document case conferences and include:
 - ✓ Date of case conference(s);
 - ✓ Names of MSS team members and/or others participating in the case conference (and note if it was conducted via phone, in person, etc.);
 - ✓ Whether or not the care plan was updated based on the case conference.
- **Care Coordination** - Providers must document all care coordination activities in the client chart.
- **Care Plan** - Each client must have a 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.

Note: All individuals who participate in the development and modification of the care plan must be documented.

- **Consent to Care** - Each client chart must contain an agency-specific “consent to care” document signed and dated by the client. It is recommended that the consent to care document be approved by the agency's legal counsel.

- **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, and
 - ✓ The name of the person or agency who was contacted.
- **Demographic and Contact Information** - Demographic and contact information about the client must be documented in the client chart. At a minimum, the following information must be collected:
 - ✓ Client name;
 - ✓ Date of birth;
 - ✓ Contact information (address & phone number(s));
 - ✓ Race (and if applicable, ethnicity and/or tribal affiliation);
 - ✓ Client's primary spoken language;
 - ✓ Client Medicaid number and effective date.
- **Freedom of Choice** - 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; and
 - ✓ Free to choose any MSS/ICM provider to receive MSS regardless of where she lives or receives health care and/or WIC services.

Note: Consent/Refusal: Document the client's consent or refusal to receive MSS/ICM services in the client's record.

- **Release of Information** - MSS services are considered health care services and are covered under HIPAA regulations. The "release of information" form is a provider agency approved form developed with the agency's legal counsel. The form must comply with RCW 70.02.030.
- **Screening** - The MSS prenatal and post pregnancy screening guides (To request a copy, send a request to FirstSteps email) contain sample screening questions to assist with accurate completion of the MSS screening tools (the DSHS numbered forms referenced in this section) and determination of client level of service. 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 tools and determination of client level of service. To request a copy of the screening guides, send a request to the First Steps mailbox at firststepsmessages@doh.wa.gov.

Maternity Support Services/Infant Case Management

- **Signature Log** - 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.
- **Outcome and Discharge** - Providers are required to document the client outcomes listed under program requirements in the billing instructions. Include the date and reason for discharge from MSS. Final client outcomes must be recorded in one summary report/document.
- **Visit Record/Notes** - For each MSS visit, the following documentation is required:
 - ✓ Date of visit;
 - ✓ Time the visit started and ended;
 - ✓ Location of visit – home, office, hospital;
 - ✓ Any interventions provided;
 - ✓ Client progress related to risk factors documented on the care plan addressed during visit;
 - ✓ Reason for not addressing prioritized risk factor at visit;
 - ✓ Any follow-up required from the previous visit; and
 - ✓ Next steps.
- **Electronic Health Records (EHR)** - Agencies using electronic documentation are expected to adhere to the same standards outlined for paper documentation. The content of the required forms must be documented and the ability to generate a report that meets the requirements outlined in this document for monitoring review must exist. If you do not have electronic signature capability, you must have a way to fulfill the signature log requirement.

What are MSS Requirements for any County with Less than 55 Medicaid Births per year 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 an MSS interdisciplinary team in which case the tribe or county is required to have at least one of the following:

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

The person must meet the qualifications detailed within these billing instructions and must complete the orientation requirements, whether delivering direct services or supervising MSS/ICM personnel. When the needs of a client are outside the scope of practice of the clinician, appropriate referrals/consultations must be attempted and documented.

What Maternity Support Services are Covered?

The Department covers maternity support services (MSS) provided by an MSS interdisciplinary team member, subject to the following criteria and other applicable WAC:

Covered services include: (See WAC 388-533-0330)

- 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; and
- Infant case management (ICM) screening.

What Maternity Support Services are not covered?

The Department covers only the services listed above. (See WAC 388-533-0330)

What Maternity Support Services does the Department pay for?

The Department pays for the covered maternity support services on a fee-for-services basis subject to the following:

MSS must be:

- Provided to a client who meets the eligibility requirements in WAC 388-533-0320;
- Provided to a client on an individual basis in a face-to-face encounter;
- Provided by a person who meets the MSS staff qualifications listed in these billing instructions;
- Documented correctly in the client's record or chart (See MSS Documentation Requirements Section found within these billing instructions);
- Billed using the eligible client's ProviderOne Client ID;
- Billed using the correct procedure codes and modifiers identified in this chapter; and
- Billed using the provider's NPI and taxonomy code 171M00000X.

Note: Travel expenses, charting time/documentation, phone calls and mileage are built into the reimbursement rate for MSS.

Note: 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.

Minimum and Maximum Number of Units for MSS

Providers must bill in units of service with one unit of service equaling 15 minutes, and:

- If two or more 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 6 units).
- No more than 6 units may be billed for one date of service.
- Limitation extension requests for units exceeding the number of allowed MSS units of service may be requested. A limitation extension request must be pre-authorized. Limitation extension requests must be submitted using Limitation Extension Request (Maternity Support Services and/or Infant Case Management) form, DSHS 13-884 and must be completed according to the directions on the form and must be submitted with:
 - ✓ General Information for Authorization Form, DSHS 13-835; and
 - ✓ Complete MSS Chart which must include the Care Plan

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

Note: Federally Qualified Health Center (FQHC's) must follow billing guidelines found in the Department's FQHC Billing Instructions.

Maternity Support Services/Infant Case Management

The Department allows the following for clients **entering MSS during pregnancy (PG):**

Client Enrolled in MSS During Prenatal Period	Level of Service and Allowable Units <i>for the entire maternity cycle.</i>
	Basic = 8 units.
	Expanded = 18 units.
Client Enrolled in MSS Post Pregnancy Period only – client did not receive any MSS during the prenatal period	Level of Service and Allowable Units <i>for the Post Pregnancy eligibility period.</i>
	Post Pregnancy Basic = 6 units.
	Post Pregnancy Expanded = 10 units.
	Post Pregnancy Maximum = 14 units.

Clarification Notes:

- 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 post pregnancy periods, the units of service available do not decrease.
- Clients enrolled in MSS prenatally must be screened post-pregnancy 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 circumstances and explain why all units were used prenatally; and
- Actions taken to link the client to other related services (medical care, WIC, etc.) that address post pregnancy needs.

In order to bill units during the pregnancy period, the Prenatal Screening Tool form, DSHS 13-874 must be completed and documented in the client’s chart.

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

In order to bill units during the post pregnancy period, the **Post Pregnancy Screening Tool form, DSHS 13-873** must be completed and in the client chart.

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

Place of Service (POS) Codes for MSS Services (CMS-1500 Claim Form, Line 24 B)

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

The Department pays for an MSS visit when the services are provided in:

- An agency's office or clinic; or
- The client's residence; or
- In the case of an unsafe place of residence or a potential problem with client confidentiality, an alternate site that is not the client's residence may be used. The reason for using an alternate site for visitation instead of the home must be documented in the client's record.

Agencies co-located on a hospital campus shall bill the office rate when seeing clients in the hospital where the agency is co-located.

Tribal health facilities may also use POS codes 07 and 08 to bill fee-for-service MSS visits.

Place of Service Code	Use for
07	Tribal 638 free standing facility
08	Tribal 638 provider based facility
11	Office (Agency's office or clinic)
12	Home (Client's place of residence) or "other" site, per client's request

- The Department recognizes taxonomy code 171M00000X as appropriate for Maternity Support Services published within these billing instructions.

MSS Coverage Table

Procedure Code	Diagnosis Code	Modifier	Brief 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
S9470	V22.2	HD	Nutritional Counseling, dietitian visit	1 unit = 15 minutes during a MSS Dietitian Visit
96152	V22.2	HD	Behavioral Health Specialist	1 unit = 15 minutes during a MSS Behavioral Health Visit
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

For tribal programs to receive reimbursement, a claim must indicate by modifier if the MSS/ICM services are for AI/AN or a non-tribal client as a *secondary modifier* on the claim.

Client	HCPCS Code and Modifier
AI/AN	XXXXXX - UA
Non-native	XXXXXXXX - SE

Fee Schedule

You may view the Department/MPA **Maternity Support Services/Infant Case Management Fee Schedule** on-line at: <http://hrsa.dshs.wa.gov/RBRVS/Index.html#M>

Infant Case Management

What Is the Purpose of Infant Case Management (ICM)?

The purpose of ICM is to improve the welfare of infants by providing parents with information and assistance in order 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 MSS may be eligible for ICM services.

What Are the Provider Requirements for ICM?

ICM services are provided by Department approved MSS/ICM providers as outlined within these billing instructions.

What are the 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 these billing instructions. 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; 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; or
 - ✓ Other social service-related fields; or
- Has a two-year associate of arts degree in a social service-related field, **plus** at least two years of full-time experience in an area listed above. In addition, the Department requires at least once per calendar month, a provider qualifying under this subsection to be under the supervision of a clinical staff person who meets the criteria in the first bullet above or a person who oversees this program within their respective agency as part of their administrative duties. Supervision may include face-to-face meetings or chart review or both.

Note: Only persons who meet the conditions outlined above are considered “qualified” to provide and bill for ICM services provided to First Steps clients. At any time the Department discovers payment was made for services provided by a non-qualified person, an overpayment will be established and monies will be recuperated.

Who Is Eligible for ICM?

To be eligible for ICM, the infant must:

- Have a valid Services Card ; and
- Be covered by a Benefit Service Package that covers ICM;
- Be within the ICM eligibility period which is the day after the maternity cycle ends, through the last day of the month of the infant’s first birthday; and
- Reside with at least one parent; and
- Not be receiving any case management services funded through Title XIX Medicaid that duplicate ICM services

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client’s eligibility.

Note: Refer to the *Scope of Coverage Chart* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Who is Considered to be a Parent for ICM?

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

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

What is the ICM Eligibility Period?

ICM eligibility begins on the first day of the month following the maternity cycle and continues until the end of the month in which the infant's first birthday occurs.

How Much ICM Does the Infant Get?

All infants/parents must be screened using the ICM Screening Tool form, DSHS 13-658, to determine if there is a need to assist the family in accessing medical, social, educational or other services. The level of assistance or number of units for which an infant may receive is based on the amount of assistance the parent(s) needs in accessing services to address identified risk(s). Up to 4 units of service are allowed for the screening process. If no risk factor is identified in Column A of the tool, the amount of services is limited to 4 units for the eligibility period unless there is a change in circumstances. Units used to screen clients are **not** in addition to the maximum allowed in each level.

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

Lower level of service allows an infant up to ten (10) units of Infant Case Management during the ICM eligibility period. This means that the parent(s) is able to access services after meeting with an infant case manager for a fairly brief amount of time. Typically, this is demonstrated when access to services is hampered due to a lack of knowledge or awareness on the part of the parent(s).

Higher level case management allows a client up to thirty (30) units of service throughout the eligibility period. For higher level services the parent demonstrates a greater need for assistance in accessing available services. Need may be demonstrated by, but not limited to, a parent not showing for scheduled appointments, a parent requesting extra services due to circumstances that prevent access, such as suffering from depression, or having additional young children in the home where the parent is so overwhelmed that simple tasks are daunting. By allowing additional units (not to exceed 30) of case management, the case manager may provide services that are appropriate for the client based on a family's identified needs.

Note: The units used to do the screening on either level of service must be deducted from the maximum number of units allowed for that level.

What If 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 to be closed. Maternity Support Services for the new pregnancy begin and are billed using MSS procedure codes. The MSS eligibility period would begin upon learning of the pregnancy. See page E.1, field 19 for CMS-1500 Claim Form instructions.

Can ICM Continue if 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.

Clarifying Information:

- 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.
- For a child with an open CPS case, who is still in his/her parents' home and no other Title XIX case management is being provided (like Early Intervention Program (EIP) services) then 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 the infant meets the eligibility criteria to receive ICM.

What Services Are Covered Under ICM?

[Refer to WAC 388-533-0380]

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

- An initial in-person screening which includes developing a care plan;
- 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); and
- Follow-up contact(s) with infants and their parent(s) to ensure the care plan continues to meet the needs of the infant and parent(s.)

What Services Are Not Covered Under ICM?

[Refer to WAC 388-533-0385]

The Department will only cover services that are listed in WAC (See WAC 355-533 0380.)

What Are Documentation Requirements for ICM?

First Steps agencies must maintain a charting system that reflects accurate and complete documentation of all ICM services. Complete client records must be available to the Department upon request.

Documentation must reflect services provided and support the number of units billed. Accurate and complete documentation allows the reader to identify risk factors for which the client is receiving services, services client is receiving, client progress, provider follow-up, and client outcomes.

Each client must have one client record (central file) that includes all chart notes by the Infant Case Manager including subcontractors or consultants.

Required record content:

- **Screening** – ICM Screening Tool form, DSHS 13-658, completed by a qualified person. To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.
- **Care Coordination** – All care coordination activities must be documented in the client chart.
- **Care Plan** – Each client must have a care plan. The care plan shall reflect an overview of the client's identified risk factors and anticipated actions the provider will take to address those risks.
- **Consent to Care** – An agency specific consent to care form signed and dated by the client.
- **Contact Log** – A chronological record of all contacts made with, or regarding a client. This includes 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; and
 - ✓ Infant's parent or guardian information

Maternity Support Services/Infant Case Management

- **Freedom of Choice** – A freedom of choice declaration signed by the client must be in the ICM chart. The declaration must inform the client that participation in ICM is optional and that 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** – ICM services are considered health care services and are covered under HIPAA regulations. The Release of Information is an MSS/ICM provider agency approved form developed with the agency's legal counsel. The form must be designed to be in compliance with RCW 70.02.030.
- **Signature Log** – All client charts must include a signature log. The printed name, title and legal signature of each agency staff providing care must be on the log. If staff initials are used in the chart, a sample must be included on the signature log. Refer to WAC 246-810-035 and WAC 246-335-110 for licensed social workers and home health records.
- **Outcome and Discharge** – Providers are required to document client outcomes. Documentation must include the date and reason for discharge from ICM. Final client outcomes must be recorded in one summary report/document for each client.
- **Visit Record/Notes** – For each ICM visit, the following information must be documented:
 - ✓ Date of visit
 - ✓ Time visit **started and ended**
 - ✓ Location of visit – home, office, hospital
 - ✓ Other non-ICM risk factors identified that may impact the infant's welfare, even if the risk factor is not addressed
 - ✓ All interventions provided – referrals, linkages, etc.
 - ✓ Client progress related to the identified risk factor
 - ✓ Follow-up required from the last visit – Did parent keep appointments, etc.
 - ✓ Next steps
 - ✓ Signature of the person providing ICM services

During the transition to implementing the program redesign, (**July 1, 2009 – August 31, 2009**) providers were allowed to use current forms along with the ICM Screening Tool form, DSHS 13-658. Any documentation format must relate to the provision of the services described in the provider application packet under core services and be able to substantiate services being billed and their impact on the client's needs/concerns described in the care plan.

To download and print Department/MPA forms, go to the Department/MPA website at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

What ICM Services Does the Department Pay For?

The Department pays for covered ICM services on a fee-for-service basis when:

- The provider meets the requirements in chapter 388-502 WAC, Administration of Medical Programs – Providers Rules;
- Provided to a client who meets the eligibility requirements in WAC 388-533-0370;
- Provided by a person who meets the provider requirements and meets the qualifications listed in these billing instructions;
- Documented in the infant's and/or infant's parent's chart/record;
- Billed using the infant's ProviderOne Client ID;
- Billed using the correct procedure codes and modifiers identified later in these billing instructions;
- Billed using the correct NPI number; and
- Billed using the Infant Case Management taxonomy code of 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.

Minimum and maximum number of units for Infant Case Management

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

- Services must be delivered face-to-face with the infant present;
- A maximum of 4 units to complete the ICM Screening Tool form, DSHS 13-658;
- Infants qualifying for a **lower contact level** of services may receive a maximum of 10 units of service throughout the ICM eligibility period as documented using the ICM Screening Tool form, DSHS 13-658;
- Infants qualifying for a **higher contact level** of services may receive a maximum of 30 units of service throughout the ICM eligibility period as documented using the ICM Screening Tool form, DSHS 13-658;
-

To download and print Department/MPA forms, go to the Department/MPA website at:

<http://www.dshs.wa.gov/msa/forms/eforms.html>.

- Clients enrolled in a managed care plan:
 - ✓ When ICM services are delivered outside the plan on a fee-for-services basis; and
 - ✓ Subject to the same program rules that apply to a client who is not enrolled in a managed care plan.
- Limitation extension requests for units exceeding the number of allowed ICM units of service. A limitation extension request must be pre-authorized. Limitation extension requests must be submitted using Limitation Extension Request (Maternity Support Services and/or Infant Case Management) form, DSHS 13-884, and must be completed according to the directions on the form and must be submitted with:
 - ✓ General Information for Authorization Form, DSHS 13-835; and
 - ✓ Complete ICM Chart which includes the Care Plan.
- If the infant's circumstances causes a change to a higher level of service, the appropriate number of units may be added.
- 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 in order for remaining units to be used.

Place of Service (POS) Codes for ICM Services

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

- An agency's office or clinic;
- The infant's home (client's residence); or
- In the case of an unsafe place of residence or a potential problem with client confidentiality, an alternate site not the client's residence may be used.

Tribal health facilities may also use the following POS codes to bill fee-for-service ICM visits.

Place of Service Code	Use for
07	Tribal 638 free standing facility
08	Tribal 638 provider based facility
11	Office (Agency's office or clinic)
12	Home (Client's place of residence)

ICM Coverage Table

Procedure Code	Diagnosis Code	Modifier	Brief 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, a claim must indicate by modifier if the MSS/ICM services are for AI/AN or a non-tribal client as a *secondary modifier* on the claim.

Client	HCPCS Code and Modifier
AI/AN	XXXXXX – UA
Non-native	XXXXXXX - SE

Fee Schedule

You may view the Department/MPA **Maternity Support Services/Infant Case Management Fee Schedule** on-line at:

<http://hrsa.dshs.wa.gov/RBRVS/Index.html#M>

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department 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; and
- Record keeping requirements.

What Records Specific to MSS/ICM Providers Must Be Kept? [Refer to WAC 388-502-0020]

Providers must make charts and records available to the Department, its contractors (such as the Department of Health), and the US Department of Health and Human Services, upon request, **for at least six years from the date of service** or longer if required by state law or regulation.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html 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	<p>These are the only appropriate code(s) for these billing instructions:</p> <table style="margin-left: 40px;"> <thead> <tr> <th style="text-align: left;">Code Number</th> <th style="text-align: left;">To Be Used For</th> </tr> </thead> <tbody> <tr> <td>07</td> <td>Tribal 638 free standing facility</td> </tr> <tr> <td>08</td> <td>Tribal 638 provider based facility</td> </tr> <tr> <td>11</td> <td>Office</td> </tr> <tr> <td>12</td> <td>Client's residence (home visit)</td> </tr> </tbody> </table>	Code Number	To Be Used For	07	Tribal 638 free standing facility	08	Tribal 638 provider based facility	11	Office	12	Client's residence (home visit)
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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.										