Washington State Health Care Authority

Medicaid Provider Guide

Maternity Support Services/Infant Case Management
[WAC 182-533-0300 through 182-533-0386]

A Billing Instruction

About This Guide

This guide supersedes all previous Agency *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
Increase data collection capabilities PN 12-90	11-01-12	Page 20-21	MSS coverage table	Added HD-TF and HD-TG modifiers to Maternity Support Services (MSS) procedure codes for clients with risk factors at expanded or maximum level. Clarified use of modifiers for American Indian/Alaska Native (AI/AN) and nonnative clients.
		Page 31	ICM coverage table	Clarified use of modifiers for American Indian/Alaska Native (AI/AN) and nonnative clients
		All	All	Made housekeeping changes for accuracy.

Alert! This MPG is currently undergoing comprehensive changes and will be republished in the near future.

How Can I Get the Medicaid Agency's Provider Documents?

To download and print the Medicaid Agency's provider notices and Medicaid provider guides, go to the Agency's website at: http://hrsa.dshs.wa.gov (click the ***Medicaid Provider Guides and Provider Notices*** link).

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.)

Important Contacts

Note: This section contains important contact information relevant to MSS/ICM. For more contact information, see the Medicaid Agency's *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	HCA Family Services Program Manager 360-725-1293 FirstSteps@hca.wa.gov
Finding out about payments, denials, claims processing, or the Medicaid Agency's managed care organizations	See the Medicaid Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Electronic or paper billing	
Finding the Medicaid Agency's documents (e.g., Medicaid provider guides, provider notices, fee schedules)	
Private insurance or third-party liability, other than Medicaid Agency managed care	
Prior authorization, limitation extensions, or exception to rule	
Policy or program oversight for Maternity Support Services	HCA Family Services Program Manager 360-725-1293 FirstSteps@hca.wa.gov
Policy or program oversight for Infant Case Management	HCA Family Services Program Manager 360-725-1293 FirstSteps@hca.wa.gov
Definitions & Abbreviations	See the online Medical Assistance Glossary.

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, 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).

- **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 182-533-0701).

- **Ancillary services** including expedited eligibility determination, case finding, outreach, and transportation services.

What Are Maternity Support Services and Infant Case Management?

MSS and ICM are two components of First Steps.

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:

- Increase 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;
- 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;
- Increased initiation and duration of breastfeeding; and
- Reduction of tobacco use during pregnancy and pediatric exposure to second-hand smoke.

Are Clients Enrolled in a Medicaid Agency Managed Care Plan Eligible?

[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 a Medicaid Agency managed care plan are eligible for MSS/ICM outside of their plan. When verifying eligibility using ProviderOne, if the client is enrolled in a Medicaid Agency 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?

[Refer to WAC 182-533-0310]

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 eligible infants.

Who Is Eligible for MSS?

To be eligible for MSS, a client must be:

- Pregnant or within 60 days post pregnancy; and
- Covered by a benefit service package that covers MSS.

Please see the Medicaid Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/billing/providerone_billing_and_resource_guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Categories of Healthcare Services Table* 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 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 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 Medicaid Agency-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 182-533-0330; 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:

  ✓ Provided;
  ✓ 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) with the Department of Social and Health Services (DSHS).

Note: To see a directory of DSHS-certified chemical dependency service providers see: http://www.dshs.wa.gov/pdf/dbhr/da/9-%20facilities.pdf. Contracted providers are designated with an asterisk (*) next to the service type.

- Staff who deliver covered services must meet staff qualifications described within this Medicaid provider guide.

- All individuals 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 182-533 WAC;
  - MSS/ICM Medicaid Provider Guide; and
  - First Steps Resource Guide found on the First Steps website at: http://hrsa.dshs.wa.gov/firststeps/.

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

- Maintain and make available to the Medicaid Agency 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 periodically view the First Steps website for updates and information regarding the program; and

- Follow all other requirements as described in WAC 182-533-0325.

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 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; 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 Resource Guide.

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

  ✓ 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 Resource Guide.

✓ 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 provider agency. The plan will document progress and experience that enhances knowledge and skills in community maternal child health nursing. The plan must be placed in the individual's personnel file;

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). Documentation of continuing education must be placed in the individual's personnel file;

OR

- Has a two year associate's degree or three year diploma in nursing; and
- 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 provider agency.** The plan will document progress and experience that enhances knowledge and skills in community maternal child health nursing. The plan must be placed in the individual's personnel file.

AND

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

  The First Steps Resource Guide is available on the Medicaid Agency's website at: http://hrsa.dshs.wa.gov/firststeps/.

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

✓ Community health worker (CHW)

Each MSS/ICM agency has the discretion to add staff to the MSS/ICM interdisciplinary team to fulfill the role of CHW. MSS/ICM agencies must ensure that the CHW:

- Has a high school diploma or the equivalent; and
- Has a minimum of one year of healthcare and/or social services experience; and
- Operates within the scope of the community health worker job description in the First Steps Resource Guide;
- 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 a CHW may provide billable services, the CHW must complete the standard required staff orientation; (as described within this Medicaid provider guide).

All CHW activities must be carried out under the direction of a clinical staff person who meets the criteria as a clinical member of the MSS team (RN, BHS, or RD). Before a CHW may provide billable services, a CHW is required to successfully complete a training plan developed by the provider agency, including observation of client service delivery and accuracy of health education messages provided. Ongoing supervision of service delivery and documentation of services is required. Supervision must occur at least monthly and will include face-to face meetings either individually or in a group and 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 considers claims for services provided by non-qualified staff as erroneous claims and will recoup any resulting overpayment.

- **Screening** – Required for each client. Screening provides a method for systematically reviewing and documenting risk factors and client need. Screening is not to be construed as an in-depth assessment for risk factors. 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. There are two screening guides available. Both the MSS Prenatal Screening Guide and the MSS Post Pregnancy Screening Guide are reference documents in which sample screening questions can be found. Both screening guides may be found on the First Steps website.

- **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. An 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 as outlined on the following pages.

- **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 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	**Seven (7)** units - includes **both:** • Prenatal; and • Post pregnancy periods. **Note:** A unit of service equals 15 minutes of one-to-one service delivered face-to-face.	• **Screen** - MSS targeted risk factors and client need (30 minutes maximum). • **Care Coordination** – Medical care and WIC, MSS team members, if applicable. • **Case Management** – Referral & linkage according to the instructions within this Medicaid provider guide. • **Basic Health Messages** – At a minimum, warning signs of pre-term labor and problems in pregnancy, tobacco cessation, abstinence from alcohol. • **Other** messages based on client need.

MSS Level of Service	Number of Units	Intervention(s)
Expanded	**Fourteen (14)** units, includes both: • Prenatal; and • Post pregnancy periods. **Note:** A unit of service equals 15 minutes of one-to-one service delivered face-to-face.	• **Screen** - MSS target risk factors and client need (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 and problems in pregnancy, tobacco cessation, abstinence from alcohol, 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).

MSS Level of Service	Number of Units	Intervention(s)
Maximum	**Thirty (30)** units, includes both: • Prenatal; and • Post pregnancy periods. **Note:** A unit of service equals 15 minutes of one-to-one service delivered face-to-face.	• **Screen** - MSS targeted risk factors & client need (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, abstinence from alcohol, 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).

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.

- **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 interdisciplinary 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. Providers are required to 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 and if so, not screen 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 quality services and reduce service duplication.

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

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

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

  To download and print Medicaid Agency forms, go to the Medicaid Agency's website at: http://hrsa.dshs.wa.gov/forms/.
- ✓ **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) must be documented and/or filed in the client chart.
- ✓ **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's ProviderOne Client ID 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 chart.

✓ **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 contain sample screening questions to assist with accurate completion of the MSS screening tools (the 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.

- ✓ **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 (found listed under program requirements in this Medicaid provider guide.) 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 intervention(s) 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 must 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 the 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 this Medicaid provider guide 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 Medicaid Agency 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 182-533-0330):

- 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 Medicaid Agency covers only the services listed above (see WAC 182-533-0330).

What Maternity Support Services Does the Medicaid Agency Pay for?

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

MSS must be:

- 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 person who meets the MSS staff qualifications listed in this Medicaid provider guide;
- 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; and
- 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.

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 per client 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, 13-884 and must be completed according to the directions on the form and must be submitted with:

- ✓ General Information for Authorization Form, 13-835; and
- ✓ Complete MSS Chart which must include the Care Plan

To download and print Medicaid Agency forms, go to the Medicaid Agency's website at: http://hrsa.dshs.wa.gov/forms/.

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

Refer to the MSS/ICM Transition Plan (Appendix)

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

Client Enrolled in MSS During Prenatal Period	**Level of Service and Allowable Units *for the entire maternity cycle.***
	Basic = 7 units.
	Expanded = 14 units.
	Maximum = 30 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 *for the Post Pregnancy eligibility period.***
	Post Pregnancy Basic = 4 units.
	Post Pregnancy Expanded = 6 units.
	Post Pregnancy Maximum = 9 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.	

Note: A unit of service equals 15 minutes of one-to-one service delivered face-to-face.

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, 13-874 must be completed and documented in the client's chart.

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

To download and print Medicaid Agency's forms, go to website at:
http://hrsa.dshs.wa.gov/forms/

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 Medicaid Agency 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 must 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 (Medicaid Agency's office or clinic)
12	Home (Client's place of residence) or "other" site, per client's request

- The Medicaid Agency recognizes taxonomy code 171M00000X as appropriate for Maternity Support Services published within this Medicaid provider guide.

MSS Coverage Table and Fee Schedule

Coverage Table

Procedure Code	Diagnosis Code	Modifiers*	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
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

Procedure Code	Diagnosis Code	Modifiers*	Brief Description	Policy/ Comments
Maternity Support Services				
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
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 (Community Health Worker)	**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 may view the Medicaid Agency's **Maternity Support Services/Infant Case Management Fee Schedule** online 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 Medicaid Agency approved MSS/ICM providers as outlined within this Medicaid provider guide.

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 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; 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 Medicaid Agency 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 Medicaid Agency 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 ;
- 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;
- 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 Medicaid Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/billing/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, 13-658, 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). Up to 2 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 2 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 Medicaid Agency forms, go to website at: http://hrsa.dshs.wa.gov/forms/.

Lower level of service allows an infant up to six (6) units of Infant Case Management during the ICM eligibility period. This means that the parent(s) is able to access services with minimal or no assistance from an infant case manager. Typically, this is demonstrated when access to services is hampered due to a lack of knowledge or awareness of available resources and services on the part of the parent(s).

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. 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 20) 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 during the ICM eligibility period must be deducted from the maximum number of units allowed for whatever level the infant/parent qualifies.

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 Completing the CMS-1500 Claim Form.)

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 182-533-0380]

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 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 182-533-0385]

The Medicaid Agency will only cover services that are listed in WAC (see WAC 182-533 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 Medicaid Agency 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, 13-658, completed by a qualified person.

  To download and print Medicaid Agency's forms, go to the Medicaid Agency's website at: http://hrsa.dshs.wa.gov/forms/.

- **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

- **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

All documentation must support the services provided regardless of documentation system used.

To download and print Medicaid Agency forms, go to the website at:
http://hrsa.dshs.wa.gov/forms/

What ICM Services Does the Medicaid Agency Pay for?

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

- The provider meets the requirements in chapter 182-502 WAC, Administration of Medical Programs – Providers Rules;
- Provided to a client who meets the eligibility requirements in WAC 182-533-0370;
- Provided by a person who meets the provider requirements and meets the qualifications listed in this Medicaid provider guide;
- 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 this Medicaid provider guide;
- 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 ICM

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 2 units to complete the ICM Screening Tool form, 13-658;
- Infants qualifying for **lower level** may receive a maximum of six (6) 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;

To download and print Medicaid Agency's forms, go to the website at: http://hrsa.dshs.wa.gov/forms/index.shtml.

- 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, 13-884, and must be completed according to the directions on the form and must be submitted with:

  - ✓ General Information for Authorization Form, 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. 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 in order for remaining units to be used.

Refer to the MSS/ICM Transition Plan (Appendix).

Place of Service (POS) Codes for ICM Services

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); 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 (Medicaid Agency's office or clinic)
12	Home (Client's place of residence)

ICM Coverage Table

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, 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 may view the Medicaid Agency's **Maternity Support Services/Infant Case Management Fee Schedule** online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html#M

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Medicaid Agency's *ProviderOne Billing and Resource Guide* at:
http://hrsa.dshs.wa.gov/billing/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 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; and
- Record keeping requirements.

What Records Specific to MSS/ICM Providers Must Be Kept?

[Refer to WAC 182-502-0020]

Providers must make charts and records available to the Medicaid Agency, its contractors 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 Medicaid Agency's *ProviderOne Billing and Resource Guide* at:
> http://hrsa.dshs.wa.gov/billing/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.

Field No.	Name	Entry
24B.	**Place of Service**	These are the only appropriate code(s) for this Medicaid provider guide: **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)
24G.	**Days or Units**	One date of service per billed line. Multiple units will be billed regularly using the 15-minute codes.

Appendix

Transition Plan for MSS & ICM Unit Allocation Beginning March 1, 2011

MSS 2009 Unit Allocation	
Clients who have had a MSS billable service **prior to March 1, 2011**	Continue with 2009 unit allocation
Services Started During	**Level of Service**
Prenatal period	Basic = 8 units Expanded = 18 units Maximum = 40 units
Post Pregnancy period only - did not receive any MSS during the prenatal period.	Post Pregnancy Basic = 6 units Post Pregnancy Expanded = 10 units Post Pregnancy Maximum = 14 units
MSS March 1, 2011 Unit Allocation	
Clients who receive their 1st MSS billable services **on or after March 1, 2011**	Assign units based on the March 1, 2011 unit allocation
Services Started During	**Level of Service**
Prenatal period	Basic = 7 units Expanded = 14 units Maximum = 30 units
Post Pregnancy period only - did not receive any MSS during the prenatal period.	Post Pregnancy Basic = 4 units Post Pregnancy Expanded = 6 units Post Pregnancy Maximum = 9 units

Note: A unit of service equals 15 minutes of one-to-one service delivered face-to-face.

ICM 2009 Unit Allocation	
Clients who receive an ICM billable service **prior to March 1, 2011**	Continue with 2009 unit allocation • ICM screening = 4 units maximum • Lower level of service = 10 units maximum which includes a maximum of 4 units for screening • Higher level of service = 30 units maximum which includes a maximum of 4 units for screening
ICM March 1, 2011 Unit Allocation	
Clients who receive their 1st ICM billable services **on or after March 1, 2011**	• ICM screening = 2 units max • Low level of service = 6 unit max which includes the 2 units max for screening • High level of service = 20 units max which includes the 2 units max for screening

MSS & ICM Clarification Notes:

- MSS and ICM are two separate components within First Steps. There are two distinct eligibility periods and MSS is based on mom's eligibility whereas ICM is based on baby's eligibility. The units assigned will have to be assessed separately for each component based on when billable services are started.

- If the client's level of service increases, she will be eligible for more units, not to exceed the units allocated for that level of service. Any units already used must be subtracted from the units allocated for the new level of service.

- If the client's level of service remains the same or moves to a lower level of service, the units of service available do not change but are still based on client need.

Note: A unit of service equals 15 minutes of one-to-one service delivered face-to-face.