Department of Social and Health Services
Health and Recovery Services Administration
and
Department of Health
Office Maternal and Child Health

Maternity Support Services/ Infant Case Management

Billing Instructions

ProviderOne Readiness Edition

[WAC 388-533-0300]

About This Publication

This publication supersedes all previous Department/HRSA *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: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected

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How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA 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/HRSA *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 Office of Maternal and Child Health 360-236-3967
Finding out about payments, denials, claims processing, or Department managed care organizations	See the Department/HRSA *Resources Available* 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 and changes in ownership for Maternity Support Services	Department of Health Office of Maternal and Child Health 360-236-3967
Policy or program oversight for Infant Case Management	Department-HRSA 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/HRSA *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.

ADATSA/DBHR Assessment Centers - ADATSA refers to the Alcohol and Drug Addiction Treatment and Support Act. DBHR is the Division of Behavioral Health and Recovery. Agencies contracted by DBHR to provide chemical dependency assessment for ADATSA clients and pregnant women. Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

Advocacy – For the purposes of this program, means actions taken to support the parent(s) in accessing needed services or goods and helping the parent(s) to develop skills to access services.

Applicant – A person who has applied for medical assistance.

Assurances Document – A signed agreement documenting that the provider understands and agrees to maintain certain required program elements; and to work toward integrating other specifically recommended practices. Also referred to as the "MSS/ICM Assurances" document.

Authorization requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or billing instructions.

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

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

Case Management – For the purposes of this program, means services to assist individuals who are eligible under the Medicaid state plan 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.

Chemical Use - Chemical use means any ingestion of psychoactive chemicals or any pattern of psychoactive chemical use. Use patterns are characterized by continued use despite knowledge of having persistent or reoccurring social, occupational, psychological or physical problems that are caused by or exacerbated by use.

Childbirth Education Classes (CBE) - A series of educational sessions offered in a group setting and led by an approved instructor that prepare pregnant woman and her support person for an upcoming childbirth. See the Department/HRSA *Childbirth Education Billing Instructions.*

Childcare -

DBHR – (Division of Behavioral Health and Recovery) means the childcare for women attending DASA-funded outpatient alcohol or drug treatment services that may be provided through the treatment facility.

First Steps - Childcare funded through the First Steps Program for the care of children of pregnant or postpregnant women who are attending appointments for Medicaid-covered services, pregnant women on physician ordered bed rest and for visits to the NICU after delivery.

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 Coordinated Services (CCS) - The federal Title V program for children with special health care needs.

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

Children with Special Health Care Needs (CSHCN) - Title V (federally funded) program for children with special health care needs.

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. Clinical supervision must be provided by someone from the same discipline with more experience and education.

Community and Family Health (CFH) - The division within the state Department of Health whose mission is to improve the health and well-being of Washington residents, with a special focus on infants, children, youth, pregnant woman, and prospective parents.

Consultation – For purposes of this program, means the practice of conferring with other professionals to share knowledge and problem-solve with the intent of providing the best possible care to clients.

Core Services – For the purposes of this program, means the services that provide the framework for interdisciplinary, client-centered Maternity Support Services and Infant Case Management. These services include: Client Risk Screening, Basic Health Messages, Basic Linkages, and Minimum Interventions**.**

Crisis Intervention – Provide short term intervention in an emergency situation.

DBHR - See ADATSA

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

EPSDT Provider - (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as a 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.

Federal Aid - Matching funds from the federal government received by the state for medical assistance programs.

First Steps - The 1989 Maternity Care Access Act, known as First Steps. This program provides maternity care for pregnant and post-pregnant women and health care for infants. The program is administered jointly by the Department and DOH. First Steps maternity care consists of obstetrical care, case management, and support services such as community health nursing, nutrition, psychosocial visits, and childbirth education classes. Ancillary services include expedited eligibility determination, case finding, outreach, childcare, and transportation. Specialized substance abuse treatment services, offered through the Omnibus Drug Act, encompass residential and outpatient treatment and transitional housing.

First Steps Consultation Team - The state team consisting of both the Department and DOH managers plus state staff representing infant case management, the First Steps Clearinghouse, and members of the interdisciplinary team: community health nurse, behavioral health specialist, nutritionist, and health educator. The First Steps Consultation team provides technical assistance to programs and professional disciplines; develops protocols and guidelines for service delivery; monitors data related to service delivery and program outcomes; and make site visits to MSS/ICM agencies for monitoring purposes.

Home visit – For the purposes of this program, means services delivered in the client's place of residence or other setting (as in the hospital), if the Maternity Support Services/Infant Case Management provider is not located on the hospital campus. If a visit is not possible, due to an unsafe place of residence or a potential problem with client confidentiality, an alternative site may be billed as a home visit.

Note: The reason for using an alternate site for visitation [instead of the home] must be documented in the client's record.

Infant Case Management (ICM) – A program that provides enhanced case management service to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle and up to the baby's first birthday.

Interagency Agreement – A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS/ICM clients).

Interdisciplinary Team – Members from different professions and occupations that work closely together and communicate frequently to optimize care for the client (pregnant women and infant). Each team member contributes their knowledge, skill set, and experience to support and augment the contributions of their team members.

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

Local match - Nonfederal funds provided by local entities to match the federal Title XIX funds provided for a given program.

Maternal and Infant Health (MIH) - A section within the state Department of Health. MIH works collaboratively with the Department to provide clinical consultation, oversight and monitoring of the MSS/ICM program.

Maternity Support Services (MSS) – Preventative health services for pregnant/postpregant-women including: professional observation, assessment, education, intervention, and counseling. The services are provided by an interdisciplinary team consisting of at minimum, a community health nurse, a nutritionist, and a behavioral health specialist. Optional members of the team are community health workers working under the direction of a professional member of the team.

Maternity cycle – Eligibility period for Maternity Support Services which begins during pregnancy and continues to the end of the month in which the 60 days post pregnancy occurs.

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*.

Minimum interventions – Defined levels of client assessment, education, intervention and outcome evaluation for specific risk factors found in client screening for MSS/ICM services, or identified during ongoing services.

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

Networking – Develop a series of linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

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

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

Post pregnancy period – The two months following a live birth, miscarriage, fetal death, or pregnancy termination.

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 to clients that will assist them in receiving medical, social, educational, or other services.

Risk factors – Biopsychosocial factors that could lead to negative pregnancy or parenting outcomes. The MSS/ICM program design identifies specific risk factors and corresponding minimum interventions.

Service plan – The written plan of care that must be developed and maintained throughout the eligibility period for each client in the MSS/ICM programs.

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.

Staff – For the purposes of this program, means the personnel employed by MSS/ICM providers.

Subcontractor - An individual or agency who has contracted with a primary MSS provider to provide services to MSS clients. This individual or agency must be informed of, and comply with, all regulations contained in the Core Provider Agreement and in the Assurances document as they pertain to service delivery to the MSS client. (These include the MSS Billing Instructions.)

Substance abuse – See Chemical Use.

Supervision – A process that involves both monitoring and teaching. Supervision should begin prior to intervention and documented as to date, subject matter, follow-up plan, and parties involved.

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.

WIC (Women, Infant, and Children) - A special supplemental nutrition program for women, infants, and children.

About the Program

What Is the Purpose of the Maternity Support Services/Infant Case Management Program?

The purpose of the Maternity Support Services (MSS)/Infant Case Management (ICM) program is to provide **enhanced support services** to eligible pregnant women through the maternity cycle and for eligible families through the month of the infant's first birthday. The purpose of the enhanced services is to improve birth outcomes and respond to clients' individual risks and needs.

This program is collaboratively managed by the Department of Health and the Department of Social and Health Services (the Department) Health and Recovery Services Administration.

Program Design

The program is designed to provide interventions as early in a pregnancy as possible in an effort to promote a healthy pregnancy and positive birth and parenting outcomes. Measures of improvement in pregnancy and parenting outcomes include:

- Increased early access and ongoing utilization of prenatal and newborn care;
- A decrease in low birth weight babies; and
- A decline in Infant Mortality Rates.

Additional Goals of Program

Additional goals of the program are:

- To decrease health disparities;
- Reduce the number of unintended pregnancies;
- Reduce the number of repeat pregnancies within two years of deliver;
- Increase the initiation and duration of breastfeeding;
- Reduce tobacco use during pregnancy and pediatric exposure to second-hand smoke;
- Reduce the incidence of SIDS; and
- Increase self-sufficiency of the mother and family unit.

Freedom of Choice/Consent for Services

MSS/ICM clients have the right to choose their MSS/ICM provider, and (if not enrolled in a managed care plan), any other Department provider, as allowed under Section 1902(a)(23) of the Social Security Act.

1. **Option to Receive Services**
   Any pregnant Medicaid client has the *option* to receive MSS but *cannot be forced* to receive MSS/ICM services that the parent(s) and/or their infant might be eligible (Social Security Act - Section 1915(g)(1)).

2. **Free Choice of MSS/ICM Providers**
   Clients (fee-for-service and managed care) have free choice of which state approved agency they receive MSS/ICM. **You may not limit the client to providers in a given county or clinic, even if the client receives all other Department-covered services through that county or clinic**.

3. **Free Choice of Other Providers**
   Clients must have free choice of providers of other medical care. Clients enrolled in a managed care plan must use a provider in the managed care plans network for medical care.

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

Childbirth Education Classes

Childbirth education classes are a service that can be offered to all Medicaid eligible women. Instruction is in a group setting and may be completed over several sessions. Childbirth education is intended to help the client and her support person(s) to understand the changes the client is experiencing, what to anticipate prior to and during labor and delivery, and to help develop positive parenting skills. Refer to the *Childbirth Education Billing Instructions.* The Childbirth Education Consultant can be reached by calling 1-360-236-3552.

Maternity Support Services

What Are Maternity Support Services?

Maternity Support Services are provided by members of the agency's interdisciplinary team: Community Health Nurse (CHN), Registered Dietitian (RD), Behavioral Health Specialist (BHS), and a Community Health Worker (CHW) (acting under the direction of a professional on the Interdisciplinary team). Refer to the First Steps Manual for detailed information regarding staffing qualifications.

The primary focus of Maternity Support Services is risk assessment, interventions, linkages and referrals. Professional interventions are based on risk factors that are known to impact pregnancy and parenting outcomes (including the Family Planning Performance Measure and the Tobacco Cessation During Pregnancy Performance Measure).

What Are the Provider Requirements for MSS?

Services must be provided only by Department-approved MSS/ICM providers. Representatives from the Department and the Department of Health (DOH) recruit and approve providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by Department/DOH program guidelines;

- Providers must:

  - ✓ Deliver both MSS and ICM services;
  - ✓ Provide services in both office and home visit settings; and
  - ✓ Assure program staffing requirements and delivery of services meet program policies.

The Department considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment.

- MSS/ICM providers must also:

  - ✓ Refer a client who may need chemical dependency assessment to a provider who is contracted with the Division of Alcohol and Substance Abuse (DASA); and
  - ✓ Screen for the eligible woman's need for childcare, discuss and encourage a safe/ healthy childcare plan, and if needed, initiate the process for First Steps Childcare services.

What Are the Provider Requirements for MSS? (Cont.)

To be reimbursed by the Department for MSS, a MSS/ICM provider must:

- Meet the requirements in chapter 388-502 WAC Administration of Medical Programs - Provider rules;
- Have a completed, approved MSS/ICM Assurances document, signed by an officer or employee qualified to sign on behalf of the provider, on file with the Department;
- Meet the Department/DOH requirements for a qualified MSS interdisciplinary team as described in the Assurance document;
- Ensure that the staff meet the minimum qualifications for the MSS roles they perform;
- Comply with the clinical supervision/clinical consultation guidelines as required in the Assurances document;
- Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;
- Ensure that all newly hired staff receive a First Steps Orientation as soon as possible, but not later than 60 days from the hire date;
- Conduct case conferencing activities as specified in the provider requirements; and
- Submit claims as directed in these billing instructions.

Note: The Department will not pay for any First Steps services provided by student interns (nursing, behavioral health or dietitian).

When Billing for First Steps Nutrition Services, Program Staff Must Meet the Following Requirements:

- Currently registered with the Commission on Dietetic Registration.

- Washington State Certified Dietitian

  ✓ Registered Dietitians (RDs) who began working in MSS on and after January 25, 2007 are required to be a Washington State certified dietitian by July 1, 2007.

  ✓ All RDs working in MSS prior to January 25, 2007 are required to be a Washington State certified dietitian by March 1, 2008.

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/HRSA *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 is not eligible, 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.

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.

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). Services will be offered during the maternity cycle as long as there is a need for identified core services and minimum interventions.

What Is Covered for MSS?

The Department covers the following for MSS:

- Community Health Nurse visits;
- Registered Dietitian visits;
- Behavioral Health Specialist visits; and
- Community Health Worker visits.

The Department will reimburse MSS/ICM providers on a fee-for-service basis for the above services only when the services are:

- Documented in the client's chart;
- Provided in a face-to-face encounter;
- Delivered by a qualified staff person acting within their area of expertise; and
- Only when used for the purposes of the MSS program to:

  - ✓ Provide risk screening;
  - ✓ Deliver basic health messages;
  - ✓ Provide interventions based on identified risk factors;
  - ✓ Provide referral and linkages to other services;
  - ✓ Provide family planning screening; or
  - ✓ Provide tobacco cessation during pregnancy performance measure requirements.

Place of Service (POS) Codes for MSS Services

The provider, in collaboration with the client, determines whether the services are 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.

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)

MSS Performance Measures

Unintended Pregnancy Family Planning Performance Measure

All MSS/ICM agencies are required to complete the MSS Family Planning Performance Measure with each client. MSS providers must include in their interventions family planning education so that each woman can decide if and when to use birth control and which method would work the best for her. The completion of the performance measure documentation must be completed in the post pregnancy period.

MSS providers must bill the family planning performance measure procedure only once per client, per pregnancy and are to bill post pregnancy.

Tobacco Cessation During Pregnancy Performance Measure

All MSS/ICM agencies are required to complete the MSS Tobacco Cessation during Pregnancy Performance Measure with each client.

MSS providers must include ongoing assessment and education regarding tobacco cessation and second hand smoke exposure reduction. Documentation must ensure that the client is asked about tobacco usage and/or exposure to secondhand smoke, and is offered an appropriate and individualized intervention; and

MSS Providers must bill the tobacco cessation performance measure procedure, only once per client, per pregnancy, in the post pregnancy period.

Maternity Support Services Client Screening Tool

MSS qualified staff must provide risk screening using one or more forms listed below:

- Prenatal New Client;
- Postpartum New Client;
- Postpartum Returning Client; and
- Infant Initial Screening

Completed screening tools must be kept in the client's chart. You may download the forms at http://hrsa.dshs.wa.gov/firststeps/Provider%20Page/First%20Steps%20Documentation/Documentation.index.htm.

Billing for MSS

- **Bill the Department using the client's ProviderOne Client ID.**

- Only the time spent providing MSS services is billable. The time the client's visit **begins** and **ends** must be recorded and documented in the client's chart.

- **An initial face-to-face visit may be billed to the Department without a signed consent form if the client refuses further services, as long as this refusal is documented in the chart. Only bill for services provided to the pregnant/post pregnant woman.**

- Travel expenses, charting time/documentation, phone calls and mileage have been factored into the reimbursement rate for MSS.

- If the client becomes pregnant again within 12 months from the previous pregnancy, enter the new "Due Date" in field 19 on the CMS-1500 Claim Form for new MSS services. This "resets" the claims processing clock for the new pregnancy.

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

Minimum and Maximum Number of Visits

- Community health nursing visits, dietitian visits, behavioral visits, and community health worker visits are subject to the following limitations per client:

  ✓ One unit of service equals 15 minutes. Providers must bill in units.

  ✓ If two or more MSS providers meet with a client at the same time, only 1 discipline can bill for each 15 minute unit. 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).

    - A minimum of 1 unit must be provided per day when billing for a visit;
    - A maximum of 6 units may be billed per day for any combination of office and/or home visits; and
    - A maximum of 60 units from all disciplines combined may be billed for office and/or home visits over the maternity cycle (pregnancy through two months post pregnancy).

Note: The Department will not pay for any First Steps services provided by student interns (nursing, behavioral health or dietitian).

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
T1019	V22.2	HD	Personal care services (Community Health Worker)	**1 unit = 15 minutes** **Use for dates of service *prior* to 9/1/2007.**
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 **Use for dates of service 9/1/2007 or after.**
Family Planning Performance Measure				
T1023	V22.2	HD	Program intake assessment	Family Planning Performance Measure may be billed **only once per client, per pregnancy** (bill postpregnancy).
Tobacco Cessation During Pregnancy Performance Measure				
S9075	V22.2	HD	Smoking Cessation Education	MSS Tobacco Cessation Performance Measure may be billed **only once per client, per pregnancy** (bill postpregnancy).

Billing Reminder: Travel expenses, charting time/documentation, phone calls and mileage are factored into the reimbursement rate for MSS/ICM.

Fee Schedule

You may view the Department/HRSA **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 Infant Case Management (ICM)?

The Infant Case Management (ICM) program is the part of MSS/ICM services for high-risk infants and their families. The goal of ICM is to improve the parent(s) self-sufficiency in gaining access to needed medical, social, educational, and other services (SSA 1915[g]).

At the end of the maternity cycle, MSS staff assess family needs as they relate to the infant. Families meeting the criteria for Infant Case Management (ICM) will be offered services that focus on referrals, linkages and client advocacy. Families who did not receive MSS may be eligible for ICM services.

What Are the Provider Requirements for ICM?

Services under this program are provided only by Department-approved MSS/ICM providers. Representatives from the Department and DOH the recruit and approve MSS/ICM providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by Department/DOH program guidelines;

- Providers must:

  - ✓ Deliver both MSS and ICM services;
  - ✓ Provide services in both office and home visit settings; and
  - ✓ Assure program staffing requirements and delivery of services meet program policies.

The Department considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment.

To be reimbursed by the Department for MSS/ICM, a provider must:

- Meet the requirements in chapter 388-502 WAC, Administration of Medical Programs – Providers rules;
- Have a completed, approved MSS/ICM Assurances document, signed by an officer or employee qualified to sign on behalf of the provider, on file with the Department;
- Ensure the MSS/ICM provider meet the minimum qualifications for the ICM roles they perform;
- Comply with the clinical supervision/clinical consultation guidelines as required in the Assurances document;
- Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;
- Ensure that all newly hired staff receive an orientation to First Steps as soon as possible, but not later than 60 days from the hire date; and
- Submit billings as described in these instructions.

Who Is Eligible for ICM?

To be eligible for ICM, the parent/infant must:

- Be covered by a Benefit Service Package that covers MSS;

  Please see the Department/HRSA *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.

- Need assistance in accessing/providing care for themselves or their family; and

- Meet at least one of the criteria listed on the ICM Intake form, DSHS 13-658. To download the form, go to http://www1.dshs.wa.gov/msa/forms/eforms.html.

Are Clients Enrolled in a Department Managed Care Plan Eligible for ICM?

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.

How Long Is a Client Eligible for ICM?

Services may continue until the end of the month in which the infant's first birthday occurs. This applies to eligible families who demonstrate a need for assistance in accessing/providing care for the parent(s) and infant and there is an active plan for care.

What If the Woman Becomes Pregnant While Receiving ICM?

If a woman becomes pregnant again while receiving ICM, ICM services are closed. Begin Maternity Support Services for the new pregnancy and bill using MSS procedure codes.

Can ICM Continue if the Infant Is Placed Outside the Home?

If the infant does not live with either biological parent, the provider must terminate or deactivate services. If the infant is returned to either biological parent before his/her first birthday, the provider may reassess for ICM eligibility.

Example A:

> 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.

Example B:

For a CPS child who is still in their biological 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, then the Department would duplicate services. ICM would be closed in order to prevent duplicate payments.

Example C:

Grandparents have legal custody of the infant. Is this billable to ICM? No, the infant must be living with a biological parent.

What Services Are Covered Under ICM?

The Department reimburses approved MSS/ICM providers on a fee-for-service basis for case management under the ICM program including:

- Assessing risk and need;
- Reviewing and updating the infant and parent(s) plan for care;
- Referring and linking the client to other agencies; and
- Advocating for the client with other agencies.

The case management activities listed above are covered under the ICM program only when:

- Documented in the client's record;
- Performed by a qualified staff person acting within his or her area of expertise; and
- Performed according to program design as described in the MSS/ICM Assurances.

Billing for ICM

- Only the time spent providing ICM services is billable. The time the client's visit **begins** and **ends** must be recorded and documented in the client's chart.

- Bill the Department for ICM services using the baby's ProviderOne Client ID. Do not use the mother's ProviderOne Client ID.

- ICM is considered family-based intervention. Therefore, the infant [and family] are only allowed one Title XIX Targeted Case Manager.

Billing for ICM (Cont.)

- Travel expenses, charting time/documentation, phone calls and mileage have been factored into the reimbursement rate for ICM.

- ICM is provided for parent/infant meeting eligibility criteria. (Services can be provided from the end of the maternity cycle through the end of the month of the infant's first birthday.) The following limitations per client apply:

  ✓ One unit of service equals 15 minutes;
  ✓ A maximum of 6 units may be billed per month; and
  ✓ A maximum of 40 units may be billed during the 10 months following the maternity cycle.

  Providers must bill in units.

- The Department recognizes taxonomy code 171M00000X as appropriate for Infant Case Management Services published in these billing instructions.

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

Fee Schedule

You may view the Department/HRSA **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/HRSA *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?

- When there is more than one provider serving a client or if the provider has subcontractors, a central file containing all information on the client related to MSS/ICM must be kept by the primary MSS/ICM agency.

- Providers must keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth (record ProviderOne Client ID)
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Place of service.

- Providers must assure that the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains authenticates charts.

- Written documentation in the client's file is required that addresses all areas listed under *Freedom of Choice/Consent* and *Confidentiality and Release of Information.*

- Copy of the following:

  - ✓ Infant Case Management (ICM) Intake form, DSHS 13-658, if appropriate;
  - ✓ MSS Risk Factor Screening Tool, DSHS 13-723;
  - ✓ Family Planning Performance Measure; and
  - ✓ Tobacco Cessation Performance Measure.

Note: During the transition period, standardized charting forms are being developed which all providers are expected to implement. The first of the forms being piloted is the MSS Risk Factor Screening Tool, DSHS 13-723. A separate packet related to documentation and charting is under development. During the transition period, agencies can continue to use current forms along with the screening tool. 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 Service Plan.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *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**	These are the only appropriate code(s) for this billing instruction: **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.