Chapter 182-533 WAC
MATERNITY-RELATED SERVICES

WAC

FIRST STEPS SERVICES FOR WOMEN AND INFANTS

182-533-0300 Services under First Steps.
182-533-0310 Maternity support services—Purpose.
182-533-0315 Maternity support services—Definitions.
182-533-0320 Maternity support services—Client eligibility.
182-533-0325 Maternity support services—Provider requirements.
182-533-0327 Maternity support services—Professional staff qualifications and interdisciplinary team.
182-533-0328 Maternity support services—Documentation requirements.
182-533-0330 Maternity support services—Covered services.
182-533-0340 Maternity support services—Noncovered services.
182-533-0345 Maternity support services—Payment.
182-533-0360 Infant case management—Purpose.
182-533-0365 Infant case management—Definitions.
182-533-0370 Infant case management—Client eligibility.
182-533-0375 Infant case management—Provider requirements.
182-533-0378 Infant case management—Documentation requirements.
182-533-0380 Infant case management—Covered services.
182-533-0385 Infant case management—Noncovered services.
182-533-0386 Infant case management—Payment.
182-533-0390 Childbirth education (CBE) classes.

OTHER MATERNITY AND INFANT SERVICES

182-533-0400 Maternity care and newborn delivery.
182-533-0600 Planned home births and births in birthing centers.

CHEMICAL-USING PREGNANT (CUP) WOMEN SERVICES

182-533-0701 Chemical-using pregnant (CUP) women program—Purpose.
182-533-0710 Chemical-using pregnant (CUP) women program—Client eligibility.
182-533-0720 Chemical-using pregnant (CUP) women program—Provider requirements.
182-533-0730 Chemical-using pregnant (CUP) women program—Covered services.

FIRST STEPS SERVICES FOR WOMEN AND INFANTS

WAC 182-533-0300 Services under First Steps. (1) Under the 1989 Maternity Care Access Act, and RCW 74.09.760 through 74.09.910, the agency established First Steps to provide access to services for eligible women and their infants.

(2) The rules for the:

(a) Maternity support services (MSS) component of First Steps are found in WAC 182-533-0310 through 182-533-0345.

(b) Infant case management (ICM) component of First Steps are found in WAC 182-533-0360 through 182-533-0386.

(c) Childbirth education (CBE) component of First Steps are found in WAC 182-533-0390.

(3) Other services under First Steps include:

(a) Medical services, including full medical coverage, prenatal care, delivery, post-pregnancy follow-up, and twelve months family planning services post-pregnancy;

(b) Ancillary services, including but not limited to, expedited medical eligibility determination; and

(c) Alcohol and drug assessment and treatment services for pregnant women available statewide and administered by the division of behavioral health and recovery (see WAC 182-533-0701).

[Statutory Authority: RCW 41.05.021 and 2011 c 5. WSR 12-01-097, § 182-533-0300, filed 12/20/11, effective 1/20/12. WSR 11-14-075, recodified as § 182-533-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0300, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0300, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 74.09.770, and 74.09.800. WSR 00-14-068, § 388-533-0300, filed 7/5/00, effective 8/5/00.]

WAC 182-533-0310 Maternity support services—Purpose. The purpose of maternity support services (MSS) is to:

(1) Improve and promote healthy birth outcomes. Services are delivered by an MSS interdisciplinary team to eligible pregnant and post-pregnant women and their infants.

(2) Help eligible clients to access:

(a) Prenatal care as early in the pregnancy as possible; and

(b) Health care for their infants.

[WSR 11-14-075, recodified as § 182-533-0310, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0310, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0310, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0315 Maternity support services—Definitions. The following definitions and those found in WAC 182-500-0005 apply to maternity support services (MSS) and infant case management (ICM) (see WAC 182-533-0360 through 182-533-0386 for ICM rules).

"Basic health messages" - For MSS, the preventive health education messages designed to promote healthy pregnancies, healthy newborns and healthy parenting during the first year of life.

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

"Care plan" - A written statement developed for a person that continues throughout the eligibility period and outlines any medical, social, environmental or other interventions to achieve an improved quality of life, including health and social outcomes.

"Case conference" - A formal or informal consultation used by the MSS interdisciplinary team to consult with each other and, when needed, other pertinent providers and/or the client to optimize the client's care.

"Case management" - Services to help individuals access needed medical, social, educational, and other services.

"Childbirth education (CBE)" - A component of the First Steps program to provide educational sessions offered in a group setting that prepares a pregnant woman and her support person(s) for an upcoming childbirth and healthy parenting.

"Department of health (DOH)" - The state agency that works to protect and improve the health of people in Washington state.

"First Steps" - The program created under the 1989 Maternity Care Access Act.

"Infant case management (ICM)" - A component of the First Steps program to provide parent(s) with information and assistance in accessing needed medical, social, educational, and other services that improve the welfare of infants.

"Infant case management (ICM) screening" - A brief in-person evaluation provided by a qualified person, under WAC 182-533-0375, to determine whether an infant and the infant's parent(s) have a specific risk factor(s).

"Linking" - Assistance to clients for identifying and using community resources to address specific medical, social and educational needs.

"Maternity cycle" - An eligibility period for maternity support services that begins during pregnancy and continues to the end of the month in which the sixtieth-day post-pregnancy occurs.

"Maternity support services (MSS)" - A component of the First Steps program to provide screening, assessment, basic health messages, education, counseling, case management, care coordination, and other interventions delivered by an MSS interdisciplinary team during the maternity cycle.

"Maternity support services (MSS) interdisciplinary team" - A provider's group of qualified staff consisting of at least a community health nurse, a certified registered dietitian, a behavioral health specialist, and, at the discretion of the provider, a community health worker. Based upon individual client need, each team member provides maternity support services and consultation. (See WAC 182-533-0327(3).)

"Medicaid agency" - The health care authority.

"Parent(s)" - A person who resides with an infant, provides the infant's day-to-day care, and meets the legal description under WAC 182-533-0370 (1)(c).

"Risk factors" - The biopsychosocial factors that could lead to poor birth outcomes, infant morbidity, and/or infant mortality.

"Screening" - A method for systematically identifying and documenting risk factors and client need.

"Washington apple health (WAH)" - The public health insurance programs for eligible Washington residents. Washington apple health is the name used in Washington state for medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. (See WAC 182-500-0120.)

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0315, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0315, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0315, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0315, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0320 Maternity support services—Client eligibility. (1) To receive maternity support services (MSS), a client must:

(a) Be covered under categorically needy, medically needy, or state-funded medical programs under Washington apple health; and

(b) Be within the eligibility period of a maternity cycle as defined in WAC 182-533-0315.

(2) Clients who meet the eligibility criteria in this section and are enrolled in an agency-contracted managed care organization (MCO) are eligible for MSS outside their plan.

(3) Clients who do not agree with an eligibility decision for MSS have a right to a fair hearing under chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0320, filed 4/16/14, effective 5/17/14. Statutory Authority: RCW 41.05.021 and 2011 c 5. WSR 12-01-097, § 182-533-0320, filed 12/20/11, effective 1/20/12. WSR 11-14-075, recodified as § 182-533-0320, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0320, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0320, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0325 Maternity support services—Provider requirements. Maternity support service providers may include community clinics, federally qualified health centers, local health departments, hospitals, nonprofit organizations, and private clinics.

(1) To be paid for providing maternity support services (MSS) and infant case management (ICM) services to eligible clients, a provider must:

(a) Be enrolled as an eligible provider with the medicaid agency (see WAC 182-502-0010).

(b) Be currently approved as an MSS/ICM provider by the medicaid agency.

(c) Meet the requirements in this chapter, chapter 182-502 WAC and the medicaid agency's current billing instructions.

(d) Ensure that professional staff providing services:

(i) Meet the minimum regulatory and educational qualifications for the scope of services provided under WAC 182-533-0327; and

(ii) Follow the requirements in this chapter and the medicaid agency's current billing instructions.

(e) Screen each client for risk factors.

(f) Screen clients for ICM eligibility.

(g) Conduct case conferences under WAC 182-533-0327(2).

(h) Develop and implement an individualized care plan for each client.

(i) Initiate and participate in care coordination activities throughout the maternity cycle with at least MSS interdisciplinary team members, the client's prenatal care provider, and the Women, Infants, and Children (WIC) Nutrition Program.

(j) Comply with Section 1902 (a)(23) of the Social Security Act regarding the client's freedom to choose a provider.

(k) Comply with Section 1915 (g)(1) of the Social Security Act regarding the client's voluntary receipt of services.

(2) MSS providers may provide services in any of the following locations:

(a) A provider's office or clinic.

(b) The client's residence.

(c) An alternate site that is not the client's residence. (The reason for using an alternate site for visitation instead of the home must be documented in the client's record.)

(3) An individual or service organization that has a written contractual agreement with a qualified MSS provider also may provide MSS and ICM services to eligible clients.

(a) The provider must:

(i) Keep a copy of the written subcontractor agreement on file;

(ii) Ensure that an individual or service organization staff member providing MSS/ICM services (the subcontractor) meets the minimum regulatory and educational qualifications required of an MSS/ICM provider;

(iii) Ensure that the subcontractor provides MSS/ICM services under the requirements of this chapter; and

(iv) Maintain professional, financial, and administrative responsibility for the subcontractor.

(b) The provider must:

(i) Bill for services using the provider's assigned billing number; and

(ii) Reimburse the subcontractor for MSS/ICM services provided under the written agreement.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0325, filed 4/16/14, effective 5/17/14. Statutory Authority: RCW 41.05.021 and 2011 c 5. WSR 12-01-097, § 182-533-0325, filed 12/20/11, effective 1/20/12. WSR 11-14-075, recodified as § 182-533-0325, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0325, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0325, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0327 Maternity support services—Professional staff qualifications and interdisciplinary team. (1) MSS providers must use qualified professionals, as specified in this section.

(a) Behavioral health specialists who are currently credentialed or licensed in Washington by the department of health under chapters 246-809, 246-810, and 246-924 WAC as one of the following:

(i) Licensed mental health counselor.

(ii) Licensed independent clinical social worker.

(iii) Licensed social worker.

(iv) Licensed marriage and family therapist.

(v) Licensed psychologist.

(vi) Associate mental health counselor.

(vii) Associate independent clinical social worker.

(viii) Associate social worker.

(ix) Associate marriage and family therapist.

(x) Certified counselor.

(b) Certified dieticians who are currently registered with the commission on dietetic registration and certified by the Washington state department of health under chapter 246-822 WAC.

(c) Community health nurses who are currently licensed as registered nurses in the state of Washington by the department of health under chapter 246-840 WAC.

(d) Community health workers (CHWs) who have a high school diploma or the equivalent and:

(i) Have a minimum of one year of health care and/or social services experience.

(ii) Carry out all activities under the direction and supervision of a professional member or supervisor of the MSS interdisciplinary team.

(iii) Complete a training plan developed by their provider.

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

(a) The interdisciplinary team must work together to address risk factors identified in a client's care plan.

(b) Each qualified staff member acting within her/his area of expertise must address the variety of client needs identified during the maternity cycle.

(c) An MSS interdisciplinary team case conference is required at least once prenatally for clients who are entering MSS during pregnancy, and are eligible for the maximum level of service. Using clinical judgment and the client's risk factors, the provider may decide which interdisciplinary team members to include in case conferencing.

(3) All tribes and any county with fewer than fifty-five medicaid births per year are not required to have an MSS interdisciplinary team, although they must meet all the other requirements in this chapter. Instead of the interdisciplinary team, these counties and tribes must have at least one of the following qualified professionals, as described in subsection (1) of this section:

(a) A behavioral health specialist;

(b) A registered dietician; or

(c) A community health nurse.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0327, filed 4/16/14, effective 5/17/14.]

WAC 182-533-0328 Maternity support services—Documentation requirements. Providers must fulfill the documentation requirements under WAC 182-502-0020 and the medicaid agency's current billing instructions including:

(1) Required supervision records for community health workers;

(2) Continued education verification and renewal of credentials for professional staff;

(3) Subcontracting documents, as specified under WAC 182-533-0325(3); and

(4) Client records, which include consent forms and documentation for screening, assessments, care plans, case conferences, case management, and care coordination for each client.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0328, filed 4/16/14, effective 5/17/14.]

WAC 182-533-0330 Maternity support services—Covered services. (1) The medicaid agency must cover these maternity support services (MSS) provided by an MSS interdisciplinary team:

(a) In-person screening(s) for risk factors related to pregnancy and birth outcomes;

(b) Brief assessment when indicated;

(c) Brief counseling;

(d) Education that relates to improving pregnancy and parenting outcomes;

(e) Interventions for risk factors identified on the care plan;

(f) Basic health messages;

(g) Case management services;

(h) Care coordination;

(i) Infant case management (ICM) screening.

(2) The medicaid agency must determine the maximum number of units of services allowed per client when directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium. (The maximum number of MSS units allowed per client is published in the agency's current billing instructions.)

(3) The medicaid agency must pay for covered maternity support services according to WAC 182-533-0345.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0330, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0330, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0330, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0330, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0340 Maternity support services—Noncovered services. (1) The medicaid agency must cover only those services listed in WAC 182-533-0330.

(2) The medicaid agency must evaluate a request for any noncovered service under the provisions of WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0340, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0340, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0340, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-533-0340, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0340, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0345 Maternity support services—Payment. The medicaid agency must pay for the covered maternity support services (MSS) described in WAC 182-533-0330 on a fee-for-service basis, subject to the requirements in this section:

(1) MSS must be:

(a) Provided to a client who meets the eligibility requirements in WAC 182-533-0320.

(b) Provided to a client on an individual basis in a face-to-face encounter.

(c) Provided by a provider that meets the criteria established in WAC 182-533-0325.

(d) Provided according to the medicaid agency's current billing instructions.

(e) Documented in the client's record or chart.

(f) Billed using:

(i) The eligible client's agency-assigned client identification number;

(ii) The appropriate procedure codes and modifiers identified in the agency's current billing instructions; and

(iii) The agency-assigned MSS/ICM provider number. (The medicaid agency pays the provider for providing MSS services to eligible clients, not the provider's subcontractor who provides MSS services. See WAC 182-533-0325(3) about subcontracting for services.)

(2) The medicaid agency:

(a) Must pay MSS in units of time with one unit being equal to fifteen minutes of one-to-one service delivered face-to-face.

(b) When directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium, may determine the maximum number of units allowed per client.

(c) Must publish the maximum number of units allowed per client in the agency's current billing instructions.

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

(4) For a client enrolled in a managed care plan who is eligible to receive MSS, the medicaid agency must pay for MSS delivered outside the plan on a fee-for-service basis as described in this section.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0345, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0345, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-011, § 388-533-0345, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0345, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0360 Infant case management—Purpose. The purpose of infant case management (ICM) is to improve the welfare of infants by providing their parent(s) with information and assistance to access needed medical, social, educational, and other services.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0360, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0360, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0360, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0360, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0365 Infant case management—Definitions. The definitions in WAC 182-533-0315 also apply to infant case management (ICM).

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0365, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0365, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0365, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0365, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0370 Infant case management—Client eligibility. (1) To be eligible to receive infant case management (ICM), an infant must meet all the following criteria:

(a) Be covered under categorically needy, medically needy, or state-funded medical programs under Washington apple health.

(b) Meet the age requirement for ICM, which is the day after the maternity cycle (defined in WAC 182-533-0315)

ends, through the last day of the month of the infant's first birthday.

(c) Reside with at least one parent who provides the infant's day-to-day care and is:

(i) The infant's natural or adoptive parent(s);

(ii) A person other than a foster parent who has been granted legal custody of the infant; or

(iii) A person who is legally obligated to support the infant.

(d) Have a parent(s) who needs assistance in accessing medical, social, educational and/or other services to meet the infant's basic health and safety needs.

(e) Not be receiving any case management services funded through Title XIX medicaid that duplicate ICM services.

(2) Clients who meet the eligibility criteria and are enrolled in a medicaid agency-contracted managed care organization (MCO) are eligible for ICM services outside their plan.

(3) If the infant's mother becomes pregnant during the ICM eligibility period and she is eligible for maternity support services (MSS), the infant and the infant's mother are no longer eligible to receive ICM services.

(4) Clients who do not agree with an eligibility decision by the medicaid agency for ICM have a right to a fair hearing under chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0370, filed 4/16/14, effective 5/17/14. Statutory Authority: RCW 41.05.021 and 2011 c 5. WSR 12-01-097, § 182-533-0370, filed 12/20/11, effective 1/20/12. WSR 11-14-075, recodified as § 182-533-0370, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0370, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0370, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0375 Infant case management—Provider requirements. (1) Infant case management (ICM) services may be provided only by a qualified infant case manager who is employed by a provider meeting the requirements in WAC 182-533-0325.

(2) The infant case manager must meet at least one of the following qualifications under (a), (b), or (c) of this subsection:

(a) Be a current member of the maternity support services (MSS) interdisciplinary team under WAC 182-533-0327.

(b) Have a bachelor of arts, bachelor of science, or higher degree in a social service-related field, such as social work, behavioral sciences, psychology, child development, or mental health, plus at least one year of full-time experience working in one or more of the following areas:

(i) Community services;

(ii) Social services;

(iii) Public health services;

(iv) Crisis intervention;

(v) Outreach and referral programs; or

(vi) Other related fields.

(c) Have an associate of arts degree, or an associate's degree in a social service-related field, such as social work, behavioral sciences, psychology, child development, or mental health, plus at least two years of full-time experience working in one or more of the following areas:

(i) Community services;

(ii) Social services;

(iii) Public health services;

(iv) Crisis intervention;

(v) Outreach and referral programs;

(vi) Other related fields.

(3) The medicaid agency requires any staff person qualifying under subsection (2)(c) of this section to be under the supervision of a clinical staff person meeting the criteria in subsection (2)(a) or (b) of this section. Clinical supervision may include face-to-face meetings and/or chart reviews.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0375, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0375, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0375, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0375, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0378 Infant case management—Documentation requirements. Providers must fulfill the documentation requirements under WAC 182-502-0020 and the medicaid agency's current billing instructions including:

(1) Required supervision records for infant case managers;

(2) Continued education verification and renewal of credentials for professional staff; and

(3) Client records that include consent forms and documentation for screening, assessments, care plans, case management, and care coordination for each client.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0378, filed 4/16/14, effective 5/17/14.]

WAC 182-533-0380 Infant case management—Covered services. (1) The medicaid agency must cover infant case management (ICM) services subject to the restrictions and limitations in this section and other applicable WAC.

Covered services include:

(a) An initial in-person screening for ICM services, which includes an assessment of risk factors and the development of an individualized care plan;

(b) Case management services and care coordination;

(c) Referral and linking the infant and parent(s) to other services or resources;

(d) Advocacy for the infant and parent(s); and

(e) Follow-up contact(s) with the parent(s) to ensure the care plan continues to meet the needs of the infant and parent(s).

(2) The medicaid agency may determine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium. (The maximum number of ICM units allowed per client is published in the agency's current billing instructions.)

(3) The medicaid agency must pay for covered ICM services according to WAC 182-533-0386.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0380, filed 4/16/14, effective 5/17/14. Statutory Authority: RCW 41.05.021 and 2011 c 5. WSR 12-01-097, § 182-533-0380, filed 12/20/11, effective 1/20/12. WSR 11-14-075, recodified as § 182-533-0380, filed 6/30/11,

effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0380, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0380, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0385 Infant case management—Noncovered services. (1) The medicaid agency must cover only those services that are listed in WAC 182-533-0380.

(2) The medicaid agency must evaluate a request for any noncovered service under the provisions of WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0385, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0385, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0385, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-533-0385, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0385, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0386 Infant case management—Payment. (1) The medicaid agency must pay for the covered infant case management (ICM) services described in WAC 182-533-0380 on a fee-for-service basis subject to the following requirements.

ICM services must be:

(a) Provided to a client who meets the eligibility requirements in WAC 182-533-0370.

(b) Provided by a person who meets the criteria established in WAC 182-533-0375.

(c) Provided according to the agency's current billing instructions.

(d) Documented in the infant's and/or the parent's record or chart.

(e) Billed using:

(i) The eligible infant's medicaid agency-assigned client identification number;

(ii) The appropriate procedure codes and modifiers identified in the agency's current billing instructions; and

(iii) The medicaid agency-assigned MSS/ICM provider number.

(2) The medicaid agency:

(a) Must pay ICM services in units of time, with one unit being equal to fifteen minutes of one-to-one service delivered face-to-face.

(b) When directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium, may determine the maximum number of units allowed per client.

(c) Must publish the maximum number of units allowed per client in the agency's current billing instructions.

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

(4) For a client enrolled in a managed care plan who is eligible to receive ICM, the medicaid agency must pay ICM services delivered outside the plan on a fee-for-service basis as described in this section.

[Statutory Authority: RCW 41.05.021. WSR 14-09-061, § 182-533-0386, filed 4/16/14, effective 5/17/14. WSR 11-14-075, recodified as § 182-533-0386, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. WSR 10-12-010, § 388-533-0386, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0386, filed 6/10/04, effective 7/11/04.]

WAC 182-533-0390 Childbirth education (CBE) classes. (1) Purpose. The purpose of childbirth education (CBE) classes is to help prepare the client and her support person(s):

(a) For the physiological, emotional, and psychological changes experienced during and after pregnancy;

(b) To develop self-advocacy skills;

(c) To increase knowledge about and access to local community resources;

(d) To improve parenting skills; and

(e) To improve the likelihood of positive birth outcomes.

(2) Definitions. The definitions in chapter 182-500 WAC, medial assistance definitions, and WAC 182-533-0315, maternity support services definitions, also apply to this section.

(3) Client eligibility. To be eligible for CBE classes, a client must be:

(a) Pregnant; and

(b) Covered under one of the medical assistance programs described in WAC 182-533-0320 (1)(a)(i) and (iv).

(4) Provider requirements. To be paid for providing CBE classes to eligible clients, an approved instructor must:

(a) Have a core provider agreement on file with the health care authority (the agency);

(b) Ensure that individuals providing CBE classes have credentials and/or certification as outlined in the agency's current published billing instructions;

(c) Deliver CBE classes in a series of group sessions; and

(d) Provide curriculum containing topics outlined in the agency's CBE curriculum checklist found in the agency's current published billing instructions. Topics include, but are not limited to:

(i) Pregnancy;

(ii) Labor and birth;

(iii) Newborns; and

(iv) Family adjustment.

(5) Documentation. Providers must:

(a) Follow the health care record requirements found in WAC 182-502-0020; and

(b) Maintain the following additional documentation:

(i) An original signed copy of each client's Freedom of Choice/Consent for Services form;

(ii) A client sign-in sheet for each class; and

(iii) Names and ProviderOne Client ID numbers of eligible clients attending CBE classes and the date(s) they participated in each CBE class.

(6) Coverage.

(a) The agency covers one CBE class series per client, per pregnancy. The client must attend at least one CBE session for the provider to be paid.

(b) CBE classes must include a minimum of eight hours of instruction and are subject to the restrictions and limitations in this section and other applicable WAC.

(7) Payment. The agency pays for the CBE classes described in subsection (6) of this section on a fee-for-service basis subject to the following:

(a) CBE must:

(i) Include all classes, core materials, publications, and educational materials provided throughout the class series. Clients must receive the same materials as are offered to other attendees; and

(ii) Be billed according to the agency's current published billing instructions.

(b) The provider must accept the agency's fee as payment in full for classes provided to a client in accordance with 42 C.F.R. § 447.15.

[Statutory Authority: RCW 41.05.021 and 2011 c 5. WSR 12-01-097, § 182-533-0390, filed 12/20/11, effective 1/20/12. WSR 11-14-075, recodified as § 182-533-0390, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. WSR 04-13-049, § 388-533-0390, filed 6/10/04, effective 7/11/04.]

OTHER MATERNITY AND INFANT SERVICES

WAC 182-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

(a) **"Birthing center"** means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.

(b) **"Bundled services"** means services integral to the major procedure that are included in the fee for the major procedure. Under this chapter, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.

(c) **"Facility fee"** means the portion of the department's payment for the hospital or birthing center charges. This does not include the department's payment for the professional fee defined below.

(d) **"Global fee"** means the fee the department pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) **"High-risk"** pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) **"Professional fee"** means the portion of the department's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 388-531-1850 for reimbursement methodology.)

(2) The department covers full scope medical maternity care and newborn delivery services to fee-for-service clients who qualify for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-462-0015 for client eligibility). Clients enrolled in the department managed care plan must receive all medical maternity care and newborn delivery services through the plan. See subsection (20) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.

(3) The department does not provide maternity care and delivery services to its clients who are eligible for:

(a) Family planning only (a pregnant client under this program should be referred to the local community services office for eligibility review); or

(b) Any other program not listed in this section.

(4) The department requires providers of maternity care and newborn delivery services to meet all of the following. Providers must:

(a) Be currently licensed by the state of Washington's department of health (DOH) and/or department of licensing;

(b) Have signed core provider agreements with the department;

(c) Be practicing within the scope of their licensure; and

(d) Have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA), etc.).

(5) The department covers total obstetrical care services (paid under a global fee). Total obstetrical care includes all of the following:

(a) Routine antepartum care that begins in any trimester of a pregnancy;

(b) Delivery (intrapartum care/birth) services; and

(c) Postpartum care. This includes family planning counseling.

(6) When an eligible client receives all the services listed in subsection (5) of this section from one provider, the department pays that provider a global obstetrical fee.

(7) When an eligible client receives services from more than one provider, the department pays each provider for the services furnished. The separate services that the department pays appear in subsection (5) of this section.

(8) The department pays for antepartum care services in one of the following two ways:

(a) Under a global fee; or

(b) Under antepartum care fees.

(9) The department's fees for antepartum care include all of the following:

(a) Completing an initial and any subsequent patient history;

(b) Completing all physical examinations;

(c) Recording and tracking the client's weight and blood pressure;

(d) Recording fetal heart tones;

(e) Performing a routine chemical urinalysis (including all urine dipstick tests); and

(f) Providing maternity counseling.

(10) The department covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section. The department pays separately for any of the following:

(a) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). The department provides a list of diagnoses and/or conditions that the department identifies as justifying more frequent monitoring visits. The department pays for either (a) or (b) of this subsection, but not both;

(b) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife. The department pays for either (a) or (b) of this subsection, but not both;

(c) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (9)(e) of this section; and/or

(d) Treatment of medical problems that are not related to the pregnancy. The department pays these fees to physicians or advanced registered nurse practitioners (ARNP).

(11) The department covers high-risk pregnancies. The department considers a pregnant client to have a high-risk pregnancy when the client:

(a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or

(b) Has a diagnosis of multiple births.

(12) The department covers delivery services for clients with high-risk pregnancies, described in subsection (11) of this section, when the delivery services are provided in a hospital.

(13) The department pays a facility fee for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

(14) The department pays a professional fee for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (4) of this section and who has privileges in the hospital;

(b) Planned home births and birthing centers.

(15) The department covers hospital delivery services for an eligible client as defined in subsection (2) of this section. The department's bundled payment for the professional fee for hospital delivery services include:

(a) The admissions history and physical examination; and

(b) The management of uncomplicated labor (intrapartum care); and

(c) The vaginal delivery of the newborn (with or without episiotomy or forceps); or

(d) Cesarean delivery of the newborn.

(16) The department pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.

(17) In addition to the department's payment for professional services in subsection (15) of this section, the department may pay separately for services provided by any of the following professional staff:

(a) A stand-by physician in cases of high risk delivery and/or newborn resuscitation;

(b) A physician assistant or registered nurse "first assist" when delivery is by cesarean section;

(c) A physician, (ARNP), or licensed midwife for newborn examination as the delivery setting allows; and/or

(d) An obstetrician/gynecologist specialist for external cephalic version and consultation.

(18) In addition to the professional delivery services fee in subsection (15) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (5) and (6) of this section, the department allows additional fees for any of the following:

(a) High-risk vaginal delivery;

(b) Multiple vaginal births. The department's typical payment covers delivery of the first child. For each subsequent child, the department pays at fifty percent of the provider's usual and customary charge, up to the department's maximum allowable fee; or

(c) High-risk cesarean section delivery.

(19) The department does not pay separately for any of the following:

(a) More than one child delivered by cesarean section during a surgery. The department's cesarean section surgery fee covers one or multiple surgical births;

(b) Postoperative care for cesarean section births. This is included in the surgical fee. Postoperative care is not the same as or part of postpartum care.

(20) In addition to the services listed in subsection (10) of this section, the department covers counseling for tobacco dependency for eligible pregnant women through two months postpregnancy. This service is commonly referred to as smoking cessation education or counseling.

(a) The department covers smoking cessation counseling for only those fee-for-service clients who are eligible for categorically needy (CN) scope of care. See (f) of this subsection for limitations on prescribing pharmacotherapy for eligible CN clients. Clients enrolled in managed care may participate in a smoking cessation program through their plan.

(b) The department pays a fee to certain providers who include smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination). The department pays only the following providers for smoking cessation counseling:

(i) Physicians;

(ii) Physician assistants (PA) working under the guidance and billing under the provider number of a physician;

(iii) ARNPs, including certified nurse midwives (CNM); and

(iv) Licensed midwives (LM).

(c) The department covers one smoking cessation counseling session per client, per day, up to ten sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information in (e) of this subsection.

(d) The department covers two levels of counseling. Counseling levels are:

(i) Basic counseling (fifteen minutes), which includes (e)(i), (ii), and (iii) of this subsection; and

(ii) Intensive counseling (thirty minutes), which includes the entirety of (e) of this subsection.

(e) Smoking cessation counseling consists of providing information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps (refer to the department's physician-related services billing instructions and births and birthing centers billing instructions for specific counseling suggestions and billing requirements):

(i) Asking the client about her smoking status;

(ii) Advising the client to stop smoking;

(iii) Assessing the client's willingness to set a quit date;

(iv) Assisting the client to stop smoking, which includes developing a written quit plan with a quit date. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see (f) of this subsection); and

(v) Arranging to track the progress of the client's attempt to stop smoking.

(f) A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. The department covers certain pharmacotherapy for smoking cessation as follows:

(i) The department covers Zyban™ only;

(ii) The product must meet the rebate requirements described in WAC 388-530-1125;

(iii) The product must be prescribed by a physician, ARNP, or physician assistant;

(iv) The client for whom the product is prescribed must be eighteen years of age or older;

(v) The pharmacy provider must obtain prior authorization from the department when filling the prescription for pharmacotherapy; and

(vi) The prescribing provider must include both of the following on the client's prescription:

(A) The client's estimated or actual delivery date; and

(B) Indication the client is participating in smoking cessation counseling.

(g) The department's payment for smoking cessation counseling is subject to postpay review. See WAC 388-502-0230, Provider review and appeal, and WAC 388-502A-1100, Provider audit-dispute process.

[WSR 11-14-075, recodified as § 182-533-0400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-014, § 388-533-0400, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770. WSR 05-01-065, § 388-533-0400, filed 12/8/04, effective 1/8/05; WSR 02-07-043, § 388-533-0400, filed 3/13/02, effective 4/13/02. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. WSR 00-23-052, § 388-533-0400, filed 11/13/00, effective 12/14/00.]

WAC 182-533-0600 Planned home births and births in birthing centers. (1) MAA covers planned home births and births in birthing centers for its clients when the client and the maternity care provider choose to have a home birth or to give birth in an MAA-approved birthing center and the client:

(a) Is eligible for CN or MN scope of care (see WAC 388-533-400(2));

(b) Has a MAA-approved medical provider who has accepted responsibility for the planned home birth or birth in birthing center as provided in this section;

(c) Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and

(d) Passes MAA's risk screening criteria. MAA provides these risk-screening criteria to qualified medical services providers.

(2) MAA approves only the following provider types to provide MAA-covered planned home births and births in birthing centers:

(a) Physicians licensed under chapters 18.57 or 18.71 RCW;

(b) Nurse midwives licensed under chapter 18.79 RCW; and

(c) Midwives licensed under chapter 18.50 RCW.

(3) Each participating birthing center must:

(a) Be licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC;

(b) Be specifically approved by MAA to provide birthing center services;

(c) Have a valid core provider agreement with MAA; and

(d) Maintain standards of care required by DOH for licensure.

(4) MAA suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards cited in subsection (3) of this section.

(5) Home birth or birthing center providers must:

(a) Obtain from the client a signed consent form in advance of the birth;

(b) Follow MAA's risk screening criteria and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate;

(c) Have current, written, and appropriate plans for consultation, emergency transfer and transport of a client and/or newborn to a hospital;

(d) Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care;

(e) Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to the department of health for testing; and

(f) Have evidence of current cardiopulmonary resuscitation (CPR) training for:

(i) Adult CPR; and

(ii) Neonatal resuscitation.

(6) Planned home providers must:

(a) Provide medically necessary equipment, supplies, and medications for each client;

(b) Have arrangements for twenty-four hour per day coverage;

(c) Have documentation of contact with local area emergency medical services to determine the level of response capability in the area; and

(d) Participate in a formal, state-sanctioned, quality assurance/improvement program or professional liability review process (e.g., Joint Underwriting Association (JUA), Midwives Association of Washington State (MAWS), etc.).

(7) MAA does not cover planned home births or births in birthing centers for women identified with any of the following conditions:

(a) Previous cesarean section;

(b) Current alcohol and/or drug addiction or abuse;

(c) Significant hematological disorders/coagulopathies;

(d) History of deep venous thromboses or pulmonary embolism;

(e) Cardiovascular disease causing functional impairment;

(f) Chronic hypertension;

(g) Significant endocrine disorders including preexisting diabetes (type I or type II);

(h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;

(i) Isoimmunization, including evidence of Rh sensitization/platelet sensitization;

(j) Neurologic disorders or active seizure disorders;

(k) Pulmonary disease;

(l) Renal disease;

(m) Collagen-vascular diseases;

(n) Current severe psychiatric illness;

(o) Cancer affecting site of delivery;

(p) Known multiple gestation;

(q) Known breech presentation in labor with delivery not imminent; or

(r) Other significant deviations from normal as assessed by the provider.

[WSR 11-14-075, recodified as § 182-533-0600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770. WSR 05-01-065, § 388-533-0600, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. WSR 00-23-052, § 388-533-0600, filed 11/13/00, effective 12/14/00.]

CHEMICAL-USING PREGNANT (CUP) WOMEN SERVICES

WAC 182-533-0701 Chemical-using pregnant (CUP) women program—Purpose. The chemical-using pregnant (CUP) women program provides immediate access to medical care in a hospital setting to chemical-using or chemical-dependent pregnant women and their fetuses. The purpose of the immediate access to medical care is to reduce harm to and improve birth outcomes for mothers and their fetuses by preventing obstetric and prenatal complications related to chemical dependency.

[WSR 11-14-075, recodified as § 182-533-0701, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.800. WSR 04-11-008, § 388-533-701 (codified as WAC 388-533-0701), filed 5/5/04, effective 6/5/04.]

WAC 182-533-0710 Chemical-using pregnant (CUP) women program—Client eligibility. (1) To be eligible for the chemical-using pregnant (CUP) women program, a woman must meet all of the following conditions:

(a) Be pregnant; and

(b) Be eligible for medicaid.

(2) Clients meeting the eligibility criteria in WAC 388-533-0710(1) who are enrolled in an MAA managed care plan are eligible for CUP services outside their plan, except Washington medicaid integration partnership clients. CUP services delivered outside the managed care plan are reimbursed and subject to the same program rules as apply to nonmanaged care clients.

(3) Clients receiving three-day or five-day detoxification services through the department are not eligible for the CUP women program.

[WSR 11-14-075, recodified as § 182-533-0710, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.800. WSR 05-08-061, § 388-533-0710, filed 3/31/05, effective 5/1/05; WSR 04-11-008, § 388-533-710 (codified as WAC 388-533-0710), filed 5/5/04, effective 6/5/04.]

WAC 182-533-0720 Chemical-using pregnant (CUP) women program—Provider requirements. (1) The medical assistance administration (MAA) pays only those providers who:

(a) Have been approved by MAA to provide chemical-using pregnant (CUP) women program services;

(b) Have been certified as chemical dependency service providers by the division of alcohol and substance abuse (DASA) as prescribed in chapter 388-805 WAC;

(c) Meet the hospital standards prescribed by the Joint Commission on Accreditation of Healthcare Organizations (JCACHO);

(d) Meet the general provider requirements in chapter 388-502 WAC; and

(e) Are not licensed as an institution for mental disease (IMD) under Centers for Medicare and Medicaid (CMS) criteria.

(2) CUP women program service providers are required to:

(a) Report any changes in their certification, level of care, or program operations to the MAA CUP women program manager;

(b) Have written policies and procedures that include a working statement describing the purpose and methods of treatment for chemical-using/abusing pregnant women;

(c) Provide guidelines and resources for current medical treatment methods by specific drug and/or alcohol type;

(d) Have linkages with state and community providers to ensure a working knowledge exists of current medical and substance abuse resources; and

(e) Ensure that a chemical dependency assessment of the client has been completed:

(i) By a chemical dependency professional as defined in chapter 246-811 WAC;

(ii) Using the latest criteria of the American Society of Addiction Medicine (ASAM); and

(iii) No earlier than six months before, and no later than five days after, the client's admission to the CUP women program.

[WSR 11-14-075, recodified as § 182-533-0720, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.800. WSR 05-08-061, § 388-533-0720, filed 3/31/05, effective 5/1/05; WSR 04-11-008, § 388-533-720 (codified as WAC 388-533-0720), filed 5/5/04, effective 6/5/04.]

WAC 182-533-0730 Chemical-using pregnant (CUP) women program—Covered services. (1) The medical assistance administration (MAA) pays for the following covered services for a pregnant client and her fetus under the chemical-using pregnant (CUP) women program:

(a) Primary acute detoxification/medical stabilization;

(b) Secondary subacute detoxification/medical stabilization; and

(c) Rehabilitation treatment and services as determined by the provider.

(2) The maximum length of treatment per inpatient stay that MAA will pay for is twenty-six days, unless additional days have been preauthorized by the MAA CUP women program manager.

(3) If a client's pregnancy ends before inpatient treatment is completed, a provider may continue the client's treatment through the twenty-sixth day.

[WSR 11-14-075, recodified as § 182-533-0730, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.800. WSR 05-08-061, § 388-533-0730, filed 3/31/05, effective 5/1/05; WSR 04-11-008, § 388-533-730 (codified as WAC 388-533-0730), filed 5/5/04, effective 6/5/04.]