WAC 182-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in chapter 182-500 WAC 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 medicaid agency's payment for the hospital or birthing center charges. This does not include the agency's payment for the professional fee.

(d) **"Global fee"** means the fee the agency 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 agency'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 182-531-1850 for reimbursement methodology.)

(2) The agency covers full scope medical maternity care and newborn delivery services for fee-for-service and managed care clients under WAC 182-501-0060.

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

(a) Family planning only programs (a pregnant client under these programs should be referred to the Washington healthplanfinder via www.wahealthplanfinder.org for eligibility review); or

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

(4) The agency requires providers of maternity care and newborn delivery services to meet all the following requirements:

(a) Providers must be currently licensed:

(i) By the state of Washington's department of health (DOH), or department of licensing, or both; or

(ii) According to the laws and rules of any other state, if exempt under federal law.

(b) Providers must have a signed core provider agreement with the agency;

(c) Providers must be practicing within the scope of their licensure; and

(d) Providers must 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)).

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

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

(b) Delivery (intrapartum care and 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 agency pays that provider a global obstetrical fee.

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

(8) The agency 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 agency's fees for antepartum care include all 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 agency covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section as follows:

(a) The agency pays for either of the following, but not both:

(i) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). The agency provides a list of diagnoses, or conditions, or both, that the agency identifies as justification for more frequent monitoring visits; or

(ii) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife.

(b) The agency pays for both of the following:

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

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

(11) The agency covers high-risk pregnancies. The agency 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 agency 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 agency pays a facility fee for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

(14) The agency 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 agency covers hospital delivery services for an eligible client as defined in subsection (2) of this section. The agency'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 agency 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 agency's payment for professional services in subsection (15) of this section, the agency may pay separately for services provided by any of the following professional staff:

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

(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

(d) An obstetrician, or gynecologist specialist, or both, 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 agency allows additional fees for any of the following:

(a) High-risk vaginal delivery;

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

(c) High-risk cesarean section delivery.

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

(a) More than one child delivered by cesarean section during a surgery. The agency'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) The agency pays for an early delivery, including induction or cesarean section, before thirty-nine weeks of gestation only if medically necessary. The agency considers an early delivery to be medically necessary:

(a) If the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation; or

(b) If the provider documents a clinical situation that supports medical necessity.

(21) The agency will only pay for antepartum and postpartum professional services for an early elective delivery as defined in WAC 182-500-0030.

(22) The hospital will receive no payment for an early elective delivery as defined in WAC 182-500-0030.

(23) In addition to the services listed in subsection (10) of this section, the agency covers counseling for tobacco/nicotine cessation for eligible clients who are pregnant or in the postpartum period as defined in 42 C.F.R. 435.170. See WAC 182-531-1720.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-22-017, § 182-533-0400, filed 10/25/19, effective 11/25/19; WSR 15-24-021, § 182-533-0400, filed 11/19/15, effective 1/1/16. 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.]