Iowa Safety Net Management Information System (SNMIS) Claims Manual

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SNMIS Claims Billing Manual

Introduction

This manual establishes the claims processing requirements for organizations and professionals billing services rendered through the Behavioral Health and Disability Services Systems in the state of Iowa. This includes a designated network of substance use disorder treatment providers, who have an existing infrastructure designed to meet the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant regulations.

The manual outlines essential service-related criteria that providers must meet to qualify for safety net funding reimbursement. It provides links to additional claims guidance including the following:

- Provider and Service Eligibility
- Behavioral Health (BH) Service Provision Requirements
- Disability Service Provision Requirements
- General Billing Policies
- Billing Codes and Fee Schedules

Available Funds

The sources of funding for behavioral health and disability services include both State and Federal resources. State funds are those designated for the Iowa Department of Health and Human Services (Iowa HHS) for specific programming through State of Iowa appropriations. Federal funds are those received through the U.S. Department of Health and Human Services. Providers who qualify for the SUPTRS fee schedule, by meeting specific requirements, are eligible to receive substance use disorder treatment service reimbursement via federal funds. Safety net funds reimbursed through SNMIS are considered the payment of last resort.

Provider and Service Eligibility

Providers Eligible to Participate

To submit claims for services through SNMIS, providers must be enrolled and in good standing with Iowa Medicaid, and any applicable licensing, certification, or accreditation bodies. SNMIS is a separate system from Medicaid but uses the same provider enrollment information. Information on enrolling with Iowa Medicaid can be found here: Medicaid Provider Enrollment.

Services listed on the Behavioral Health Fee Schedule and the Disability Services Fee Schedule are reimbursable for an “open network” of providers. Any provider who is enrolled with Iowa Medicaid and providing services within the scope of their license, accreditation, or certification may bill for services rendered. Qualifications to provide specific services are detailed in the fee schedules.

Services listed on the SUPTRS Fee Schedule are reimbursable only to a “designated network” of providers who are approved by Iowa HHS. Iowa Medicaid-enrolled, non-profit/not-for-profit

organizations (NFPs) are eligible to submit payment for services through SNMIS. Service providers must meet the qualification requirements to provide the service. An NFP is an entity formed for purposes other than generating a profit and where no part of the organization's income is distributed to its members, directors, or officers.

Financial Eligibility for Individuals

General Safety Net Eligibility Provisions

- Safety Net services are considered public benefits governed by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which outlines which individuals are qualified to receive such benefits. Under PRWORA, undocumented individuals are ineligible to receive public benefits. This also extends to qualified aliens who are in the 5-year waiting period after attaining qualified status. The federal EMTALA law still applies for emergency services.
- Safety Net crisis services are not subject to eligibility requirements.

Behavioral Health and SUPTRS Eligibility

For behavioral health services including substance use disorder services under the SUPTRS fee schedule, providers shall complete the financial eligibility form for each individual prior to providing service for the first time and at least annually thereafter. The form and supporting documentation must be kept on file and furnished to Iowa HHS upon request. A copy of the completed form, including the determination of eligibility, must be provided to the individual receiving services or their guardian.

Eligibility for Behavioral Health services funded through SNMIS begins the first day of the month of application.

- Behavioral Health Eligibility Form (Spanish Version)

Reimbursement for behavioral health services and substance use disorder services is subject to the financial eligibility and resource requirements for Iowa residents in Iowa Administrative Code (IAC) 441—301.1. This includes:

- Income for adults, and household income for children, is equal to and less than 200% of the federal poverty level.
- Resource limits are equal to and less than $2,000 in countable value `for a single-person household or $3,000 in countable value for a multi person household. The following resources are exempt:
    - A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead will include all land that is contiguous to the home and the buildings located on the land.
    - One automobile used for transportation.
    - Tools of an actively pursued trade.
    - General household furnishings and personal items.
    - Burial account or trust limited in value as to that allowed in the medical assistance program.
    - Cash surrender value of life insurance with a face value of less than $1,500 on any one person.

    - Any resource determined excludable by the Social Security Administration because of an approved Social Security Administration work incentive.
- Additional exemptions may apply to individuals who do not qualify for federally funded or state-funded services or other support:
    - A retirement account that is in the accumulation stage.
    - A medical savings account.
    - An assistive technology account.
    - A burial account or trust limited in value as to that allowed in the medical assistance program.
- Assets in an ABLE account and distributions from the account for qualified disability expenses should be disregarded when determining the designated beneficiary's eligibility for Behavioral Health safety net services. A distribution from an ABLE account is not income, but rather, is a conversion of resource from one form to another. Do not count distributions from an ABLE account as income to the designated beneficiary.

For individuals seeking gambling disorder treatment services, the following may also be taken into consideration:

- Burden of gambling related debt reduces the patient income to or below 200% of the federal poverty level.
- For individuals without financial resources to pay for gambling disorder treatment services, providers must actively support enrollment in Medicaid.

Disability Services Eligibility

For disability services, the form will be completed by the Disability Access Point (DAP). The form and supporting documentation must be kept on file and furnished to Iowa HHS upon request.

Payment for any services rendered without first determining financial eligibility or provided to an individual who does not meet requirements, is subject to recoupment by Iowa HHS. Financial and resource requirements, and needs-based eligibility for Iowa residents in Iowa Administrative Code (IAC) 441—223.1.

Need-based eligibility includes:

- An individual must have a disability and reside in or be at risk of residing in institutional settings due to the individual's disability.
- The results of a standardized functional assessment must support the type and frequency of disability services identified in the individual's case plan.

Reimbursement for disability services is subject to financial eligibility and resource requirements for Iowa residents in IAC 441—223.1. This includes:

- An adult with disabilities will have an income equal to or less than 200% of the federal poverty level.
- A family of a child with disabilities will have an income equal to or less than 200% of the federal poverty level.

- There are no resource limits for families of children seeking services. For adults, resource limits are equal to or less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multi person household. The following resources are exempt:
    - A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead will include all land that is contiguous to the home and the buildings located on the land.
    - One automobile used for transportation.
    - Tools of an actively pursued trade.
    - General household furnishings and personal items.
    - Burial account or trust limited in value as to that allowed in the medical assistance program.
    - Cash surrender value of life insurance with a face value of less than $1,500 on any one person.
    - Any resource determined excludable by the Social Security Administration because of an approved Social Security Administration work incentive.
- Additional exemptions may apply to individuals who do not qualify for federally funded or state-funded services or other support:
    - A retirement account that is in the accumulation stage.
    - A medical savings account.
    - An assistive technology account.
    - A burial account or trust limited in value as to that allowed in the medical assistance program.
- Assets in an ABLE account and distributions from the account for qualified disability expenses should be disregarded when determining the designated beneficiary's eligibility for non-Medicaid safety net Disability Services. A distribution from an ABLE account is not income, but rather, is a conversion of resource from one form to another. Do not count distributions from an ABLE account as income to the designated beneficiary.

Disability Services Authorizations

Disability services must be determined based on an individual's functional assessment and documented in the Individual's Service Plan.

Individual Service planning is followed by the creation of documentation of decisions via Notices of Decisions (NODs), which will provide documentation of decision and authorized planning for services, as well as service codes and an eight-digit Aura client ID for SNMIS billing.

Service limits are equal to those established for the home- and community-based services waiver for individuals with disabilities in the medical assistance program created in Iowa Code chapter 249A.

Annual reviews are conducted by the Disability Service Navigator (DSN) to ensure that the individual continues to meet eligibility requirements for necessary services.

Client Appeals

If a client is dissatisfied with a financial eligibility determination, they have a right to appeal the decision. The person completing the Financial Eligibility form with the individual is responsible for

providing a copy of the appeal rights information. Additional information, including the appeals form for the behavioral health and disability services system for can be found at https://hhs.iowa.gov/appeals.

Requirements for Provision of Behavioral Health Services

Crisis Services

Crisis services are provided to individuals experiencing a behavioral health crisis aimed at assessment and intervention to stabilize the individual's level of functioning.

Crisis services are not subject to financial or needs-based eligibility and are available to any person who needs the service. Crisis services that are reimbursable through SNMIS are:

- Mobile Response
- Crisis Evaluation (including crisis screening and assessment)
- Crisis Stabilization Residential
- Crisis Stabilization Community Based
- 23-hour Observation and Holding

Payment will be approved for services provided by qualified crisis provider staff in the individual's home or location in the community where the individual is experiencing a behavioral health crisis. Payment shall be made only for time spent in face-to-face services with the individual. The provision of crisis services must meet requirements in IAC 441—Chapter 24.

Crisis services for individuals who have co-occurring, or multi-occurring conditions focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual, without regard to which condition is primary. Crisis services are not to be denied due to the presence of a co-occurring substance use disorder, or developmental or neurodevelopmental disability.

Treatment and Support Services

Treatment and support services are clinical inpatient, outpatient, or community-based care for individuals with a behavioral health condition or disorder diagnosed utilizing the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA). The type, length, and intensity/frequency of interventions used by a behavioral health provider are based on the presenting symptoms of the individual.

Behavioral health treatment services are subject to financial eligibility requirements. Services that are reimbursable through SNMIS are:

- Diagnostic Evaluation
- Outpatient Therapy
- Multisystemic Therapy
- Functional Family Therapy
- Substance Use Disorder Counseling

- Psychiatric Medication Prescribing and Management
- Partial Hospitalization
- Inpatient Hospitalization
- Intensive Outpatient Programs (IOP)
- Substance Use Disorder Intensive Outpatient Programs
- Assertive Community Treatment (ACT)
- Intensive Psychiatric Rehabilitation (IPR)
- Community Psychiatric Support Programs
- Subacute Services
- Peer Support
- Long-Acting Injectables
- Psychological and Neuropsychological Testing

Payment will be approved only for services provided within the scope of practice of the clinician or program's license or accreditation.

Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs)

Behavioral Health services provided by an Iowa Community Mental Health Center designated and accredited under 441 IAC Chapter 24 or a Certified Community Behavioral Health Clinic (CCBHC) designated by Iowa HHS are eligible for reimbursement at the rates provided in the SNMIS CMHC and CCBHC fee schedule. Services that are reimbursable through SNMIS are:

- Diagnostic Evaluation
- Outpatient Therapy
- Multisystemic Therapy
- Substance Use Disorder Counseling
- Psychiatric Medication Prescribing and Management
- Inpatient Hospitalization
- Intensive Outpatient Programs (IOP)
- Substance Use Disorder Intensive Outpatient Programs
- Assertive Community Treatment (ACT)
- Community Psychiatric Support Programs
- Long-Acting Injectables
- Peer Support
- Psychological and Neuropsychological Testing
- Transportation (Gas Cards)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Behavioral Health and CHMC/CCBHC Service-Specific Requirements

Transportation

CMHC providers may offer assistance with transportation for recipients' travel to and from treatment and recovery services. This assistance is provided in the form of gas cards that can be

supplied to individuals. Reimbursement through SNMIS is made to the provider after the provider supplies a gas card to the recipient. Reimbursement includes the cost of the gas card plus an administrative fee for the provider.

The provider must track all transportation gas cards dispensed within service recipient records for monitoring purposes. This documentation must include dates that transportation services were provided, the exact cost of each service, and who the service recipient is. The transportation service provided must be prudent and efficient with respect to the service recipient's destination and other available means for travel. Documentation must also include a Receipt Form for each gas card provided. The Receipt Form must be signed by the recipient and must show the exact service cost. Before additional gas cards can be distributed, the recipient must provide a receipt/invoice showing the use of the service. This receipt/invoice must be returned to the provider for verification that the service was used in alignment with this guidance.

Recipients must meet all applicable service recipient eligibility requirements as outlined in Iowa Administrative Rules 441—301.1(225A). Recipients must be 18 years of age or older. Individuals who are eligible for Medicaid are not eligible for this service, with the following exceptions:

- Gas cards may be used if the person's Medicaid coverage does not include Non-Emergency Medical Transportation (NEMT). This means that people with coverage through hawk-I or through IHAWP without medically exempt status would be eligible for gas cards.
- Gas cards to be used for recovery programs that are not reimbursable by Medicaid and therefore NEMT does not cover transportation to those services.

Persons may not utilize the transportation service if they are experiencing acute intoxication, need medical supervision, are experiencing active suicidal ideations, or present as being a harm to themselves or others. Limitations per service recipient are to be determined by the CBO.

Mobile Response in the Emergency Department (ED)

Mobile response providers are required to respond to a behavioral health crisis. This does not necessarily mean that they will need to dispatch a team for every call from an ED. The appropriate response may vary depending on the situation and should be determined in the process of triaging the call. Hospitals with on-site psychiatric care should generally have the resources to de-escalate a crisis or to provide an assessment of the individual. Other hospitals may not have staff trained to de-escalate a crisis situation and would need a mobile response team to respond on-site. For any case where the individual does not require de-escalation but does need a mental health assessment, the hospital should do the assessment if they have psychiatric staff available or use the BH-ASO's statewide contracted telehealth providers for the assessment if there are no psychiatric staff on-site.

If a mobile response provider dispatches to the ED to de-escalate a crisis per the above guidelines, they can bill for the service. SNMIS does not cover payment of ancillary services such as labs, radiology, or pharmacy services provided in the ED, but may cover specific services that are included in the SNMIS fee schedules, such as a diagnostic/crisis evaluation.

Peer Support

The services are provided to eligible individuals by other mental health and substance use consumers who are specifically trained to provide peer support services. The Peer Support

Specialist, Family Peer Support Specialist or Recovery Coach has received training for mental health services and/or substance use through a state recognized peer training program. Services are targeted toward the support of persons with a serious and persistent mental illness, serious emotional disturbance or substance use disorder. Peer support services focus on individual support from the perspective of a trained peer and may also include service coordination and advocacy activities as well as rehabilitative services. Peer support services are initiated when there is a reasonable likelihood that such services will benefit an eligible person's functioning and assist them in maintaining community tenure. Peer Support and Parent Peer Support services may be provided to members who are receiving therapeutic foster care services.

Functional Family Therapy

Family Functional Therapy (FFT) is an evidenced based family therapy targeted at individuals who are appropriate candidates for this treatment. FFT provides clinical assessment and treatment for the individual and their family to improve communication, problem-solving, and conflict management to reduce problematic behavior of the member. It is a short-term, intensive treatment strategy that is built on a foundation of respect for individuals, families, and cultures.

FFT is designed to improve family communication and supports, while decreasing intense negativity and dysfunctional patterns of behavior. Therapy also includes training parents how to assist their child, based on their diagnosis.

The FFT model includes an emphasis on assessment in understanding the purpose that behavior problems serve within the family relationship system, followed by treatment strategies that pave the way for motivating the individual and their families to become more adaptive and successful in their lives. Services are provided across a variety of settings, and practitioners must be certified by HHS approved certification agencies.

Expectations of FFT include ALL the following:

- Practitioners must obtain certification and demonstrate adherence to the treatment model (model fidelity), including participation in ongoing supervision;
- An initial diagnostic interview/assessment will be completed prior to initiation of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed;
- Assessments and treatment shall address mental health/substance abuse needs, and mental health and/or emotional issues related to medical concerns;
- The treatment plan will be individualized and will include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional. The treatment plan will be developed with the individual and the identified appropriate family members as part of the outpatient family therapy treatment planning process;
- Treatment plans will be reviewed every 90 days or more often if clinically indicated.

Service Eligibility Criteria. All of the following must be met:

- The individual is 21 years of age or younger;

- The individual displays externalizing behavior which adversely affects functioning across domains (i.e., home, school, work, social, etc.).
- Recipients are referred by other service providers and agencies on behalf of the individual and/or family;
- At least one adult caregiver is available to provide support and is willing to be involved in treatment;
- Current DSM diagnosis is primary focus of treatment symptoms and impairments are the result of a primary disruptive/externalizing behavior disorder although internalizing psychiatric conditions and substance use disorders may be secondary.

Discharge Criteria. FFT is considered completed when ANY of the following have been met:

- The individual's documented treatment plan goals have been substantially met, including discharge planning;
- The individual/family no longer meets admission criteria or meets criteria for a less or more intensive level of care;
- The individual and/or family have not benefited from FFT despite documented efforts to engage and there is no reasonable expectation of progress at this level of care despite treatment.

Exclusion Criteria. ANY of the following criteria are sufficient for exclusion from FFT services:

- The individual is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is not available through the provision of this therapy;
- Individuals living independently, or members for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers;
- Referral problem is limited to serious sexual misbehavior.

Intensive Psychiatric Rehabilitation (IPR)

Services are comprehensive outpatient services based in the individual's home or residence and/or community setting. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are directed primarily to individuals with severe and persisting mental disorders, and/or complex symptoms who require multiple mental health and psychosocial support services. Such services are active and rehabilitative in focus and are initiated and continued when there is a reasonable likelihood that such services will lead to specific observable improvements in the individual's functioning.

Community Support Program

Services are provided to adults with a severe and persistent mental illness. These services are designed to support individuals as they live and work in the community. These services address mental and functional disabilities that negatively affect integration and stability in the community. Staff attempt to reduce or manage symptoms/reduced functioning that result from a mental illness. Providers are expected to have knowledge and experience in working with this population. Staff should have the ability to create relationships with this population that provide a balance between

support of the mental illness and allow for maximum individual independence. Community Support Program components include all of the following:

- Monitoring of mental health symptoms and functioning/reality orientation
- Transportation
- Supportive relationship
- Communication with other providers
- Ensuring individual attends appointments/obtains medications
- Crisis intervention/developing crisis plan
- Coordination and development of natural support systems for mental health support

There are two levels of Community Support Services. The level of CSS provided must be consistent with the individual's assessed need at a certain point in time or across a time period. While minimum contact requirements are included in the descriptions below, providers should see each recipient at a frequency consistent with that individual's assessed needs. At both levels, staff must plan service components in conjunction with a Mental Health Professional such as the individual's therapist.

High Intensity Service Eligibility Criteria: High Intensity Community Support services are for individuals who:

- Experience increased psychiatric symptoms that require increased support and close follow-up to continue living in the community. *Or*
- Have persistent psychiatric symptoms and a pattern of community living that require long-term support and close follow-up to assist in living in the community.

High Intensity Community Support is provided through 5-12 contacts per month. Contacts may be face-to-face or by telephone, with a minimum of 4 face-to-face contacts required per month. Staff must have at least 2 contacts with a Mental Health Professional who is working with the recipient. All contacts with the recipient and the mental health professional must be documented in the progress notes.

Low Intensity Service Eligibility Criteria: Low Intensity Community Support services are for individuals who require periodic supportive services to maintain their level of independent functioning in the community. Without Low Intensity Community Support these individuals may become socially isolated and may exhibit increased symptoms of mental illness and associated functioning disabilities that put them at risk for a more restrictive level of care than their normal community environment.

Low Intensity Community Support services are provided through 2-4 contacts per month, with occasional episodes of increased frequency. Contacts may be face-to-face or by telephone, with a minimum of one face-to-face contact required per month. Staff must have at least one contact with a mental health professional who is working with the recipient. All contacts with the recipient and the mental health professional must be documented in the CSS progress notes.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an integrated, evidence-based approach that offers providers the tools to effectively and efficiently screen individuals for risky substance use and gambling. SBIRT refers to the following process:

- Screening: Universal screening for quickly assessing use and severity of substance use and/or gambling.
- Brief Intervention: Brief motivational and awareness-raising intervention given to individuals determined to be at risk for problematic substance use and/or gambling.
- Referral to Treatment: Referrals to specialty care for individuals at high risk for a substance use and/or gambling disorder.

SBIRT Screening services may occur in a group setting, but Brief Interventions and Referrals to Treatment must be provided on an individual basis.

SBIRT services are to be provided by qualified CMHC or CCBHC staff in a variety of locations, outside of a CMHC or CCBHC facility. Examples include primary care settings and schools.

SBIRT services are to be billed using a “duration-based" reimbursement approach, meaning only the time the provider spends delivering the SBIRT services may be billed. SBIRT services are not to be billed using a “client-based" reimbursement approach.

SBIRT claims are to be submitted using a 15-minute unit rate of reimbursement for the service (rounding to the closest interval). For example, if the session is 22 minutes, one unit would be reported on the claim. If the session is 23 minutes, two units would be reported on the claim. Because reimbursement is duration-based rather than individualized, providers must use “1111111” as the recipient ID on the claim. For each SBIRT 15-minute session billed, the provider must document the date, the place of service, and the number of individuals served.

Refer to the fee schedules for detailed billing information, including service codes and descriptions.

Commitment and Jail-Based Services

Behavioral health services related to mental health commitments are reimbursable through SNMIS for services listed on the Behavioral Health and CMHC fee schedules, such as diagnostic evaluation and inpatient hospitalization. Other commitment related expenses such as attorney fees and secure transportation may be reimbursed by invoicing Iowa HHS’s Behavioral Health Administrative Services Organization (BH-ASO).

Jail-based services are **not** reimbursable through the SNMIS system. All costs for jail-based services are to be paid by the county where the individual is incarcerated. Counties may be reimbursed for these costs through the BH-ASO.

Requirements for Provision of Substance Use and Gambling Disorder Treatment Service

Outpatient Treatment Services

Substance use and gambling disorder treatment services are subject to financial eligibility requirements. Services that are reimbursable through SNMIS are:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Assessment
- Outpatient Treatment
- Intensive Outpatient (IOP) Treatment
- Partial Hospitalization (SUD only)
- Residential Treatment (SUD only)

Recovery and Support Services

Substance use and gambling disorder recovery and support services are subject to financial eligibility requirements. Services that are reimbursable through SNMIS are:

- Medically Assisted Treatment Medication Costs
- Peer Recovery Coaching
- Transportation (Gas Cards)
- NARR Level 4 Recovery Housing (for Women and Children)

Outpatient Gambling Disorder Treatment Requirement

Per Iowa Code 135.150, a person shall not maintain or conduct a gambling treatment program funded through the department unless the person has obtained a license for the program from the department. The department shall adopt rules to establish standards for the licensing and operation of gambling treatment programs under this section. The rules shall specify, but are not limited to specifying, the qualifications for persons providing gambling treatment services, standards for the organization and administration of gambling treatment programs, and a mechanism to monitor compliance with this section and the rules adopted under this section.

A clinical determination of medical necessity is required for reimbursement of services. Medical necessity is based on the third edition of the American Society of Addiction Medicine (ASAM) criteria. An individual must have a current substance use or gambling disorder diagnosis to be eligible for SNMIS payment of these services.

SUPTRS Service-Specific Requirements

Transportation

SUPTRS providers may offer assistance with transportation for recipients' travel to and from treatment and recovery services. This assistance is provided in the form of gas cards that can be supplied to individuals. Reimbursement through SNMIS is made to the provider after the provider supplies a gas card to the recipient. Reimbursement includes the cost of the gas card plus an administrative fee for the provider.

The provider must track all Transportation gas cards dispensed within service recipient records for monitoring purposes. This documentation must include dates that transportation services were provided, the exact cost of each service, and who the service recipient is. The transportation service provided must be prudent and efficient with respect to the service recipient's destination and other available means for travel. Documentation must also include a Receipt Form for each gas card provided. The Receipt Form must be signed by the recipient and must show the exact service cost. Before additional gas cards can be distributed, the recipient must provide a receipt/invoice showing the use of the service. This receipt/invoice must be returned to the provider for verification that the service was used in alignment with this guidance.

Recipients must meet all applicable service recipient eligibility requirements as outlined in Iowa Administrative Rules 441—301.1(225A). Recipients must be 18 years of age or older. Individuals who are eligible for Medicaid are not eligible for this service, with the following exceptions:

- Gas cards may be used if the person's Medicaid coverage does not include Non-Emergency Medical Transportation (NEMT). This means that people with coverage through hawk-I or through IHAWP without medically exempt status would be eligible for gas cards.
- Gas cards to be used for recovery programs that are not reimbursable by Medicaid and therefore NEMT does not cover transportation to those services.

Persons may not utilize the transportation service if they are experiencing acute intoxication, need medical supervision, are experiencing active suicidal ideations, or present as being a harm to themselves or others. Limitations per service recipient are to be determined by the CBO.

Recovery Peer Coaching

Recovery Peer Coaching means individual face-to-face meetings between a patient and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective. The services are provided to eligible individuals by other mental health and substance use consumers who are specifically trained to provide peer support services. The Peer Support Specialist, Family Peer Support Specialist or Recovery Coach has received training for mental health services and/or substance use through a state recognized peer training program Services are targeted toward the support of persons with a serious and persistent mental illness, serious emotional disturbance or substance use disorder. Peer support services focus on individual support from the perspective of a trained peer and may also include service coordination and advocacy activities as well as rehabilitative services. Peer support services are initiated when there is a reasonable likelihood that such services will benefit an eligible person's functioning and assist them in maintaining community tenure. Peer Support and Parent Peer Support services may be provided to members who are receiving therapeutic foster care services.

NARR Level 4 Recovery Housing (Women and Children)

Recovery houses are safe, healthy, family-like, substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long- term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services.

Eligible individuals must have their children living with them (have custody of their children) or are pregnant. The service may only be provided as a step-down from residential substance use disorder treatment.

Recovery Housing services may only be provided by SUPTRS providers who are designated by Iowa HHS to provide women and children's services. Recovery Residences must meet the following criteria:

- Clinical and Social Model Integration: Level 4 homes (Type C) must offer clinical addiction treatment while maintaining a community-based social model of recovery. Level 4 Residences must use evidence-based, licensed clinical services that blend experiential knowledge and learning.
- Design for sociability: The service and living environment provides communal dining and social spaces that strongly encourage socializing to promote recovery and healthy interactions.
- Design for personal space: The residents typically share rooms but have personal or private space. A balance of shared and private space facilitates both relationship building and personal empowerment.
- Facility oversight and security: The physical design enables easy oversight of the premises as well as personal security that promotes a supportive recovery environment. Space is open and free of physical barriers that would separate or seclude residents.
- Care and Upkeep: High levels of physical maintenance, house- cleaning and upkeep are vital.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an integrated, evidence-based approach that offers providers the tools to effectively and efficiently screen individuals for risky substance use and gambling. SBIRT refers to the following process:

- Screening: Universal screening for quickly assessing use and severity of substance use and/or gambling.
- Brief Intervention: Brief motivational and awareness-raising intervention given to individuals determined to be at risk for problematic substance use and/or gambling.
- Referral to Treatment: Referrals to specialty care for individuals at high risk for a substance use and/or gambling disorder.

SBIRT Screening services may occur in a group setting, but Brief Interventions and Referrals to Treatment must be provided on an individual basis.

SBIRT services are to be provided by qualified SUPTRS Designee staff in a variety of locations, outside of a SUPTRS facility. Examples include primary care settings and schools.

SBIRT services are to be billed using a “duration-based" reimbursement approach, meaning only the time the provider spends delivering the SBIRT services may be billed. SBIRT services are not to be billed using a “client-based" reimbursement approach.

SBIRT claims are to be submitted using a 15-minute unit rate of reimbursement for the service (rounding to the closest interval). For example, if the session is 22 minutes, one unit would be reported on the claim. If the session is 23 minutes, two units would be reported on the claim. Because reimbursement is duration-based rather than individualized, providers must use “1111111” as the recipient ID on the claim. For each SBIRT 15-minute session billed, the provider must document the date, the place of service, and the number of individuals served.

Refer to the fee schedules for detailed billing information, including service codes and descriptions.

Requirements for Provision of Disability Services

Long Term Services and Supports (LTSS)

LTSS includes activities that support individuals with disabilities at the most independent level of care possible, including facility diversion or transition to community-based services. Individuals must have an assessed need for assistance with activities of daily living or need assistance due to their inability to function independently in their home or community related to their disability. Assessment tools and level of care tiers will be utilized like those for Medicaid Home and Community-Based Services (HCBS) Waiver and Habilitation programs.

Long Term Services and Supports that are reimbursable through the SNMIS are:

- Supported Community Living (SCL) and Home-Based Habilitation
- Intensive Residential Service Homes (IRSH)
- Residential Care Facility
- Adult Day Service
- Respite
- Attendant Care Services
- Personal Response System
- Portable Locator System
- Supported Employment including Individual Placement and Supports (IPS)
- Long-Term Job Coaching
- Prevocational Services
- Vocational Skills Training
- Day Habilitation

- Home Delivered Meals
- Home Maintenance Support (Homemaker)
- Transportation

The individual shall have a service plan which is developed by the interdisciplinary team. This must be completed before service provision and annually thereafter, or more often if there is a change in the individual's needs. The interdisciplinary team shall include the individual, or if a minor the individual's custodial parent(s) or guardian.

General Billing Policies

All safety net service providers are reimbursed based on a fee schedule.

All providers must follow standard billing procedures unless otherwise specified in this billing manual. Standard procedures include, but are not limited to, use of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes and modifiers, International Classification of Diseases – 10th Edition (ICD-10) diagnosis codes, and other standard codes as detailed in this manual and on the fee schedules.

Registration and Claim Form Instructions

Enrolled providers must register with Electronic Data Interchange Support Services (EDISS) for the SNMIS line of business. When registering and submitting claims, providers must use **Payer ID 18049** which is the same as the Medicaid Payer ID, but must also use **Receiver ID 0028**, which is different than the Medicaid receiver ID and will be used to differentiate claims being submitted to SNMIS from those submitted to Medicaid.

For providers who are using a vendor/clearinghouse for electronic claim submission, the vendor will also be required to update their registration in EDISS to select the SNMIS line of business.

During registration, providers must set up the transactions for claims submission, and to receive a remittance advice. Select the 837P transaction for professional claims, and/or the 837I transaction for institutional claims, as well as the 835 transaction for the remittance advice.

After successfully registering for the SNMIS line of business, providers will be required to submit 10 test claims for each type of claim (professional or institutional) that they intend to use. It may be possible to skip this step if the provider is using a vendor that has completed enough test claims to have "blanket approval" for production status.

Claim form instructions and billing procedures can be found in the SNMIS Companion Guide.

Providers will submit electronic claims within 45 days from the date of service. A claim may be resubmitted or adjusted if it is submitted within 45 days from the last date of adjudication. No claim will be paid past 180 days from the date of service. Electronic Health Record (EHR) systems may have the ability to submit electronically through an Electronic Data Interchange (EDI) clearinghouse; providers may also opt use the free ABILITY PC-ACE Pro software to generate claims that can be submitted electronically through the Iowa portal.

SNMIS will adjudicate these claims and determine whether to pay or deny the request and a notification will be sent to the provider via an electronic remittance advice. Providers are expected to resolve any system errors or denied claims issues within 45 days of receiving the notification.

To check the status of a claim submission, contact your vendor if you are submitting through a clearinghouse; otherwise, if you are directly submitting claims to SNMIS, go to the Noridian Iowa User Portal to obtain your 277CA (Claims Acknowledgement) which is the report that lets you know if claims were received successfully. From the main menu, select Batch FTP, then the Download button, and in the downloads select the file ending in 277CA.edi.

Similarly, to obtain your remittance advice for claims that have been adjudicated, check with your clearinghouse vendor, or for direct submitters, go to the Noridian Iowa User Portal to obtain your 835 (Remittance Advice). From the main menu, select Batch FTP, then the Download button, and in the downloads select the file ending in 835.edi.

For assistance with registration or resolving claim issues, providers can reach out via the Iowa HHS Behavioral Health email box at BHassistance@hhs.iowa.gov or the Disability Services email box at DSassistance@hhs.iowa.gov. Please include all applicable NPI numbers and as much detail as possible about the issue, such as claim submission or payment dates, codes billed, and Transaction Control Numbers (usually shown as TCN or ICN on your remittance advice).

Claim adjustments to make corrections for claims that that were paid incorrectly, such as those due to an incorrect number of units, missing reimbursement for a covered service, or correcting claims that had a line denied with other paid claims, can be submitted to SNMIS and must include the original Transaction Control Number (TCN) and dates of service. These adjustments will use frequency code “7”.

Credit claims are used for returning funds/overpayments that will require SNMIS to take money back, such as those due to duplicate claims, incorrect billings that need to be voided, payment for services not rendered, or client eligibility issues. These can be submitted to SNMIS and must include the original TCN and dates of service. These adjustments will use frequency code “8”.

When a claim adjustment or credit claim results in funds owed back to SNMIS, the amount will be offset against other claims processed in that cycle. If the amount in that claim cycle is not enough to cover the adjustment, the provider will have a credit balance that will be offset with future claims.

For claims that were fully denied, corrections should be submitted as a new claim rather than an adjustment.

Billing Policies

The Behavioral Health and Disability Service System is the payor of last resort. Providers must bill Medicaid for individuals eligible for Medicaid. Medicaid eligibility may be checked by calling the Iowa Medicaid Eligibility Verification System (ELVS) line at (800) 338-7752 or accessing the Medicaid secure web portal.

Providers must utilize all available funding from third party payors including Medicaid. Safety net funding cannot be used when there is another available payment source.

Safety net payment may be made when a service is not covered by another payment source, however reimbursement cannot be made when funding is available through other sources.

- For example, if an eligible individual has insurance coverage for mental health therapy visits, but their plan does not cover other services such as Crisis Stabilization Residential Services (CSRS), the therapy visits would not be reimbursable under safety net funding, but the CSRS could be reimbursed.

An individual may have different payors for different treatment services.

- For example, an individual may receive medical care through an insurance health plan, or at a Federally Qualified Health Center (FQHC) but may not have coverage for substance use disorder Licensed Program Services. In this example, medical care would be paid for by the health plan or the FQHC, and the substance use disorder treatment Licensed Program Services could be paid by safety net funding.

Safety net funding can pay for Medicaid (b)(3) services that are also on the SNMIS fee schedule but are not covered by Medicaid during the gap period between enrollment in Medicaid and assignment to a managed care organization.

Refusal by an individual's Managed Care Organization (MCO), insurer, or other payor to authorize a service covered by that payor, or the denial of a covered service claim by an MCO, insurer, or other payor, does not make that individual eligible for safety net funding and does not make that service payable through SNMIS.

Billing SNMIS as secondary to another payment source will not be allowed. This includes situations where a person has insurance coverage but has a high deductible or copayment. The behavioral health safety net service system is intended to provide services to Iowans who are uninsured or underinsured, but not to supplement other reimbursement.

When billing the safety net system, reimbursement must be accepted as payment in full. Additional fees such as co-payments must not be charged to safety-net service recipients.

Providers shall immediately repay Iowa HHS in full for any claims where the provider received payment from another party after being paid with Behavioral Health Service System funding. If a provider owes any repayment amount, Iowa HHS may offset the sum owed by withholding payment from future claims.

Iowa residents who meet the eligibility requirements may receive services from the enrolled and qualified providers of their choice.

General Requirements for Coverage and Payment

In the provision of services, providers are required to adhere to all state and federal laws and regulations; as well as any requirements related to licensure, accreditation, or certification.

To be reimbursed for services, providers must adhere to the following standards for service documentation and maintenance of fiscal and clinical records.

Telehealth

Telehealth is allowed for any SNMIS reimbursable service where the allowable Place of Service codes shown on the SNMIS fee schedules include telehealth codes. SNMIS reimbursed telehealth

services require use of BOTH audio and video components to be billable. SNMIS reimburses only for the fee schedule service delivered via telehealth, but not for origination fees, platform fees, or other costs such as equipment or support.

Documentation

Providers must maintain records for seven years from the date of service as evidence that the services provided were:

- Medically necessary
- Consistent with the diagnosis of the individual's condition, and
- Consistent with evidence-based practice

Individual Record

The individual record shall indicate the individual's history including other known services and supports, plan of care, and progress in response to the services rendered including any changes in treatment, alteration of the plan of care, or revision of the diagnosis. Documentation must include any treatment plan, crisis stabilization plan, comprehensive service plan, or similar plan of care applicable under the provider's scope of licensure, accreditation, or certification.

At the conclusion of services, the individual's record shall include a discharge summary that identifies:

- Reason for discharge
- Date of discharge
- Recommended action or referrals upon discharge
- Treatment progress and outcomes. The discharge summary shall be included in the individual's record within 72 hours of discharge

For Mobile Response, a contact note which includes recommended follow-up, actions, and referrals will meet the requirement for a discharge summary.

Progress Notes

The provider's file for each individual must include progress notes for each date of service that details specific services rendered related to the covered service for which a claim is submitted. The following items must be included in each progress note entry, for each individual, and for each date of service:

- The date and amount of time services were delivered, including the beginning and ending time of service delivery, including AM or PM.
- The full name of the provider agency.
- The first and last name and title of provider staff rendering the service, as well as that person's signature and any accompanying credentials.
- A description of the specific components of the service being provided, including the nature of contact, relative to the service that was rendered. The progress note must describe what specifically was done, and how the service addressed the symptoms or behaviors resulting from the individual's condition.
- The place or location where service was rendered.
- The type and number of units provided.

- For services other than Mobile Response, progress notes shall include the progress and barriers to achieving the goals and objectives stated in the treatment plan, service plan, or crisis stabilization plan.

Access to Records

Providers shall permit any authorized representative of Iowa HHS, and where federal funds are involved the Comptroller General of the United States, or any other authorized representative of the United States government, to access and examine, audit, excerpt, and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records or other records of the provider relating to orders, invoices or payments, wherever such records may be located. A provider shall not impose a charge for audit or examination of the provider's books and records.

Billing Codes and Fee Schedules

All services which may be reimbursed through SNMIS are detailed in the following fee schedules:

Behavioral Health Services Fee Schedule

CMHC and CCBHC Fee Schedule

Disability Services Fee Schedule

SUPTRS Fee Schedule

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa HHS to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status.

If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa HHS, Lucas Building, Bureau of Human Resources, 4th Floor, 321 East 12th Street, Des Moines, IA 50319 -0114 or via email HR@hhs.iowa.gov.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Additionally, program information may be made available in languages other than English.

This institution is an equal opportunity provider.