Iowa Medicaid B3 Provider Manual (Guide)

Last Updated: 1/15/2026

IOWA Health and Human Services

Contents

Section 1 - Overview

Overview & Purpose

Iowa Medicaid members enrolled with a Managed Care Organization (MCO) have access to an expanded array of mental health and substance use disorder services. These services are often referred to as “B3” services because they are authorized as a 1915(b)(3) waiver exemption by the Centers for Medicare and Medicaid Services (CMS).

Eligibility & Scope

Individuals not enrolled with an MCO do not have coverage for B3 mental health and substance use disorder services. Iowa Health and Wellness Not Medically Exempt and Healthy and Well Kids in Iowa (Hawki) members are not eligible for any B3 services.

Reference: Iowa HHS document 519 “Comparison of Medicaid Basic Benefits Based on Eligibility Determination” Comm 519 - Comparison of Medicaid Basic Benefits

Incarcerated Iowans are not eligible for any of the B3 services (i.e. jails, halfway houses).

Diagnosis: The array of B3 Services is intended to support individuals with behavioral health conditions and require a member to have either a current mental health diagnosis or a substance use disorder diagnosis. There is no standard functional impairment form that is required for members to access B3 services.

Section 2 - Provider Eligibility & Enrollment

Provider Eligibility

Individuals not enrolled with an MCO do not have coverage for B3 mental health and substance use disorder services. Iowa Health and Wellness Not Medically Exempt and Healthy and Well Kids in Iowa (Hawki) members are not eligible for any B3 services.

How To Enroll

- Verify your provider type is eligible to provide the service(s) you wish to provide
- Verify you are enrolled with Iowa Medicaid
- Contract with each MCO
- Complete a contract with MCOs to set reimbursement rates for the B3 services you are eligible and wish to provide. Individually contracted rates will be in place until or upon development of a State-wide fee schedule.

Iowa Medicaid Enrollment
Contact Provider Services Monday through Friday from 8 a.m. to 5 p.m. by
Phone (Toll Free): 800-338-7909
Phone (Des Moines): 515-256-4609
Email: imeproviderservices@hhs.iowa.gov

Iowa Total Care Contracting & Credentialing
Email: NetworkManagement@IowaTotalCare.com

Molina Health Care Contracting & Credentialing
Email: IAProviderContracts@MolinaHealthcare.com

Wellpoint Contracting & Credentialing
Email: providernetworkia@wellpoint.com

Section 3 – Service Definitions & Scope of Care

Covered Services Overview:

Detailed Definitions (one per subsection)

H0018TG

- Level III.7 Community-based Substance Use Disorder Treatment
- 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a licensed substance abuse facility

Provider Type	21, 23, 49, 62
Licensure	Provider must have an active license by Iowa Health and Human Services Substance Use Providers licensed under Iowa Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT or state 'Iowa Administrative Code 641-Chapter 155'
Assessment Requirements	ASAM updated every 7 days or state 'See Iowa Administrative Code 641-Chapter 155.21(11)'
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine **OR** See Iowa Administrative Code 641-Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0017TF

- Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Substance Use Disorder Treatment – Hospital Based

- Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 is designed to treat people who have significant social and psychological problems. Services are based on a therapeutic treatment community. A step-down or alternative to Level III.7

Provider Type	1, 26, 41
Licensure	Provider must have an active license by Iowa Health and Human Services. Substance Use Providers licensed under Iowa Administrative Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT **OR** See Iowa Administrative Code, 641-Chapter 155
Assessment Requirements	ASAM updated every 7 days See Iowa Administrative Code641 Chapter 155.21(11)
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine **OR** See Iowa Administrative Code 641 Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0018TF

- Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Substance Use Disorder Treatment – Community Based

- Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 is designed to treat people who have significant social and psychological problems. Services are based on a therapeutic treatment community. A step-down or alternative to Level III.7

Provider Type	**21, 23, 49, 62**
Licensure	Provider must have an active license by the Iowa Health and Human Services to provide the 3.3/3.5 Level of Care. Substance Use Providers licensed under Iowa Administrative Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT **OR** See Iowa Administrative Code 641 Chapter 155
Assessment Requirements	ASAM updated every 7 days or state 'See Iowa Administrative Code 641 Chapter 155.21(11)'
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine **OR** See Iowa Administrative Code 641 Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H2034

- Level III.1 Clinically Managed Low Intensity Residential Substance Use Disorder Treatment

- Level III services offer organized treatment services that feature a planned regimen of care in a 24-hour residential setting. All Level III programs serve individuals who, because of their specific functional deficits, need a safe and stable environment to develop their recovery skills. The sublevels within Level III exist on a continuum ranging from the least intensive to the most intensive medically monitored intensive inpatient services. Level III.1 – at least 5 hours/week of treatment plus the structured recovery environment

Provider Type	**21, 23, 49, 62**
Licensure	Provider must have an active license by Iowa Health and Human Services. Substance Use Providers licensed under Iowa Administrative Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT **OR** See Iowa Administrative Code, 641 Chapter 155
Assessment Requirements	ASAM updated every 7 days or state 'See Iowa Administrative Code 641 Chapter 155.21(11)'
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine **OR** See Iowa Administrative Code 641 Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

Outpatient Services

H2017U1-U5

- Intensive Psychiatric Rehabilitation
- Modifiers
    - U1: Readiness Assessment
    - U2: Readiness Development
    - U3: Goal Setting
    - U4: Goal Achieving
    - U5: Goal Keeping

Rehabilitation and Support 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

Provider Type	**1, 13, 21, 49, 59, 62, 63**
Licensure/Accreditation	Community Mental Health Centers (CMHCs), other agencies providing mental health services, and accredited organizations under Iowa Administrative Code 441Chapter 24
Service Settings & Exclusions	Adult only service for members 18+
Training/Education	State recognized training program See "Intensive psychiatric rehabilitation practitioner" Iowa Administrative Code 441 Chapter. 24 Definitions)
Assessment Requirements	See Iowa Administrative Code 441 Chapter 24.4.11
Documentation Requirements	See Iowa Administrative Code 441 Chapter 24.4.11
Frequency, Duration, Limits	4-10 hours per week = 16 to 40 billable units per week (see Chapter 24.4.11)
Unit Type	1 unit = 15 minutes
Rates	Rates Negotiated between Provider and MCO

H0037 Low or H0037TF High

- Community Support Services
- Community Support Services (CSS) 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. CSS staff attempt to reduce or manage symptoms/reduced functioning that result from a mental illness. CSS providers are expected to have knowledge and experience 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 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

CSS Service Levels

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

High Intensity CSS Criteria for Admission

High Intensity CSS is for members 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.

Frequency of Contact/Service Provision

High Intensity CSS is provided through 5-12 member contacts per month. Contacts may be face-to-face or by telephone.

- A minimum of 4 face-to-face contacts required per month between CSS staff and member.
- CSS staff must have at least 2 monthly contacts with a Mental Health Professional who is working with the member. These contacts do not count towards the 5-12 member contacts.
    - Examples include calling Mental Health Professional's office to confirm member's appointment attendance or emailing provider with key monthly updates on member.
- All contacts with the member and the mental health professional must be documented in the CSS progress notes.

Service Monitoring/Authorization

High Intensity CSS services must be authorized by the member's MCO. For authorization of High Intensity CSS to continue, the member must continue to meet the Criteria for Admission and there must be expected treatment benefits associated with High Intensity CSS.

Low Intensity CSS Criteria for Admission

Low Intensity CSS is for members who require periodic supportive services to maintain their level of independent functioning in the community. Without Low Intensity CSS, these members 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.

- **Frequency of Contact/Service Provision** - Low Intensity CSS is provided through 2-4 member contacts per month, with episodes of increased frequency, as needed. Contacts may be face-to-face or by telephone.
    - A minimum of 1 face-to-face contact required per month.
    - CSS staff must have at least 1 contact monthly with a Mental Health professional who is working with the member. This contact does not count towards the 2-4 member contacts per month.
    - Examples include calling Mental Health Professional's office to confirm member's appointment attendance, or emailing provider with key monthly updates on member
    - All contacts with the member and the mental health professional must be documented in the CSS progress notes.

- **Service Monitoring/Retrospective Review** - Low Intensity CSS services require authorization through the member's MCO. Members must continue to meet the Criteria for Admission and there must be expected treatment benefits associated with Low Intensity CSS.

- **Community Support Services (H0037)** identifies low and high intensity needs. Members who are low intensity will be billed using no modifier. Members who are high intensity will be billed using the TF modifier. High intensity members will receive 5-12 contacts per month.

Provider Type	**1, 13, 21, 49, 59, 62, 63**
Licensure/Accreditation	Community Mental Health Centers and accredited organizations under Iowa Administrative Code 441.24
Training/Education	I*owa Administrative Code 441.24.54(5)b (4)* *b. Performance indicators.* 1. The following staff qualifications shall be met: a. Have knowledge and experience in working with the target population. 2. Have the ability to create relationships with the individuals served that balance support of the mental illness and the need to allow for maximum individual independence. 3. Have a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field, including but not limited to psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy.
Assessment Requirements	An assessment should outline that there is medical necessity for the service
Documentation Requirements	Documentation should clearly outline the interventions and member reactions. It should clearly outline the need for services.
Frequency, Duration, Limits	This service cannot be provided when a member is already accessing habilitation or ACT services.
Unit Type	1 unit = 1 month
Rates	Rates Negotiated between Provider and MCO

H0045

- Respite
- Modifiers:
    - No modifier: Standard/most typical – all ages
    - U4: For members in Therapeutic Foster Care Program - Ages 6 through 11
    - U5: For members in Therapeutic Foster Care Program - Ages 12 through 17

- In-/Out-of-Home Respite consists of community- and home-based services that can be provided in a variety of settings. Respite care is a brief period of rest and support for individuals and/or families. Respite care is intended to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current issues related to a mental health diagnosis. Respite may be provided for up to 72 hours and can be planned or in response to a crisis. A comprehensive respite program must provide or ensure linkages to a variety of residential alternatives for stabilizing and maintaining individuals who require short-term respite in a safe, secure environment with 24-hour supervision outside a hospital setting. Respite is a community-based alternative to inpatient hospitalization that provides a temporary, safe, and secure environment with a flexible level of supervision and structure. These services are designed to divert individuals from an acute hospitalization to a safe environment where medical and psychiatric symptoms can be monitored. Respite services can be planned or unplanned. Therapeutic foster care providers may utilize this service, by accessing another therapeutic foster care provider. If a member is receiving a Home and Community Based (HCBS) waiver, this service must be utilized through waiver prior to accessing B3 respite services.

Provider Type	1, 9, 13, 21, 23, 25, 26, 27, 41, 59, 62, 63, 64, 80, 81, 99
Licensure	Hospitals, agencies, Community Mental Health Centers contracted using MCO credentialing standards and holding national accreditation (JCAHO, CARF, COA, AOA, or AAAHC) or under Iowa Administrative Code Chapter 24) *HCBS Waiver respite agencies may contract to deliver B3 respite when they meet one of the above qualifications.
Training/Education	Providers should have knowledge and experience working with adults with mental illness
Assessment Requirements	See Iowa Administrative Code
Documentation Requirements	See Iowa Administrative Code Chapter 24.4.11
Frequency, Duration, Limits	This service cannot be provided when a member is already accessing habilitation or ACT services.
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0038

- Peer Support, Family Peer Support, and Recovery Coach
- Modifiers used for members in Therapeutic Foster Care
    - U4: Ages 6 through 11
    - U5: Ages 12 through 17
- The services are provided to eligible individuals by people with lived experience with mental health and substance use and who are specifically trained to provide peer support services (adult peer, recovery coach and family peer support). 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 support specialist 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.
- There are no minimums or caps/limits on the number of units a member can receive. Medical necessity always applies.
- The service/code is for individuals or families, not groups of members nor groups of families.
- If a member is receiving inpatient (i.e. Hospital) or residential services (i.e. SUD treatment, PMIC) the provider cannot bill additionally for Peer Support. Outpatient providers (i.e. Intensive Outpatient Programs, Partial Hospitalization Programs) may provide and bill for Peer Support services to occur outside of the outpatient program timeframe.

Provider Type	1, 13, 21, 49, 59, 62, 63, 88
Licensure/Certification	Certification is optional through the Iowa Board of Certification.
Service Settings & Exclusions	Individual Peer Support, Family Peer Support or Recovery Coaching can be performed via telehealth or in person. Exclusion: Group Setting
Training/Education	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. Peer Support Specialist, Family Peer Support Specialist and Recovery Coach has received training for behavioral health services and/or substance use through a state recognized peer training program (Iowa Peer Workforce Collaborative and CCAR). A training certification is required for a provider to bill Medicaid. Best practice is for the Peer Support Specialist, Family Peer Support Specialist and Recovery Coach to obtain state approved training within six months of employment.
Assessment Requirements	An assessment should outline that there is medical necessity for the service
Documentation Requirements	If the Peer Support Specialist, Family Peer Support Specialist or Recovery Coach is in their first 6 months of employment and are not yet certified, then their documentation will be reviewed and co-signed by a certified Peer Support Specialist, Family Peer Support Specialist or Recovery Coach
Unit Type	1 unit = 15 minutes
Rates	Rates Negotiated between Provider and MCO

H2022 (X1-X5)

- Integrated Services and Supports
- Modifiers
    - X1: 1:1 Supervision will be utilized in cases where a member needs increased supervision due to safety concerns. The intent of this service is to help members stay in the least restrictive environment possible while putting supports in place to improve and maintain their safety. This modifier covers increased supervision for 1 - 8 hours per day.

    - X2: 1:1 Supervision will be utilized in cases where a member needs increased supervision due to safety concerns. The intent of this service is to help the member stay in the least restrictive environment possible while putting supports in place to improve and maintain their safety. This modifier covers increased supervision for 8.25 – 16 hours per day.

    - X3: 1:1 Supervision will be utilized in cases where a member needs increased supervision due to safety concerns. The intent of this service is to help members stay in the least restrictive environment possible while putting supports in place to improve and maintain their safety. This modifier covers increased supervision for 16.25 - 24 per day.

    - X4: Mentoring is centered around improving members' well-being by providing a positive role model who can support them through growth, struggles, and life transitions. Mentoring allows members to participate in activities such as going to a movie, shopping, going out to eat, or favorite sporting event. Because mentoring is focused on building a healthy attachment to an adult, mentoring is not dependent on the treatment progress.

    - X5: Other services and supports cover a broad array of services. Examples of these services include transportation for treatment, and hotel costs related to visiting a member in treatment.

- Service available to eligible adults and children.
- Integrated Services & Supports are informal services/supports offered by providers, family/friends, and other members of the natural support community. These interventions help individuals to remain in or return to their homes and limit the need for more intensive out-of-home mental health treatment. Integrated services and supports are specifically tailored to an individual consumer's needs at a particular point in time and are not a set menu of services.

  A joint treatment planning process may identify the need for integrated services/supports. The consumer/family member must lead the planning process, and other members of the team must give their input as well. Individual contacts with the individual/family may also identify the need. Ideally, this provides more flexibility to individuals with unique services to address mental health needs and augment and complement those provided through other funders and systems. The services/supports must be integrated into the treatment plan. Integrated Services and Supports may have natural support involvement that requires reimbursement and, at other times, be part of the family process.

Provider Type	1, 9, 13, 21, 23, 25, 26, 27, 41, 59, 62, 63, 64, 80, 81, 99
Licensure	Hospitals, agencies, Community Mental Health Centers contracted using MCO credentialing standards and holding national accreditation (JCAHO, CARF, COA, AOA, or AAAHC) or under Iowa Administrative Code 441 Chapter 24) *HCBS Waiver respite agencies may contract to deliver B3 respite when they meet one of the above qualifications.
Training/Education	Providers should have knowledge and experience working with adults and children with mental illness
Assessment Requirements	An assessment should outline that there is medical necessity for the service
Documentation Requirements	An active mental health treatment plan exists and indicates how H2022 would address the member's current need.
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

Section IV: Person-Centered Planning

Providers will embrace:

- Person-Centered thinking helps to establish the means for a person to live a life that they and the people who care about them have good reason to value.
- Person-Centered planning is a way to assist people who need supports to construct and describe what they want and need to bring purpose to their life.
- Person-Centered practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

Section V: Authorization of Services & Referral

Prior Authorization Steps

- Verify Member has full Medicaid, if members have Iowa Health & Wellness Not Medically Exempt or Hawk-I they are not eligible for B3 services.

- Verify the Managed Care Organization (MCO) the member is assigned to. Members who are assigned to Fee for Service (FFS) are not eligible to receive these services.

- Complete Medicaid Outpatient Prior Authorization Form

- Complete B3 Template and attach with Medicaid Outpatient Prior Authorization form for Integrated Services and Supports (H2022), or respite (H0045), with no modifier.

- Submit to MCO per their identified process

Section V: Billing, Claims, & Reimbursement

Fee Schedule & Rates

Providers and MCOs negotiate the reimbursement rates for all B3 services. The Provider must contact their Provider Representative at each of the MCOs.

Codes & Modifiers

Where applicable, claims must be billed using procedure code and modifier combination Select B3 services are allowed to be billed on the UB-04 Claim form, please see Info Letter 2156 for detailed information

Ensure the member receiving the services and for which the claim is submitted, is eligible for services (i.e. not Iowa Health & Wellness – not Medically Exempt, and not Hawki)

Claims Submission Process

- Please see the provider manual for detailed information about claims submissions.
- No paper claims submissions accepted; electronic claims only accepted.

Timely Filing & Frequency

- Please see the provider manual for detailed information about claims timely filing requirements. Standard timely filing requirements apply.

Denials, Corrections, Recoupments, and Appeals

- Please see provider manual for detailed information about claims denials, corrections, recoupments and appeals. Standard processes apply.

MCO Contacts for Billing and Claims Questions

Wellpoint Iowa, Inc.
Phone: 1-833-731-2143
Email: ProviderSolutionsIA@wellpoint.com
Website: https://www.provider.wellpoint.com/iowa-provider/home

Molina Healthcare of Iowa
Phone 1-844-236-1464
Email: IAProviderContracts@MolinaHealthcare.com
Website: www.molinahealthcare.com/providers/ia/medicaid/home

Iowa Total Care of Iowa
Phone: 1-833-404-1061
Email:NetworkManagement@IowaTotalCare.com
Website: www.iowatotalcare.com/providers.html

Provider Type

Key	
1	Hospital
9	Home Health Agency
13	Rural Health Clinics
21	CMHC
23	Residential Care Facility
25	ICF/ID State
26	Mental Hospital
27	ICF/ID Community-Based
41	PMIC
49	FQHC
59	Indian Health Service
62	Behavioral Health
63	Remedial Services/BHIS
64	Habilitation
72	Public Health Agencies
80	Crisis Response
81	Sub-acute facilities
88	CCBHC
99	Waiver Providers

Appendix A – B3 Menu of Services / Codes

Service	Claim Form Typ	HCPCS/CPT Code	Revenue Code	Modifier(s)	Bill Typ	Service Unit
Integrated Services & Supports	CMS-1500	H2022	N/A	X1 – X5	N/A	1 Unit = 1 Day
Peer Support, Family Peer Support & Recovery Coaching	CMS-1500	H0038	N/A	No modifier required, unless provider is Therapeutic Foster Care **(See B3 Manual)**	N/A	1 Unit = 15 Minutes
Respite	CMS-1500	H0045	N/A	No modifier required, unless provider is Therapeutic Foster Care **(See B3 Manual)**	N/A	1 Unit = 1 Day
Community Support Services	CMS-1500	H0037	N/A	*Low:* No Modifier*High:* TF Modifier	N/A	1 Unit = 1 Month
Intensive Psychiatric Rehabilitation	CMS-1500	H2017	N/A	U1 – U5	N/A	1 Unit = 15 Minutes
Residential SUD Services (ASAM 3.1)	CMS-1450	H2034	906	None	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Hospital Based)*(ASAM 3.3/ 3.5)*	CMS-1450	H0017	906	TF	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Community Based)*(ASAM 3.3/3.5)*	CMS-1450	H0018	906	TF	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Community Based)*(ASAM 3.7)*	CMS-1450	H0018	906	TG	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day

Appendix B – Frequently Asked Questions (FAQ)

Question	Answer
How will providers be notified of changes to the manual?	We are working on a notification process and will share once determined.
Until clarified, should we follow the new manual monthly contact expectations or June's letter that states quarterly contact?	The B3 Manual supersede previous Informal Letters (ILs).
When we apply to provide B3 services, how long does it take to hear back? Do you have any information regarding the back log at Medicaid Enrollment?	HHS provider enrollment recommends contacting provider enrollment and copy in Sabrina Johnson, Sabrina.Johnson@hhs.iowa.gov if greater than 30 days.
I am a Medicaid provider as Psychiatric Mental Health Nurse Practitioner (PMHNP). Do I need to apply again as B3?	If already enrolled as NP and provider type is eligible for B3 services, no new Medicaid enrollment type needed
Can H0038 be provided in a member's home when receiving H2016 U9 or U7 services?	This is currently under review with the State
If a member remains fully covered while incarcerated, can H0038 be provided within corrections? If a member remains enrolled with full Medicaid coverage still while incarcerated, can H0038 billable Peer Support services be provided within the correctional setting during that incarceration period?	If member is incarcerated, they should not be assigned to a MCO. They should flip to FFS, therefore, H0038 (or any B3 service) cannot be provided.
Does the state consider PSS and CSS services duplication? Can a client be enrolled and receive both services?	To be reviewed and clarified, by whom?

Question	Answer
Can H0038 services be provided in a to a member, specifically in the member's home when the individual is currently receiving H2016 U9 or H2016 U7 services?	To be reviewed and clarified, by whom?
Is there a 3-hour time cap on billing for Peer Support per month still?	It is the minimum allowed - not the cap. Is there really a minimum?
Is the rule regarding H0038 correct in the provider manual? It references 24.4.11 which does not seem to fit.	This will be corrected in the next version of the Manual.
Is a client having in day treatment (IOP or EOP) double dipping to have CSS as well	Both can occur. Needs to be appropriate and have clear documentation on why it is being utilized. Can't be provided at the same time, but same day different times is allowed.
H0037 cannot be provided when also receiving hab services? Even if there is no duplication of services like if only getting supported employment	No, this is considered duplicative.
Please clarify Wellpoint's explanation of receiving a letter indicating an authorization is needed for H0037 but does not mean one is needed or denials on claims indicating an authorization is needed? Can we get clarification on Wellpoint's authorization requirements for H0037? In the past, we were told "prior auth" wasn't needed but there was an enrollment notification that needed to be done, and we have been getting authorizations from Wellpoint. Can you please clarify?	Wellpoint requires providers to fill out the Prior Auth request form and submit it as notification only; no clinical documentation is needed, and no clinical review is done by the MCO. Wellpoint's system denies claims if no prior auth request is on file.
Can someone utilize habilitation and CSS	No, this is considered duplicative.
Is there a definition of the types of services under the Community Support Services code? The manual doesn't provide many references.	No. See Iowa Code

Question	Answer
Are there limitations to where CSS services can occur? If someone is living in a halfway house, sometimes their Medicaid can show as incarceration status. It would be beneficial if CSS could bill for CSS services when a client is hospitalized to help with coordination of discharge planning due to no IHH anymore	CSS services require a member to have Medicaid and be enrolled with an MCO. If a member is in a halfway house, they are technically incarcerated and on FFS, not with a MCO and not eligible for B3 Services.
Can you clarify in the manual if CSS services are able to work on vocational goals? work and school related goals	These services are designed to support individuals as they live and work in the community. If vocational and school goals offer that support, then “yes”.
Face to face meetings are supposed to be away from the office to my understanding. Community-based is the key.	Ideally, yes. CSS staff should meet at locations preferred by clients, hence the name of the service – Community Support Services
How can we bill 1:1 support for youth in shelter care? H2022	Be a provider with Iowa Medicaid Contract with the MCO Connect with care/case management with the MCO to coordinate.
Will BHIS be an option as a service under B3 services?	No BHIS is currently a Medicaid service.
Will H0015 be added to the manual?	No, this is a covered benefit with Medicaid.
What does telehealth services look like for B3 services?	The list of approved telehealth services is found on the HHS Fee Schedule webpage.
What will future monthly trainings look like that you have scheduled? Will you be presenting new content? Will it be more like an "open office hours"?	ITC will host monthly sessions every third Wednesday as informal office hours and updates. Molina and Wellpoint representatives will also join the call.
Where should we direct additional questions that we may have after this call?	To MCO provider reps listed on slides. Any door is fine; teams will compile for FAQ.
What is non par?	Non-par means not participating in the MCO network. Non-par services require authorization.

Question	Answer
What does it mean if only non-par?	It means your practice does not have an executed contract with the MCO. Without a contract, the plan's in-network payment rates, rules, and workflows do not automatically apply.
Would it be possible for the MCOs to create an example of an ideal progress note, treatment plan, and communication template for communication with a MHP so all providers of this service can be on the same page?	No.
Can we bill for family expenses to visit youth in residential SUD treatment?	Yes, in-state travel and hotel can be reimbursed under H2022 X5 modifier when applicable. Prior auth is required.
Do we bill H0038 on a 1500 claim form?	Yes, Peer Support on 1500.
The commercial insurances we have tried submitting to do not recognize the H0037 code, and when we have attempted to bill to get a denial, they deny the claim with a contractual adjustment code (CO), which typically means the MCO won't pay either. We are unclear on how to proceed with these claims.	Medicare as primary: If Medicare does not cover the service/code, Medicaid may pay in its usual manner. For services Medicaid covers but Medicare does not, submit directly to the Medicaid MCO and note "Medicare non-covered" with your Medicare denial or policy reference. Iowa's billing manual states Medicaid pays for services it covers that Medicare does not. Health & Human Services Commercial insurance as primary. When there is other insurance on file, providers generally must bill that insurer first and attach the primary EOB when billing Medicaid, except for specific federal exceptions Health & Human Services
What is the time frame associated with a prior authorization request for (B)(3) services? Are there any safeguards in place for patients who require the service, but are delayed due to new authorization requirements?	Check each MCO's PA tool for current requirements; B3 services follow same turnaround time frames as all other services.
Clarify billing primary insurance for B3. Medicare and Commercial COB expectations.	If Medicare non-covered, bill MCO with denial or policy reference. For commercial, bill primary first unless excluded; attach EOB.