Behavioral Health Services

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CLINICIANS ELIGIBLE TO PARTICIPATE

Mental health services are generally provided through the Iowa Plan for Behavioral Health ("Iowa Plan"). The Iowa Plan is Iowa's managed care program for certain publicly funded mental health and substance abuse services. The following clinicians are eligible to enroll and provide assessment and treatment planning:

- Those licensed by the Iowa Board of Social Work pursuant to 645 Iowa Administrative Code (IAC) Chapter 280 as independent social workers.
- Those licensed by the Iowa Board of Social Work pursuant to 645 IAC Chapter 280 as master social workers who:
  - Hold a master's or doctoral degree as approved by the Board of Social Work, and
  - Provide treatment under the supervision of an independent social worker licensed pursuant to 645 IAC Chapter 280.
- Those licensed by the Iowa Board of Behavioral Science pursuant to 645 IAC Chapter 31 as marital or family therapists or mental health counselors.
- Those certified as alcohol and drug counselors by the Iowa Board of Certification.

Except for alcohol and drug counselors, clinicians in other states are eligible to participate when they are duly licensed to practice in that state.

B. COVERED SERVICES

Payment will be approved for services as authorized by state law and within the scope of practice of the clinician's license. Services can be provided if:

- The member's diagnosis is not covered by the Iowa Plan, or
- The member is not an Iowa Plan enrollee.

Payment will be approved for services provided by the clinician in the clinician's office, a nursing home, the member's home, or a residential facility.

Payment shall be made only for time spent in face-to-face services with the client. No payment shall be made for services not rendered personally by the clinician.

1. Assessment

The assessment is a diagnostic tool for gathering information to:

- Establish or support a diagnosis, and
- Provide the basis for the development or modification to the treatment plan and development of discharge criteria.

Components of a clinical assessment include:

- Client demographic information
- Presentation/complaint
- Medical history and medications
- Treatment history
- Substance use history
- Mental status
- DSM diagnosis
- Functional assessment (with age-appropriate expectations)

2. Diagnosis

Assign a multi-axis diagnosis or diagnostic impression in accordance with the current edition of the International Classification of Disease, Tenth Revision (ICD-10).

Report only diagnostic codes that are clearly and consistently supported by the documentation in the record. Information relating to a diagnosis that is over 12 months old needs to be confirmed.

3. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 IAC 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- For per minute electronic services enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

4. Treatment Plan

A treatment plan is a required document in the file. Treatment plans should be individualized to reflect the member's unique needs and goals. The plan must be developed based on a diagnostic evaluation that:

- Includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation, and
- Reflects the need for services.

Treatment plans should include:

- Client specifics, incorporating client goals, needs resources, abilities, and outcomes
- Motivation for change
- Functional impairments to be addressed
- Measurable objectives and goals to determine functional improvement
- Parties responsible for each measurable goal or outcome
- Timeline for goal achievement based on specific needs, resources, abilities of client
- Barriers to goal achievement
- Coordination of treatment with other agencies or treatment providers
- Estimated discharge date

5. Treatment

Treatment must be consistent with generally accepted professional medical standards. Services must be:

- Individualized,
- Specific,
- Consistent with the symptoms or confirmed diagnosis of the illness under treatment, and
- Not in excess of the member's needs.

Payment will be approved for the following:

- Individual outpatient services
- Couple, marital, family, or group outpatient services
- Reassessment, including:
  - The assessment of current symptoms and behaviors related to the diagnosis and progress toward treatment goal,
  - Justification of changed or new diagnosis, and
  - Response to other concurrent treatments such as medications.

Upon discharge, provide final recommendations to the member, including further services and providers, if needed, and activities recommended to promote further recovery. Keep a copy in the member's file.

6. Exclusions

Payment will not be made for the following:

- Services performed without relationship for a specific condition, risk factor, symptom, or complaint
- Services covered under Part B of Medicare except for the Part B Medicare deductible or coinsurance
- Services using investigational or experimental methods
- Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons
- Services for nonspecific conditions of distress, such as job dissatisfaction or general unhappiness
- Services in a medical institution

C. BASIS OF PAYMENT

Behavioral health providers are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Click here to view the fee schedule for Behavioral Health providers.

D. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Refer to the current fee schedule for a listing covered of codes.

Providers who do not have Internet access can obtain a copy upon request from the IME.

It is the provider's responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME. Claim forms must be completed with all required elements. Claims submitted without a procedure code and an ICD-10-CM diagnosis code will be denied.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Behavioral Health providers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click here to view a sample of the CMS-1500.

Click here to view billing instructions for the CMS-1500.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf