

Community Mental Health Centers Provider Manual




 Iowa Department of Human Services	Provider Community Mental Health Centers	Page 1
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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CENTERS ELIGIBLE TO PARTICIPATE

Community mental health centers (CMHCs) are eligible to participate in the Medicaid program providing they are in compliance with the community mental health center standards established by the Department of Human Services, Division of Mental Health and Disability Services (MHDS).

In order for CMHCs to participate in the Medicaid day treatment programs for adults or children, they must additionally be certified for each program by the Division of MHDS.

B. COVERAGE OF SERVICES

Payment will be approved for all reasonable and necessary services provided by a psychiatrist or by a psychologist on the staff of a CMHC without other supervision who is on, or meets the requirements of, the National Register of Health Service Providers in Psychology.

Each CMHC must submit the names of those psychologists who meet the requirements of the National Register to the Iowa Medicaid Enterprise (IME) and obtain approval before billing their services. The CMHC must show the psychologist's name and discipline in the description of service on each of the psychologist's services claimed.

1. Conditions of Payment

Payment will be approved for services provided by other psychologists, social workers, or psychiatric nurses on the staff of the center, subject to the following conditions:

- ◆ Each member must have an initial evaluation. This includes at least one personal evaluation interview with a mental health professional, as defined under Iowa Code, Section 228.1. The evaluation interview must be completed before the submission of the first claim for services rendered to that member.

If the evaluation interview results indicate a need for a referral for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made.



Exception: A preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes is payable without the psychiatric personal interview or staffing requirements.

- ◆ Pursuant to 441 Iowa Administrative Code (IAC) 78.16(1)"b"(2), the peer review process in place for the CMHC shall be used for the purposes of providing ongoing review and assessment of the member.

The peer review process shall involve all necessary professional staff of the CMHC involved in direct service delivery and supervision thereof, as specified or otherwise defined in the CMHC's peer review process.

Results of the peer review process and information collected as a result thereof relative to a given member shall be recorded and placed in the member's record, as appropriate and necessary and placed in the member's permanent record.

- ◆ Consistent with the preceding bullet point, there must be regular and ongoing review and assessment of the member's treatment needs, treatment plans, and the appropriateness of services rendered.

This ongoing review and assessment must be conducted by appropriate staff, as required by the peer review process specified under 441 IAC 78.16(1)"b"(2).

The treatment plans for and services rendered to patients of the CMHC shall be evaluated and revised as necessary and appropriate, consistent with the CMHC's peer review process.

- ◆ Regular and ongoing reviews under the peer review process, described in the preceding two bullet points, are not payable as separate services. The CMHC must maintain the results of and information related to the peer review process. These records are subject to review and audit by the Department of Human Services, the IME, or others the Department or the IME may designate for such purposes.
- ◆ Clinical records of Medicaid members shall be available to the IME on request. All such records shall be held confidential.
- ◆ Coverage of services provided by staff of the center, including adult or children day treatment services, is limited to services provided on-site of the CMHC or in a recognized and enrolled satellite office of a CMHC.

Exception: Day treatment program services may include off-premise activities when the activity is therapeutic and is integrated into the day treatment program's description and milieu plan.



Each CMHC shall provide and update the IME with the current address of the CMHC and any satellite offices. For Medicaid purposes, to be considered a satellite office of an accredited CMHC, an office must meet the following conditions:

- The services provided in the satellite office must be accessible to all persons in the center's service area.
- The location and hours of the satellite office must be made available to the public.
- The board of the CMHC must officially recognize the location as a satellite office.

It is the responsibility of the CMHC to contact the IME and provide an update whenever there is a change of address, when a new satellite office is opened or an office closes.

If a psychiatrist on the staff of the CMHC provides service to a hospitalized member, the psychiatrist may bill the IME under the psychiatrist's own private practice provider number. If the psychiatrist wishes to submit claims under the private practice number and have the IME pay the CMHC, the provider number of the CMHC and the provider number of the physician must be entered in the appropriate area of the claim form.

The psychiatrist must submit to the Provider Enrollment Unit of the IME a signed authorization allowing payment to be made directly to the CMHC.

This procedure is applicable only to the psychiatrist.

Psychiatric nurses, psychologists and social workers may render services under the supervision of the physician when following the staffing regulations. Services rendered on the premises of the CMHC or the satellite office do not require the presence of the physician.

- ◆ The Centers for Medicare and Medicaid Services (CMS) has preadmission screening and resident review (PASRR) requirements for nursing facilities. All persons entering a nursing facility receive a Level I screen to determine if they have or if there is a suspicion they have a mental illness, intellectual disability, or a related condition.



If it is determined there is or may be one of the above disabilities, the person is referred for a Level II evaluation which must be completed before placement in a nursing facility and payment by Medicaid. The Level II evaluation will evaluate the condition and make recommendations for level of care, placement, treatment, and services related to the disability. The nursing facility will develop a plan based on these recommendations to meet the member's needs. These services may be provided in a nursing home.

2. Day Treatment for Adults

Payment to a CMHC will be approved for day treatment services for persons aged 21 or over if the center is certified by MHDS for day treatment services and the services are provided on the premises of the CMHC or a satellite office of the CMHC.

CMHCs with day treatment programs for persons aged 21 or over shall address:

- ◆ Documented need for day treatment services for adults in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.
- ◆ Goals and objectives of the day treatment program for adults that meet the day treatment program guidelines noted below.
- ◆ Organization and staffing, including how the day treatment program for adults fits with the rest of the CMHC, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employees, contractual, or consultant.
- ◆ Policies and procedures for the program, including admission criteria, member assessment, treatment plan, discharge plan, and post-discharge services, and the scope of services provided.
- ◆ Any accreditations or other types of approvals from national or state organizations.
- ◆ The program's physical facility and equipment.

Day treatment services for adults shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.



Service components include training in independent functioning skills necessary for self-care, emotional stability, and psychosocial interactions, and training in medication management. Services are structured with an emphasis on program variation according to individual need.

To be payable by Medicaid, services shall meet the applicable criteria found in [Conditions of Payment](#).

Services may be provided for a period of three to five hours per day, three or four times per week.

Day treatment services provided for more than five sessions require individualized treatment plans. The treatment plan must state the type, amount, frequency, and duration of the service and the anticipated goals. The treatment plan shall be developed by a board-eligible or board-certified psychiatrist, a staff psychiatrist, or a psychologist meeting the requirements of the National Register of Health Service Providers in Psychology.

Day treatment is available to any Medicaid member aged 21 or over for whom the service is appropriate, that is, the service is reasonable and necessary for the treatment of the person's condition. It is likely that the primary users of the service will be persons with chronic mental illness, due to the nature of the service.

The Iowa Legislature has appropriated special funds to the Department for certain Medicaid services that will be used primarily by members with an intellectual disability, chronic mental illness, or a developmental disability. To ensure that funds are properly allocated, a CMHC which provides day treatment services to these Medicaid members shall report certain information to the Department. This includes information as to the diagnostic category applicable to the member and information concerning the member's legal settlement.

As day treatment programs for adults and children have different focuses, persons aged 18 through age 20 with chronic mental illness may be better served by the adult day treatment program. As a result, persons between the ages of 18 and 20 with chronic mental illness may access the day treatment program which best meets their needs, day treatment for adults or day treatment for children.



3. Day Treatment for Children

Payment to a CMHC will be approved for day treatment services for persons aged 20 or under if:

- ◆ The center is certified by the MHDS for day treatment services.
- ◆ The services are provided on the premises of the CMHC or a satellite office of the CMHC.

Exception: Day treatment program services may include off-premise activities when the activity is therapeutic and is integrated into the day treatment program's description and milieu plan.

Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441 IAC Chapter 114.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment hours may be gradually decreased as day treatment services transition to discharge of the member from the program.

Persons aged 18 through age 20 with chronic mental illness may have varying needs. Access is available from the day treatment program which best meets their needs: day treatment for adults or day treatment for children.

To be payable by Medicaid, services shall meet the applicable criteria found in [Conditions of Payment](#).

CMHCs with day treatment programs for persons aged 20 or under shall address:

- ◆ Documented need for day treatment services for children in the area served by the program, including:
 - Studies.
 - Needs assessments.
 - Consultations with other health care professionals.



- ◆ Goals and objectives of the day treatment program for children that meet the guidelines below:
 - Organization and staffing, including:
 - How the day treatment program for children fits with the rest of the CMHC.
 - The number of staff.
 - Staff credentials.
 - The staff's relationship to the program, e.g., employees, contractual, or consultant.
 - Policies and procedures for the program, including:
 - Admission criteria.
 - Member assessment.
 - Treatment plan.
 - Discharge plan.
 - Post-discharge services.
 - The scope of services provided.
- ◆ Any accreditations or approvals from national or state organizations.
- ◆ The program's physical facility and equipment.

a. Admission Criteria

The admission criteria for day treatment for persons aged 20 or under are:

- ◆ The member is at risk for exclusion from normative community activities or residence due to factors such as:
 - Behavioral disturbance
 - Chemical dependence
 - Depression
- ◆ The member exhibits one or more of the following:
 - Psychiatric symptoms
 - Disturbances of conduct
 - Decompensating conditions affecting mental health
 - Severe developmental delays
 - Psychological symptoms
 - Chemical dependency issues



- ◆ These symptoms are sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- ◆ Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate. This includes individual or group therapy services provided by:
 - A physician in the physician's office.
 - Auxiliary staff of a physician in the physician's office.
 - A qualified mental health professional employed by a CMHC.
- ◆ The member's principle caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the member, and to enable adequate control of the member's behavior. The caretaker must be involved in the member's treatment.

If the principle caretaker is unable or unwilling to participate in the provision of services, document how services will benefit the child without caretaker involvement. Services will be covered when the plan reflects reasonable opportunity for success. Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

- ◆ The member has the capacity to benefit from the interventions provided. Examples:

- A member with an intellectual disability may not be appropriate for a day treatment program if the member is unable to participate and benefit from group milieu therapy.
- A member exhibiting acute psychiatric symptoms (e.g., hallucinations) may be too ill to participate in the day treatment program.



b. Coordination of Services

Provide programming services in accordance with the individual treatment plan. Appropriate day treatment staff develop the plan in collaboration with the member and appropriate caretaker figure (parent, guardian, or principal caretaker). The services shall be under the supervision of the program director, coordinator, or supervisor.

Primary care staff of the CMHC shall coordinate the program for each member. The day treatment program shall offer a coordinated, consistent array of scheduled therapeutic services and activities. These may include:

- ◆ Counseling or psychotherapy,
- ◆ Theme groups,
- ◆ Social skills development,
- ◆ Behavior management, and
- ◆ Other adjunctive therapies.

At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each member shall consist of active treatment components which are determined by the individual treatment plan based upon a comprehensive evaluation of member needs, as well as specifically addressing the targeted problems of the population served.

Active treatment has been defined as treatment in which the therapist assumes significant responsibility and often intervenes.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment.

Medicaid will not make separate payment for family therapy services. Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the members, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.



c. Documentation

The program shall maintain a distinct clinical record for each member admitted. At a minimum, documentation shall include:

- ◆ The specific services rendered,
- ◆ The date and actual time services were rendered,
- ◆ Who rendered the services,
- ◆ The setting in which the services were rendered,
- ◆ The amount of time it took to deliver the services,
- ◆ The relationship of the services to the treatment regimen described in the plan of care, and
- ◆ Updates describing the member's progress.

Example: John Jones' Clinical Record

Day treatment services provided June 1, 2013, from 9:00 a.m. to 11:00 a.m. at Brookes CMHC.

Objective I

Will develop and maintain a relapse prevention plan including action steps to take in order to stop his offense cycle.

Treatment Note

Arrives late looking very disheveled. Begins with making a lot of excuses with rapid speech and flushed cheeks. Give feedback regarding observing his anxiety at "not being perfect" (trigger for cycle) went over his thinking – I'm too busy – what self-talk would put him back into control (positively). Also informed "my family is moving." Another trigger – discussed strategies for dealing with this to prevent relapse.

Joe Brown, MSW



Objective II

Increase the use of "I statements" in communications.

Treatment Note

Reports being more open with Mom when Mom makes hurtful comments. States he uses "I statements." He said his Mom often responds saying "you take things too personally." This was discussed and he acknowledged Mom's response intensifies his hurt and anger... but he doesn't continue to express himself. He states he will talk to Mom and continue using "I" statements.

Suzy Smith, RN

Example: Dawn Williams' Clinical Record

Day treatment services provided June 2, 2013, from 2:00 p.m. to 4:00 p.m. at Brookes CMHC.

Objective I

Identifies and processes feelings about parental divorce.

Treatment Note

Processed sense of loss. Identified multiple facets to her loss – parental absence, changes in family patterns. Discussed desire to get things "right" in her behavior and parents will reunite.

Interventions

Normalized grief. Empathized with loss. Did reality testing around issue of reconciling parents.

Joe Brown, MSW

Objective II

Will use weekly play therapy to express feelings.

Treatment Note

Used play time to work on family unity, nurturing and structure themes. Played out resolution to conflict. Also played out her improved self-esteem.

Suzy Smith, RN



d. Individual Treatment Plan

Prepare a treatment plan for each member receiving day treatment services. The treatment plan shall be developed or approved by one of the following:

- ◆ A board-eligible or board-certified psychiatrist.
- ◆ A staff psychiatrist.
- ◆ A physician.
- ◆ A psychologist registered on the National Register of Health Service Providers in Psychology or the Iowa National Register of Health Service Providers in Psychology.

Approval will be evidenced by a signature of the physician or health service provider in psychology. Formulate a preliminary treatment plan within three days of program participation after admission. Replace it within 30 calendar days by a comprehensive, formalized plan using the comprehensive assessment.

This individual treatment plan should reflect the member's diagnosis and the member's strengths and weaknesses and identify areas of therapeutic focus. Relate the treatment goals (general statements of member outcomes) to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Outline:

- ◆ The hours and frequency the member will participate in the program.
- ◆ The type of services the member will receive.
- ◆ The expected duration of the program.

Objectives shall be related to the goal and have specific anticipated outcomes. State the methods that will be used to pursue the objectives. Review and revise as needed the plan but review at least every 30 calendar days.

e. Programming

Day treatment services for children shall be a time-limited, goal-oriented, active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu.



Time-limited means that the member is not expected to need services indefinitely, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the member in order that the service is no longer necessary.

Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family-focused. The overall expected outcome is clinically adaptive behavior on the part of the member and the family. At a minimum, day treatment services are expected to improve the member's condition, restore the condition to the level of functioning before onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization.

Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive, and complimentary schedule of therapeutic activities, and shall have the capacity to treat a wide array of clinical conditions. The following services shall be available as components of the day treatment program:

- ◆ **Assessment services.** All day treatment members shall receive a formal, comprehensive bio-psychosocial assessment of day treatment needs. If applicable, include a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. Address in the assessment whether medical causes for the child's behavior have been ruled out.

An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same. If not, parts of the assessment which reflect current functioning may be used as an update.

Using the assessment, produce a comprehensive summation, including the findings of all assessments performed. Use the summary in forming a treatment plan, including treatment goals.



Also consider and consistently monitor indicators for discharge planning, including:

- Recommended follow-up goals.
 - Provision for future services.
- ◆ **Educational component.** The day treatment program may include an educational component as an additional service. The member's educational needs shall be served without conflict from the day treatment program.

Hours in which the member is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

Example:

The member attends the day treatment program from 9:00 a.m. to 3:00 p.m. The member attends the educational component from 9:00 a.m. to noon.

The hours the member attended the educational component are deducted from the day treatment hours. The billable day treatment hours for Medicaid are three hours. The day treatment program may wish to pursue funding of educational hours from local school districts.

These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

Exception: Individual or family therapy services received on days in which the member does not attend day treatment can be separately billed.

This exception does not eliminate or reduce the need for individual, group, or family therapy to be an integral part of the active treatment programming. Such therapy shall be provided during at least 50 percent of the scheduled program hours. Rather, it provides additional therapies for persons in need of more intensive treatment.



Example:

The member attends the day treatment program on Monday, Wednesday, and Friday. Additional individual therapy is provided on Tuesdays to deal with a specific issue that is not addressed by the day treatment program. The CMHC submits a separate claim for the Tuesday services.

- ◆ **Evaluation services.** Evaluation services shall determine need for day treatment before program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed.

Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months may be substituted if there has not been a change. Medicaid will not make separate payment for these services under the day treatment program.
- ◆ **Psycho-social rehabilitation services.** Active treatment examples include, but are not limited to:
 - Individual and group therapy;
 - Medication evaluation and management;
 - Expressive therapies;
 - Theme groups, such as communication skills, assertiveness training, other forms of community skills training, or stress management;
 - Chemical dependency counseling, education, and prevention;
 - Symptom recognition and reduction;
 - Problem solving;
 - Relaxation techniques; and
 - Victimization (sexual, emotional, or physical abuse issues).



Other program components may be provided, such as:

- Personal hygiene,
- Recreation,
- Community awareness,
- Arts and crafts, and
- Social activities designed to improve interpersonal skills and family mental health.

Although these other services may be provided, they are not the primary focus of treatment.

- ◆ **Psychotherapeutic treatment services.** (Examples: individual, group, and family therapy)

f. Program Requirements

Day treatment programs for persons aged 20 or under shall meet the following criteria:

- ◆ Staffing shall be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants.

Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. "Professional" or "clinical" staff are those staff who are either mental health professionals as defined in 441 IAC 24.61(225C, 230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional.

All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative, clerical, or support activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio. Certified occupational and recreational therapy assistants are not countable in the staff-to-patient ratio.



- ◆ Staffing shall reflect how program continuity will be provided, and shall reflect an interdisciplinary team of professionals and paraprofessionals.
- ◆ Staffing shall include a designated director who is a mental health professional. The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.
- ◆ Staffing shall be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the CMHC who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular, and documented.

The employee or consultant shall have a minimum of a bachelor's degree in a human-services-related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

Exception: Certified occupational and recreational therapy assistants are eligible to provide direct services under the general supervision of an occupational or recreational therapist and the mental health professional.

- ◆ The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.
- ◆ Programming shall meet the individual needs of the member. A description of services provided for members shall be documented, along with a schedule of when service activities are available, including the days and hours of program availability.
- ◆ There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.



- ◆ The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with local school districts and educational cooperatives. Relationships with other entities are encouraged. Such as:

- Physicians,
- Hospitals,
- Private practitioners,
- Halfway houses,
- The Department,
- The juvenile justice system,
- Community support groups, and
- Child advocacy groups.

The provider's program description shall describe how community links will be established and maintained.

- ◆ Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

g. Stable Milieu

The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of members exists as much as possible. The milieu will consider the developmental and social stage of the participants, such that no member will be significantly involved with other members who are likely to contribute to retardation or deterioration of the member's social and emotional functioning.

To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.



h. Discharge Criteria

The length of stay in a day treatment program for children shall not exceed 180 treatment days per episode of care. For members whose length of stay exceeds 180 treatment days, document the rationale for continued stay in the member's case record and treatment plan every 30 calendar days after the first 180 treatment days.

Discharge criteria for the day treatment program for children shall incorporate at least the following indicators:

- ◆ If the member has improved:
 - The member's clinical condition has improved, as shown by symptom relief, behavioral control, or indication of mastery of skills at the member's developmental level.
 - Reduced interference with and increased responsibility with social, vocational, interpersonal, or education goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
 - Treatment goals in the individualized treatment plan have been achieved.
 - An aftercare plan has been developed that is appropriate to the member's needs and agreed to by the member and family, custodian, or guardian.
- ◆ If the member does not improve:
 - The member's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
 - Member, family, or custodian noncompliance with treatment or with program rules exists.

Post-discharge services shall include a plan for discharge that provides appropriate continuity of care.



C. BASIS OF PAYMENT

Effective for services rendered on or after October 1, 2006, CMHCs and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

Effective for services rendered on or after July 1, 2014, CMHCs may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the Department of Human Services. Once a CMHC chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology.

For CMHCs that elect the 100 percent of reasonable costs basis of reimbursement and for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3), rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following:

- ◆ Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the IME shall make interim payments to the provider based upon 105 percent of the greater of:
 - The statewide fee schedule for CMHCs effective July 1, 2006, or
 - The average Medicaid managed care contracted fee amounts for CMHCs effective July 1, 2006.
- ◆ For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the IME shall make interim payments based upon the average statewide interim rates for CMHCs at the time services are rendered. A new provider may submit a projected cost report that the IME will use to develop a provider-specific interim rate.
- ◆ Cost reports as filed are subject to review and audit by the IME. The IME shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitation in the Department's administrative rules.



- ◆ The IME shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.
- ◆ The IME shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

Reporting Requirements

All providers, other than CMHCs and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) which have elected the alternative reimbursement methodology approved by the Department, shall submit cost reports using form 470-4419, *Community Mental Health Center Financial and Statistical Report*. A hospital-based provider shall also submit the Medicare Cost Report, CMS Form 2552. Click [here](#) to view form 470-4419 online.

- ◆ Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.
- ◆ Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.
- ◆ Costs reported for CMHC services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under CMHC services.
- ◆ Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, PO Box 36450, Des Moines, IA 50315. A provider that is not hospital-based shall submit form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both form 470-4419 and CMS Form 2552 on or before the last day of the fifth month after the end of the provider's fiscal year.



- ◆ A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.
- ◆ If a provider fails to submit a cost report that meets the requirements of this paragraph, the IME shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim payment for group therapy is based on the actual number of persons who comprise the group, but not less than six. For example, if eight persons are considered to comprise the group, payment is based on eight persons. However, if the group is composed of four persons, payment is nevertheless based on six persons.

Day treatment services are considered a total package of services. Do not bill individual therapy or group therapy services separately to Medicaid when these therapy services are being provided during hours in which the member is being served by a day treatment program.

D. PROCEDURE CODES AND NOMENCLATURE

Iowa Medicaid uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes are divided into three levels.

- ◆ Level 1 is the current CPT-4 codes.
- ◆ Level 2 codes are specifically designed regional five-digit codes beginning with letters A through V, approved by the federal Centers for Medicare and Medicaid Services.
- ◆ Level 3 codes are specifically designed local codes beginning with letters W through Z.

Note that most Level 3 codes (i.e., "local" codes) have been cross-walked to either CPT or Level 2 codes, pursuant to requirements of the Health Insurance Premium and Portability Act (HIPAA) of 1996. The only Level 3 "local" codes that now remain are those that would be considered an "atypical" service by CMS, whose standard for such is:

- ◆ Not rendered by a traditional health care provider,
- ◆ Not a typical health care service, and
- ◆ Not a service normally payable by other health insurance plans or programs.



Claims submitted without a procedure code and appropriate ICD-10-CM diagnosis code will be denied.

Practitioners rendering services under the CMHC's provider number are able to bill for services with the appropriate procedure and diagnosis codes, consistent with their licensure, scope of practice, specialty area, and the service being rendered.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Community Mental Health Centers 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>