

Subacute Mental Health Services

Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider

Subacute Mental Health Services

Page

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

The following organizations are eligible to enroll and provide short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition:

Subacute mental health care facilities which are licensed by the Department of Inspections and Appeals in accordance with [481 IAC 71.3\(135G\)](#) are eligible to participate in the program by providing subacute mental health services.

Subacute mental health care facility rules are located at [481 IAC Chapter 71](#).

Medicaid provider qualifications are located at [441 IAC 77.56\(249A\)](#).

Subacute mental health care facility standards are located at [Iowa Code Chapter 135G](#) and [Iowa Code 225C.6](#).

1. Enrollment

Providers eligible to participate must be enrolled with the Iowa Medicaid Enterprise (IME) in order to credential and contract with the managed care organizations and to bill the Iowa Medicaid Enterprise for services provided to Fee-For-Service (FFS) members.

Each provider shall provide the IME Provider Services Unit with the current address of the provider's primary location and any satellite locations. It is the responsibility of the provider to contact the IME Provider Services Unit and provide an update whenever:

- ◆ There is a change of address.
- ◆ Other changes occur that affect the accuracy of the provider enrollment information.



2. Provider Requirements

As a condition of enrollment, providers of subacute mental health services must:

- ◆ Request criminal history record information, child abuse, and adult abuse background checks on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 135C.33(5).
- ◆ Follow standards in 441 IAC 79.3(249A) for maintenance of records. These standards pertain to all Medicaid providers. See [Documentation](#).
- ◆ Assure that any services delivered by an individual or agency, either through employment by or a contract with the enrolled provider, shall comply with the requirements that are applicable to the enrolled provider.

3. Staff Requirements

Staffing of subacute mental health care services at a minimum includes:

- ◆ Twenty-four-hour-per-day, seven-day-per-week availability of on-call psychiatrist or advanced registered nurse practitioner with at least one year of experience in psychiatric care;
- ◆ Twenty-four-hour-per-day, seven-day-per-week availability of on-call registered nurse with at least two years of experience in psychiatric care or a registered nurse with a bachelor of science in nursing (BSN) and at least one year of experience in psychiatric care;
- ◆ A mental health professional;
- ◆ Direct care staff with at least three years of experience in a mental health care setting; and
- ◆ Social service staff at the bachelor level with at least one year of experience in a mental health care setting.



B. COVERED SERVICES

Legal reference: [441 IAC 78.61\(249A\)](#)

Subacute mental health treatment is designed to resolve the presence of acute or crisis mental health symptoms, or the imminent risk of onset of acute or crisis mental health symptoms for members experiencing a decreased level of functioning due to a mental health condition.

The subacute treatment setting provides a protective environment that includes stabilization, support, diagnostic evaluation and treatment, wellness, and transition to ongoing services provided 24-hours-a-day, 7-days-a-week. Subacute mental health care facilities are intended to be short-term, intensive, recovery-oriented services and are designed to stabilize the member.

Subacute mental health service means all of the following:

- ◆ A comprehensive set of wraparound services for persons who have had or are at imminent risk of having acute or crisis mental health symptoms that do not permit the persons to remain in or threatens removal of the persons from their home and community
- ◆ Services directed at individuals who have been determined by a mental health professional and a licensed health care professional, subject to the professional's scope of practice, not to need inpatient acute hospital services.
- ◆ Intensive, recovery-oriented treatment and monitoring of the person with direct or remote access to a psychiatrist or advanced registered nurse practitioner.
- ◆ An outcome-focused, interdisciplinary approach designed to return the person to living successfully in the community.
- ◆ Services that may be provided in a wide array of settings ranging from the person's home to a facility providing subacute mental health services.
- ◆ Services that are time limited to not exceed ten days.

Payment will be approved for services as authorized by state law and within the scope of the provider's license. Services may be provided if the following criteria are met.



1. Admission Criteria for Subacute Mental Health Care Facilities

The member must meet all of the following criteria:

- ◆ Eligibility for individualized subacute mental health services will be determined by the standardized preadmission screening used by the facility, which shall be conducted by a mental health professional, as defined in Iowa Code section 228.1(6).
- ◆ In order to be admitted, the individual must:
 - Be 18 years or older;
 - During the past year, have had a diagnosable mental, behavioral or emotional disorder that meets the diagnostic criteria specified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
 - Demonstrate a high degree of impairment through significantly impaired mental, social, or educational functioning arising from the psychiatric condition or serious emotional disturbance;
 - Demonstrate an impairment that severely limits the skills necessary to maintain an adequate level of functioning outside a treatment program and requires active treatment to obtain an adequate level of functioning;
 - Demonstrate a low level of stability through any two of the following conditions:
 - The individual presents moderate to high risk of danger to self or others.
 - The individual lacks adequate skills or social support to address mental health symptoms.
 - The individual is medically stable but requires observation and care for stabilization of a mental health condition or impairment.



2. Continued Stay Criteria for Subacute Mental Health Care Facilities

By the tenth day following admission and every ten calendar days thereafter, the mental health professional shall conduct and document an assessment of the resident and determine if:

- ◆ The severity of the behavioral and emotional symptoms continues to require the subacute level of intervention and the DSM diagnosis remains the principal diagnosis.
- ◆ The prescribed interventions remain consistent with the intended treatment plan outcomes.
- ◆ There is documented evidence of active, individualized discharge planning.
- ◆ There is a reasonable likelihood of substantial benefit in the resident's mental health condition as a result of active intervention of the 24-hour supervised program.
- ◆ Symptoms and behaviors that required admission are continuing.
- ◆ A less intensive level of care would be insufficient to stabilize the resident's condition.
- ◆ New issues that meet the admission guidelines in 441 IAC 71.13(2) have appeared.
- ◆ The resident requires further stabilization subsequent to acute care to treat active mental health symptoms such as psychosis, depression or mood disorder.

Payment will be approved for subacute mental health services provided by qualified subacute mental health facilities.

Subacute mental health services for individuals who have co-occurring or multi-occurring diagnoses focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual, without regard to which condition is primary.

Subacute mental health services are not to be denied due to the presence of a co-occurring substance abuse condition or developmental or neurodevelopmental disability.



C. REQUIREMENTS FOR SERVICE COVERAGE AND PAYMENT

1. Treatment Plan

Legal reference: [481 IAC 71.14\(135G\)](#)

A treatment plan must be developed with each resident. The plan must be:

- ◆ Based on initial and ongoing assessment of need,
- ◆ Designed to resolve the acute or crisis mental health symptoms or the imminent risk of acute or crisis mental health symptoms, and
- ◆ Completed within six hours of admission.

The treatment plan must be documented in the resident's record and must include the following:

- ◆ The resident's name.
- ◆ The date the plan is developed
- ◆ Standardized diagnostic formulations, including but not limited to, the current Diagnostic and Statistical Manual (DSM) or the current International Statistical Classification of Diseases and Related Health Problems (ICD).
- ◆ Problems and strengths of the resident that are to be addressed.
- ◆ Observable and measurable individual objectives that relate to the specific problems identified.
- ◆ Interventions that address specific objectives, identification of staff responsible for interventions, and planned frequency of interventions.
- ◆ Signatures of mental health professionals responsible for developing the plan, including the qualified prescriber.
- ◆ Signatures of the resident and any parent, guardian, conservator, or legal custodian. Reasons for refusal to sign or inability to participate in treatment plan development must be documented.
- ◆ A projected discharge date and anticipated post-discharge needs, including documentation of resources needed in the community.



- ◆ Review of the treatment plan by the appropriate treatment staff at least daily and upon completion of the stated goals or objectives and documentation of the following:
 - Progress toward each treatment objective, with revisions as indicated; and
 - Status of discharge plans, including availability of resources needed by the resident in the community, with revisions as indicated.

2. Documentation

Legal reference: [441 IAC 79.3\(249A\)](#)

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

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

a. Medical Record

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

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

- ◆ Reason for discharge.
- ◆ Date of discharge.
- ◆ Recommended action or referrals upon discharge.
- ◆ Treatment progress and outcomes.

The discharge summary shall be included in the member's record within 72 hours of discharge.



b. Progress Notes

The provider's file for each Medicaid member must include progress notes for each date of service that details specific services rendered related to the covered subacute mental health service for which a claim is submitted.

The following items must be included in each progress note entry, for each Medicaid member, 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 actually rendering service, as well as that person's signature.
- ◆ A description of the specific components of the Medicaid-payable behavioral health intervention service being provided (using service description terminology from this manual).
- ◆ The nature of contact, relative to the Medicaid-payable service that was rendered. The progress note must describe what specifically was done, relative to both:
 - The goal as stated in the member's treatment plan or implementation plan, and
 - How the behavioral health intervention service provided addressed the symptoms or behaviors resulting from the member's psychological disorder.
- ◆ The place or location where service was actually rendered.
- ◆ The nature, extent, and number of units billed.
- ◆ Progress notes shall include the progress and barriers to achieving:
 - The goals stated in the treatment plan, and
 - The objectives stated in the implementation plan.



D. DEFINITIONS

"Assessment" means the evaluation of a person in psychiatric crisis in order to determine the person's:

- ◆ Current and previous level of functioning,
- ◆ Psychiatric and medical history,
- ◆ Potential for dangerousness,
- ◆ Current psychiatric and medical condition factors contributing to the crisis, and
- ◆ Support systems that are available.

"Face-to-face" means services provided in person or using telehealth in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

"Informed consent" refers to time-limited, voluntary consent. The individual using the service or the individual's legal guardian may withdraw consent at any time without risk of punitive action. "Informed consent" includes:

- ◆ A description of the treatment and specific procedures to be followed,
- ◆ The intended outcome or anticipated benefits,
- ◆ The rationale for use,
- ◆ The risks of use and nonuse, and
- ◆ The less restrictive alternatives considered.

The individual using the service or the legal guardian has the opportunity to ask questions and have them satisfactorily answered.

"Licensed health care professional" means:

- ◆ A person licensed under Chapter 148 to practice medicine and surgery or osteopathic medicine and surgery,
- ◆ An advanced registered nurse practitioner licensed under Chapter 152 or 152E, or
- ◆ A physician assistant licensed to practice under the supervision of a physician as authorized in Chapters 147 and 148C.

"Mental health crisis" means a behavioral, emotional, or psychiatric situation which results in a high level of stress or anxiety for the individual or persons providing care for the individual and which cannot be resolved without intervention.



"Mental health professional" means an individual who has either of the following qualifications:

- ◆ The individual meets all of the following requirements:
 - The individual holds at least a master's degree in a mental health field, including but not limited to, psychology, counseling and guidance, nursing, and social work, or is an advanced registered nurse practitioner, a physician assistant, or a physician and surgeon or an osteopathic physician and surgeon.
 - The individual holds a current Iowa license if practicing in a field covered by an Iowa licensure law.
 - The individual has at least two years of post-degree clinical experience, supervised by another mental health professional, in assessing mental health needs and problems and in providing appropriate mental health services.
- ◆ The individual holds a current Iowa license if practicing in a field covered by an Iowa licensure law and is:
 - A psychiatrist,
 - An advanced registered nurse practitioner who holds a national certification in psychiatric mental health care and is licensed by the board of nursing,
 - A physician assistant practicing under the supervision of a psychiatrist, or
 - An individual who holds a doctorate degree in psychology and is licensed by the board of psychology.

E. BASIS OF PAYMENT

See [PROCEDURE CODES AND NOMENCLATURE](#) for details on the basis of payment for subacute mental health services.

F. PROCEDURE CODES AND NOMENCLATURE

Covered procedure codes are located at:

https://dhs.iowa.gov/sites/default/files/Crisis_Response_and_Subacute_Mental%20Health_Services_Fee_Schedule.pdf



G. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for subacute mental health services are billed on federal form UB-04, *Health Insurance Claim Form*.

MHSA Fee Schedule Service	Chapter 24 Service Title	Procedure Code	Specialty Modifiers	Location of Service Modifier	Certified Service Modifier	Unit of Service	Revenue Code	Claim Type
Subacute Mental Health Services	Chapter 71 License	H2013				Per diem 8 to 24 hours	0190	UB-04

Click [here](#) to view a sample of the UB-04

Click [here](#) to view billing instructions for the UB-04

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>

NOTE: The beginning and ending time recorded in the progress notes must match the units billed on the claim for that date of service.

When billing the IME for subacute mental health services a valid ICD-10 mental health diagnosis code must be entered on the claim form in addition to the procedure and revenue code. Claims billed without a valid mental health diagnosis code will be denied.

Each Managed Care Organization (MCO) uses their own claims payment system and may have billing procedures which vary from FFS policy. It is important that providers review the MCO's claims instructions and submit claims for payment in accordance with the MCO's policies.