

Habilitation Services

Provider Manual





Iowa
Department
of Human
Services

Provider
Habilitation Services

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Date
June 1, 2014

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

Requirements for providers eligible to enroll under the category “home- and community-based habilitation services” vary depending on the service to be provided. Below is a list of services available and the requirements needed to provide services.

1. Case Management

Case management providers must be accredited under 441 Iowa Administrative Code (IAC) Chapter 24.

2. Home-Based Habilitation

Home-based habilitation providers must meet any of the following:

- ◆ Certified by the Department of Human Services (DHS or Department) to provide supported community living (SCL) under the HCBS intellectual disability (ID) waiver or the brain injury (BI) waiver.
- ◆ Certified under 441 IAC Chapter 24 to provide supported community living.
- ◆ Accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.
- ◆ Accredited by the Council on Accreditation of Services for Families and Children (COA).
- ◆ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ◆ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).



3. Day Habilitation

Day habilitation providers must meet any of the following:

- ◆ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation.
- ◆ Accredited by CARF to provide a different service, but since the last accreditation survey has begun providing services that qualify as day habilitation. When the current accreditation runs out:
 - The new CARF accreditation must include services that qualify as day habilitation, or
 - The provider must become accredited under one of the other accreditation options.
- ◆ Not accredited by CARF, but has applied for CARF accreditation. The accreditation process must be completed within 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.
- ◆ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ◆ Not accredited by CQL, but has applied for CQL accreditation. The accreditation process must be completed within 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.
- ◆ Certified under 441 IAC Chapter 24 to provide day treatment or supported community living services.
- ◆ Certified by DHS to provide day habilitation under the HCBS intellectual disability (ID) waiver.
- ◆ Accredited by the International Center for Clubhouse Development (ICCD).
- ◆ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).



4. Prevocational Habilitation

Prevocational habilitation providers must meet any of the following:

- ◆ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as an organizational employment service provider or community employment service provider.
- ◆ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ◆ Accredited by the International Center for Clubhouse Development (ICCD).
- ◆ Certified by the Department to provide prevocational services under the HCBS intellectual disability waiver or brain injury waiver.

5. Supported Employment Habilitation

Supported employment habilitation providers must meet any of the following:

- ◆ Certified by the Department to provide supported employment services under the HCBS intellectual disability waiver or brain injury waiver.
- ◆ Certified under 441 IAC Chapter 24 to provide supported community living services.
- ◆ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as an organizational employment service provider or community employment service provider.
- ◆ Accredited by the Council on Accreditation of Services for Families and Children (COA).
- ◆ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ◆ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- ◆ Accredited by the International Center for Clubhouse Development (ICCD).



B. PROVIDER ENROLLMENT

Providers eligible to participate must become enrolled with the Iowa Medicaid Enterprise (IME). To enroll with the IME, providers must first be enrolled in the Iowa Plan for Behavioral Health Provider Network.

Iowa Plan for Behavioral Health Public Sector Network Department
2600 Westown Parkway, Ste 200
West Des Moines, IA 50266
Group/Individual: (800) 638-8820, ext. 85051
Organization: (800) 638-8820, ext. 85048
Fax: (888) 656-5163

To obtain enrollment forms from the IME, contact the IME Provider Enrollment Unit at (800) 338-7909 (option 2), locally in Des Moines at (515) 256-4609, or by email at: imeproviderservices@dhs.state.ia.us. Enrollment forms are also available on the IME web site at: <http://dhs.iowa.gov/ime/providers/enrollment>

Complete all of the following forms:

- ◆ *Provider Enrollment Application*, form 470-0254. Click [here](#) to view a sample of the form.
- ◆ Iowa Medicaid Provider Agreement General Terms, form 470-2965. Click [here](#) to view a sample of the form.
- ◆ IRS W9 form. Click [here](#) to view a sample of the form.

Attach documentation showing how the accreditation or certification requirements are met. Typically this can be in the form of a copy of an accreditation certificate or a letter from the accrediting body.

Applications for providers of home-based habilitation or day habilitation that are not yet accredited but have applied for accreditation with one of the listed accrediting bodies will have 12 months to complete the accreditation process.



Any time an accreditation or certification expires, the provider must renew the accreditation or become accredited through one of the other options for the service to be provided. A provider, whose certification lapses, will no longer be considered a qualified provider.

Each provider shall provide the IME Provider Services Unit with the current address of the provider's primary location and any satellite offices or other locations where habilitation services are provided. 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, or
- ◆ Other changes occur that affect the accuracy of the provider enrollment information.

1. Provider Requirements

As a condition of enrollment, providers of habilitation services must:

- ◆ Comply with requirements regarding organization and staff as set forth at 441 IAC 77.25(2). This includes:
 - Completing child abuse, dependent adult abuse, and criminal history record checks on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 249A.29.
 - Ensuring that direct care staff are at least 16 years of age.
 - Ensuring that direct care staff do not provide services to their immediate family members.
- ◆ Comply with requirements for incident management and reporting as set forth at 441 IAC 77.25(3).
- ◆ Comply with requirements for restraint, restrictions, and behavioral intervention as set forth at 441 IAC 77.25(4). This includes:
 - Providers that do not use restraint, restrictions or behavioral intervention must have a written policy stating this.
 - Members and their legal guardians must be informed about the provider's policy and procedures.
 - Restraint, restriction, and behavioral intervention may be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.



- Procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a non-aversive program.
- Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- ◆ Follow standards in 441 IAC 79.3(249A) for service documentation and maintenance of fiscal and clinical 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, complies with the requirements that apply to the enrolled provider.

2. Setting Requirements

The state plan HCBS is furnished to members who reside in their home or in the community, not in an institution. Each member receiving state plan HCBS:

- ◆ Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services, or
- ◆ Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the state and approved by CMS.

All residential settings where habilitation services are provided must document the following in the member's person-centered service or treatment plan:

- ◆ The setting is integrated in, and facilitates the member's full access to, the greater community, including opportunities to:
 - Seek employment and work in competitive integrated settings,
 - Engage in community life,
 - Control personal resources, and
 - Receive services in the community, like individuals without disabilities;
- ◆ The setting is selected by the member among all available alternatives and identified in the person-centered service plan;



- ◆ A member's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- ◆ Member initiative, autonomy, and independence in making major life choices, including but not limited to:
 - Daily activities,
 - Physical environment, and
 - With whom to interact are optimized and not regimented; and
- ◆ Member choice regarding services and supports, and who provides them, is facilitated.

Residential settings that are provider-owned or provider-controlled or operated including licensed residential care facilities (RCF) for 16 or fewer persons must document the following in the member's person-centered service or treatment plan:

- ◆ The setting is integrated in, and facilitates the member's full access to, the greater community, including opportunities to:
 - Seek employment and work in competitive integrated settings,
 - Engage in community life,
 - Control personal resources, and
 - Receive services in the community, like individuals without disabilities;
- ◆ The setting is selected by the member among all available alternatives and identified in the person-centered service plan;
- ◆ An member's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- ◆ Member initiative, autonomy, and independence in making major life choices, including but not limited to:
 - Daily activities,
 - Physical environment, and
 - With whom to interact are optimized and not regimented;
- ◆ Member choice regarding services and supports, and who provides them, is facilitated;
- ◆ Any modifications of the conditions (for example to address the safety needs of a member with dementia) must be supported by a specific assessed need and documented in the person-centered service plan;



- ◆ The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord and tenant laws of the state, county, city, or other designated entity;
- ◆ Each member has privacy in their sleeping or living unit;
- ◆ Units have entrance doors lockable by the member, with only appropriate staff having keys to doors;
- ◆ Members sharing units have a choice of roommates in that setting;
- ◆ Members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
- ◆ Members have the freedom and support to control their own schedules and activities, and have access to food at any time;
- ◆ Members are able to have visitors of their choosing at any time; and
- ◆ The setting is physically accessible to the member.

C. MEMBERS ELIGIBLE TO RECEIVE SERVICES

Medicaid members may receive habilitation services when they meet the following requirements:

1. Financial Eligibility

The member's countable income used in determining Medicaid eligibility must not exceed 150 percent of the federal poverty level. The member's DHS income maintenance worker does the poverty-level calculation at the time Medicaid eligibility is determined.

The member must be eligible for Medicaid under one of the existing coverage groups (for example: SSI-disabled, CMAP, MEPD, etc.). Each coverage group may have its own rules for determining countable income. The income maintenance worker will apply those rules when determining Medicaid eligibility.

This income limit is set in federal law. Therefore, the Department cannot change the limit or grant an exception to it.



2. Member Enrollment for Members Not Eligible to Enroll in the Iowa Plan for Behavioral Health

The enrollment process is initiated by the case manager or member and typically follows these steps:

- ◆ The case manager makes a request for habilitation services through ISIS by going to the “Add/Cancel Program” tab in ISIS, entering the required information, and clicking the “Initiate Program” button.
- ◆ ISIS then checks for Medicaid eligibility and that the member meets the income limit (see [Financial Eligibility](#)). If financial eligibility cannot be determined, ISIS sends a message to the income maintenance worker asking the worker to enter the correct poverty level for the person. If this happens, the case manager should wait a week before trying again.
- ◆ After Medicaid eligibility and financial eligibility are confirmed, the slot manager for IME checks for slot availability. If no slot is available, the member is placed on the waiting list.
- ◆ For adults, the county of legal settlement is determined.
- ◆ The case manager completes an assessment of the members functioning and submits it to the IME Medical Services Unit (see [Assessment](#)). IME will make the determination of whether or not the member meets the needs-based criteria (see [Need for Service](#)). In some cases, the reviewer may ask for more information.
- ◆ If the member is determined eligible, the case manager then uses the same assessment to develop the Individual Comprehensive Plan with the member’s interdisciplinary team (see [Comprehensive Service Plan](#)).
- ◆ The case manager then enters the member’s service plan information into ISIS.
- ◆ The IME Medical Services Unit reviews the service plan information for authorization (see [Service Authorization](#)).
- ◆ ISIS sends a notification to the case manager and the county CPC for an adult.
- ◆ The case manager sends a *Notice of Decision* to the member and the member’s service providers to notify them of the approved services.



3. Enrollment for Enrollees into the Iowa Plan for Behavioral Health

To enroll in the Iowa Plan for Behavioral Health for habilitation services, the case manager or integrated health home coordinator should contact Magellan at (800) 638-8820 to request an appointment to review a new habilitation request.

4. Need for Service

The member must be in need of habilitation services as demonstrated by meeting the following functional criteria.

The member meets at least one of the following risk factors:

- ◆ The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).
- ◆ The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

“Psychiatric treatment” and “history of psychiatric illness” refer to conditions where diagnosis is typically made and treatment is typically ordered by a psychiatrist, but do not include primary diagnoses of intellectual disability, developmental disability, dementias or substance abuse.

However, diagnoses of intellectual disability, developmental disability, dementia, or substance abuse are acceptable as co-occurring disorders. Substance-abuse-induced disorders are not considered psychiatric illness.

In addition, the member has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

- ◆ The member is unemployed or employed in a sheltered setting or has markedly limited skills and a poor work history.
- ◆ The member requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.



- ◆ The member shows severe inability to establish or maintain a personal social support system.
- ◆ The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- ◆ The member exhibits inappropriate social behavior that results in demand for intervention.

The IME Medical Services Unit determines the need for service based on an assessment done by the case manager or integrated health home coordinator. See [Assessment](#) for more information.

5. Assessment

The case manager or integrated health home coordinator must complete an assessment of the member's current functioning, including the member's situation, needs, strengths, abilities, desires, and goals.

Any assessment that meets the standards in 441 IAC 24.4(2) may be used. The assessments used by case management providers accredited under 441 IAC Chapter 24 meet this standard, so the case manager can use the same assessment as is used for case management.

The case manager or integrated health home coordinator submits the comprehensive functional assessment to the IME Medical Services Unit by fax at: (515) 725-0931. Please be sure the assessment is clearly marked for habilitation services. Case managers and integrated health home coordinators may also send a social history as an attachment if it is felt that additional information is needed.

Habilitation questions for the Medical Services Unit may be sent by email to: habilitationservices@dhs.state.ia.us. Do **not** use this email address to submit assessments. Contact the IME Medical Services Unit by phone at (800) 383-1173, or locally in the Des Moines at (515) 256-4623.

The IME Medical Services Unit will respond to initial assessments within two business days and will respond to annual reviews within five business days. In some cases, the reviewer may ask for additional information to be sent.



6. Comprehensive Service Plan

Services must be included in a comprehensive person-centered service plan. The comprehensive person-centered service plan must be developed through a person-centered planning process driven by the member in collaboration with the member's interdisciplinary team, as established with the case manager or integrated health home coordinator.

The member's comprehensive service plan must be updated at least annually and when a change in the member's circumstances or needs change significantly, and at the request of the member.

The comprehensive person-centered service plan:

- ◆ Includes people chosen by the member.
- ◆ Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible.
- ◆ Is timely and occurs at times and locations of convenience to the member.
- ◆ Reflects cultural considerations and uses plain language.
- ◆ Includes strategies for solving disagreements.
- ◆ Offers choices to the member regarding services and supports the member receives and from whom.
- ◆ Provides a method to request updates.
- ◆ Is conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
- ◆ Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.
- ◆ May include whether and what services are self-directed.
- ◆ Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others.
- ◆ Includes risk factors and plans to minimize them.
- ◆ Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative.



The HCBS-written, person-centered service plan documentation:

- ◆ Reflects the member's strengths and preferences.
- ◆ Reflects clinical and support needs.
- ◆ Includes observable and measureable goals and desired outcomes:
 - Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate; and
 - Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
- ◆ Identifies for a member receiving home-based habilitation:
 - The member's living environment at the time of enrollment,
 - The number of hours per day of on-site staff supervision needed by the member, and
 - The number of other members who will live with the member in the living unit.
- ◆ Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS including:
 - Name of the provider
 - Service authorized
 - Units of service authorized
- ◆ Includes risk factors and measures in place to minimize risk.
- ◆ Includes individualized backup plans and strategies when needed:
 - Identifying any health and safety issues applicable to the member based on information gathered before the team meeting, including a risk assessment.
 - Identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
 - Including applicable services providers shall administer for emergency backup staff.
- ◆ Includes individuals important in supporting the member.
- ◆ Includes the names and signatures of the individuals and providers responsible for monitoring the service plan.



- ◆ Is written in plain language and understandable to the member.
- ◆ Documents the informed consent of the member for any restrictions on the member's rights, including:
 - Maintenance of personal funds and self-administration of medications,
 - The need for the restriction, and
 - Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- ◆ Any rights or restrictions must be implemented in accordance with 441 IAC 77.25(4).
- ◆ Is distributed to the member and others involved in the service plan.
- ◆ Includes purchase and control of self-directed services.
- ◆ Excludes unnecessary or inappropriate services and supports staff.

NOTE: The member's case manager or integrated health home coordinator prepares the comprehensive person-centered service plan. HCBS habilitation service providers must complete their own service plan that provides detailed information on how they will implement the services for the member. These plans must reflect the comprehensive person-centered service plan and comply with the provider's licensure and accreditation requirements as applicable.

7. Service Authorization

a. Members Enrolled in the Iowa Plan for Behavioral Health

Following the IDT meeting and development of the comprehensive service plan, the case manager or integrated health home coordinator contacts Magellan to schedule a service authorization appointment.

The case manager or integrated health home (IHH) staff should contact Magellan at (800) 638-8820.



b. **Members Not Enrolled in the Iowa Plan for Behavioral Health**

Following the IDT meeting and when the comprehensive service plan is complete, the case manager is responsible for entering service plan information in ISIS, including the:

- ◆ Services selected,
- ◆ Effective dates of the services,
- ◆ Provider selected, and
- ◆ Number of units of each service needed per month.

The IME Medical Services Unit must authorize the habilitation services before services may be provided. The IME Medical Services Unit will respond (authorize, deny, or request additional information) to the plan in ISIS.

A provider may bill only for dates of service on or after the effective date of the service plan. Plans may be authorized only for a maximum of 12 months.

8. **ISIS Instructions for Case Managers for Members Not Enrolled in the Iowa Plan for Behavioral Health**

a. **Opening the Case**

Habilitation cases should be started in “pending” status until the assessment is approved. To open a pending case in ISIS:

- ◆ Go to the “Add/Cancel Program” tab.
- ◆ Enter the member’s state identification number (Medicaid number) in the “State ID” field.
- ◆ Do **not** enter a beginning date in the “Program Start Date” field. Leave this field blank.
- ◆ Select habilitation services from the “Program” drop-down box.
- ◆ Click the “Initiate Program” button.
 - If the member is not Medicaid-eligible, ISIS displays a message stating, “Member is not Medicaid eligible. Refer member to apply for Medicaid.” Contact the member’s income maintenance worker if there are any questions about eligibility status.



- If ISIS displays an error message stating, "The percent of poverty level is missing or is 000 or 999," this means that the calculation of federal poverty level that the income maintenance worker enters is blank or is either 000 or 999. These are generic codes that don't give the real poverty level.

When this occurs, ISIS sends a message to the income maintenance worker asking them to enter the correct poverty level calculation in the ABC system. It may take up to a week for this to be entered and be transferred over to ISIS. When the income maintenance worker receives this message, wait a week and try again.

Knowing the poverty level is necessary for ISIS to start the case, because the federal law that authorizes the habilitation services program limits eligibility to members at or below 150 percent of the federal poverty level (see [Financial Eligibility](#)).

- If the member is eligible for Medicaid and meets financial eligibility, ISIS begins the Program Request and initiates a milestone for the case manager asking, "You have requested Habilitation Services. Do you want to continue?"

b. Habilitation Services Workflow

This description of workflow is specific to habilitation services. For general instructions on how to respond to ISIS milestones, please see the *ISIS User's Guide* ([DHS Employees' Manual, Chapter 14-M](#)).

After the case manager confirms that the case should continue, ISIS generates a milestone to the case manager asking, "Is this consumer a minor or an adult?" This milestone determines whether legal settlement determination milestones need to be completed.

- ◆ If the member is 18 years of age or older, the case manager should choose the "Adult" response.
- ◆ For adults, legal settlement determination milestones are sent to the county central point of coordination administrator and, when necessary, to the legal settlement arbitrator for the Department. If the member is 17 years of age or younger, the case manager should choose the "Minor" response.



- ◆ ISIS generates a milestone to the case manager stating, “Complete assessment and send to IME Medical Services” (see [Assessment](#)). When the assessment has been sent, the case manager should choose the “completed” response.
- ◆ ISIS generates a milestone for the IME Medical Services reviewer to enter the assessment decision. Possible responses include:
 - **OK.** This response indicates that the assessment shows that the member meets program eligibility criteria (see [Need for Service](#)).
 - **Denied.** This response indicates that the assessment shows that the member does not meet program eligibility criteria. It generates a milestone to the case manager stating, “Services have been denied. Send NOD. Check for other services.”
 - **Physician Review.** This response indicates that it is not clear from the assessment information whether or not the member meets program eligibility criteria. An independent physician will review the information and make a recommendation. This option generates another “Enter Assessment Decision” milestone that can then be approved or denied.
 - **Assessment Not Received.** If the assessment has not been received after seven days, this response will generate a milestone for the case manager that states, “Assessment was not received. Please resend to Medical Services.” This option also generates another “Enter Assessment Decision” milestone that can then be approved or denied.
- ◆ When the IME Medical Services Unit has approved program eligibility, ISIS sends the case manager a milestone stating, “Complete Individual Comprehensive Plan.” When the interdisciplinary team has met and developed the comprehensive service plan (see [Comprehensive Service Plan](#)), the case manager can select the “completed” response.



- ◆ ISIS generates a milestone for the case manager stating “Complete Service Plan Entries.” The case manager should then enter the services from the comprehensive service plan in ISIS. The general procedure for entering service plans is outlined in the [ISIS User's Guide](#), with the following exceptions:
 - When entering habilitation services, the case manager does not enter the provider's rate. When the provider number is added for the selected service, ISIS looks up that provider's rate for the corresponding procedure code and enters it automatically.
 - If a rate is displayed as \$0.00, the provider does not have an established rate for that procedure code. Check with the provider to obtain the correct provider number for that service. If a provider's rate has just been approved, it may take a week for it to be loaded into ISIS.
 - If a provider's rate changes after a plan is already approved, the case manager does not need to change the rate in ISIS. When a new rate is loaded in ISIS, service plans are automatically updated with the new rate.
 - When a valid service plan has been entered, ISIS generates a milestone to the IME Medical Services Unit to authorize the plan. The Medical Services Unit checks the plan to see if the services are appropriate based on the assessment information previously submitted by the case manager.

The Medical Services Unit may respond by notifying the case manager that plan changes are needed. Information about these changes will be in the “notes” shown on the status page.

ISIS will generate another “Complete Service Plan Entries” milestone for the case manager to answer when the changes are complete.

- ◆ When the service plan is either authorized or denied, ISIS sends a notification milestone to the case manager. The case manager then issues the appropriate *Notice of Decision* to the member, with a copy to the providers.



c. Making a Pending Case Active

After the assessment date has been added on a pending case, the provider must make the case active:

- ◆ Go to the "Add/Cancel program" tab.
- ◆ Enter the member's state identification number.
- ◆ Enter the begin date (making sure it is on or after the assessment date shown in the service plan).
- ◆ Pick "Habilitation Services" from the dropdown menu.
- ◆ Click the "Initiate Program" button.

ISIS will then add the begin date to the program request that has already been started.

d. Closing a Case

To close a habilitation services case in ISIS:

- ◆ Go to the "Add/Cancel Program" tab.
- ◆ Click on the "Cancel Consumer" link.
- ◆ Enter the member's state identification number (Medicaid number) in the "State ID" field.
- ◆ Enter the date services will end in the "Program End Date" field.
- ◆ Select "Habilitation Services" from the "Program" drop-down box.
- ◆ Click the "Cancel Program" button.

e. Reopening a Closed Habilitation Services Case

Losing Medicaid eligibility for brief periods of time is a common occurrence for some members who are eligible through the MEPD or Medically Needy eligibility groups. This typically happens when Medicaid eligibility is determined at the beginning of a month and the member becomes ineligible because the MEPD premium has not yet been paid or the Medically Needy spenddown has not been met.



When Medicaid eligibility is lost, ISIS automatically closes the case. If Medicaid eligibility for the month is regained when the premium is paid or the spenddown is met, the case must be reopened in ISIS in order for habilitation services to continue. To reopen the case:

- ◆ Go to the “Add/Cancel Program” tab in ISIS and start a new program request in the same manner as when opening a new case.
- ◆ When entering the beginning date in the “Program Start Date” field, make sure the date is one day after the date the original program request ended.
- ◆ ISIS then merges the new program request with the one that was previously closed and the program will continue uninterrupted.

Example: Mr. Doe is receiving habilitation services in April. On May 1, he has not yet paid his MEPD premium and he does not become eligible for Medicaid for the month of May. ISIS automatically closes the habilitation services program request with an end date of April 30.

On May 15, Mr. Doe’s premium is received and his Medicaid eligibility is granted retroactively to May 1. Mr. Doe’s case manager enters a habilitation services program request in ISIS with a beginning date of May 1. ISIS automatically reopens the previous program request and removes the end date.

D. COVERED SERVICES

For all habilitation services, the member must have a need for this type of support and the need must be identified in the member’s comprehensive service plan. The provider’s documentation needs to state how the service is related to the member’s goal as well as the member’s response to the service.

Habilitation services provided under Iowa Medicaid to members include the following.



1. Case Management

Case management assists members in gaining access to needed home- and community-based habilitation services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. This includes the following activities:

- ◆ Explaining the member's right to freedom of choice.
- ◆ Assuring that all unmet needs of the member are identified in the comprehensive service plan.
- ◆ Explaining to the member what abuse is and how to report abuse.
- ◆ Explaining to the member how to make a complaint about the member's services or providers.
- ◆ Monitoring the comprehensive service plan, with review occurring regularly.
- ◆ Assessing and monitoring the member and their situation following a major or critical incident.
- ◆ Meeting with the member face-to-face at least quarterly.
- ◆ Assessing and revising the comprehensive service plan at least annually to determine achievement, continued need, or change in goals or intervention methods. The review shall include the member and shall involve the interdisciplinary team as listed in the person-centered service planning section.
- ◆ Notifying the member of any changes in the service plan by sending the member a notice of decision. When the change is an adverse action such as a reduction in services, the notice shall be made 30 days before the change and shall include appeal rights.

Case management may only be provided as a service through the habilitation program to a member who is not enrolled in an integrated health home and is not authorized to receive Medicaid targeted case management under 441 IAC Chapter 90.



2. Home-Based Habilitation

Home-based habilitation consists of individualized services and supports that assist with the acquisition, retention, or improvement in skills related to living in the community.

These services are provided in the member's home or community and assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and can be provided at any time of day or night that is necessary to meet the member's needs. This includes the following supports:

- ◆ Adaptive skill development
- ◆ Assistance with activities of daily living
- ◆ Community inclusion
- ◆ Transportation (except to and from a day program)
- ◆ Adult educational supports
- ◆ Social and leisure skill development
- ◆ Personal care
- ◆ Protective oversight and supervision

Example: Mr. Doe needs help with cooking and laundry skills. Provider staff come to his apartment for an hour in the daytime and an hour in the evening to assist him in gaining cooking skills. Staff also work with Mr. Doe on laundry skills for two hours every Saturday afternoon. These activities would be considered adaptive skill development and are reimbursable.

Example: Jane Doe's symptom of paranoia keeps her from going grocery shopping because she feels like other people in the store are spying on her. Provider staff take her grocery shopping for two hours every Wednesday afternoon. Staff assist her in using coping skills and "reality checks" to allay her feelings of paranoia. This activity includes adaptive skill development, community inclusion, and transportation and is reimbursable.

Example: Despite dealing with bipolar disorder for many years, John Doe is returning to college at his local community college. Provider staff assist him in learning appropriate behavior for that setting, and on developing time management skills. They also assist him in completing the necessary paperwork and scheduling requirements. These activities would be considered adult educational supports and are reimbursable.



Transportation is acceptable if it supports the acquisition, retention, or improvement of another skill, such as grocery shopping, getting medical care, etc.

Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

Home-based habilitation cannot be provided to members who reside in a residential facility of more than 16 beds.

Even when home-based habilitation is provided using a daily rate, it does not include room and board or maintenance costs.

Activities associated with vocational services, day care, medical services, or case management cannot be included in home-based habilitation.

Example: Even when done in a member's home, providing assistance in completing a job application would be a vocational service, not a home-based habilitation service, and would not be allowed.

Example: Assisting a member in making a medical appointment or calling in a refill for a prescription would be providing assistance with accessing medical services, but are **not** medical services themselves, and would be allowed.

3. Day Habilitation

Provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help; socialization and adaptive skills that enhance social development; and development of skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the member's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).



Day habilitation services focus on enabling the member to attain or maintain the member's maximum potential and shall be coordinated with any needed therapies in the member's person-centered services and supports plan, such as physical, occupational, or speech therapy.

- ◆ Personal care and assistance may be a component part of day habilitation services as necessary to meet the needs of a member, but may not comprise the entirety of the service.
- ◆ Members who receive day habilitation services may also receive educational, supported employment, and prevocational services. A member's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.
- ◆ Day habilitation services may be furnished to any member who requires and chooses them through a person-centered planning process.
- ◆ For members with degenerative conditions, day habilitation may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills.
- ◆ Day habilitation services may also be used to provide supported retirement activities. As some people get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs or other senior-related activities in their communities.

Services must enhance or support the member's:

- ◆ Intellectual functioning.
- ◆ Physical and emotional health and development.
- ◆ Language and communication development.
- ◆ Cognitive functioning.
- ◆ Socialization and community integration.
- ◆ Functional skill development.
- ◆ Behavior management.
- ◆ Responsibility and self-direction.
- ◆ Daily living activities.
- ◆ Self-advocacy skills.
- ◆ Mobility.



Example: Jane Doe has difficulty in recognizing appropriate physical boundaries and often stands too close to others, violating their sense of personal space. Provider staff work with Jane to help her learn appropriate boundaries, and redirect her when this behavior occurs. This would be considered behavior management, and is a reimbursable service.

Example: John Doe tends to isolate himself and has very little interaction with other people. Provider staff at his day habilitation program help John with learning social skills assisting him with participating in activities in the community where he can practice using these skills with staff assistance. This would be considered socialization and community integration, and is a reimbursable service.

Example: A day habilitation provider takes a group of five members to a local festival. Two members have goals in their comprehensive service plans that involve increasing socialization and community inclusion; the other three do not have an identified need for this.

This activity would be considered socialization and community integration and would be reimbursable for the two members with a need for this support identified in their comprehensive service plan, but would not be reimbursable for the other three members.

Day habilitation may be furnished in any of a variety of settings in the community. Day habilitation services are not limited to fixed-site facilities, however, services cannot be provided in the member's residence. If the member lives in a residential facility of more than 16 persons, day habilitation can be provided in an area of the facility that is apart from the member's sleeping accommodations, such as a common room where residents normally congregate.

Transportation between the member's place of residence and the day habilitation site, or other community settings, in which the service is delivered, is provided as a component of day habilitation services and the cost of this transportation is included in the rate paid to providers of day habilitation services.



Day habilitation is:

- ◆ Delivered in accordance with an approved comprehensive person-centered service plan which identifies the specific skills training and assistance to be provided and the amount and frequency with which it will be provided.
- ◆ Coordinated with any needed therapies in the member's comprehensive service plan, such as physical therapy, occupational therapy, or speech therapy.
- ◆ The provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence, sleeping accommodations or other residential living arrangement.
- ◆ Face-to-face skill development training and supports, such as:
 - Assistance with the acquisition, retention, or improvement of self-help,
 - Socialization and adaptive skills that enhance activities of daily living, and
 - Social development and community participation.
- ◆ An organized program of activities designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.
- ◆ Designed and delivered in a manner that is individualized and focused on enabling the member to attain or maintain the member's maximum potential.
- ◆ Provided and documented in accordance with 441 IAC Chapters 77, 78, and 79.

Day habilitation is not:

- ◆ Supervision or protective oversight.
- ◆ Indirect services such as meetings, documentation or collateral contacts.
- ◆ Payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).
- ◆ Payment for services provided in a residential care facility (RCF) that the RCF is required to provide as a condition of licensure.
- ◆ Payment for services that duplicates services which are provided by the Department of Education.
- ◆ Available to Intellectual Disability Waiver members under the age of 16.



4. Prevocational Habilitation

Services that provide learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the member and the member's service and supports planning team through an ongoing person-centered planning process.

Members receiving prevocational services must have employment-related goals in their person-centered services and supports plan. The general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.

Prevocational services should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills. Examples include, but are not limited to:

- ◆ Ability to communicate effectively with supervisors, co-workers, and customers.
- ◆ Generally accepted community workplace conduct and dress.
- ◆ Ability to follow directions.
- ◆ Ability to attend to tasks.
- ◆ Workplace problem solving skills and strategies.
- ◆ General workplace safety and mobility training.



Participation in prevocational services is not a required pre-requisite for member or small group supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.

Documentation is maintained in the member's case file that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Prevocational services may be furnished in a variety of locations in the community and are not limited to fixed-site facilities.

Prevocational services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.

Vocational services are services that teach job task-specific skills required by a member for the primary purpose of completing those tasks for a specific facility-based job and are not delivered in an integrated work setting through supported employment. Vocational services are not covered through waivers.

The distinction between vocational and prevocational services is that prevocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. These goals are described in the member's person-centered services and supports plan and are designed to teach skills that will lead to integrated competitive employment.

A member receiving prevocational services may pursue employment opportunities at any time to enter the general work force. Prevocational services are intended to assist members to enter the general workforce.



Members participating in prevocational services may be compensated in accordance with applicable federal laws and regulations. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

All prevocational and supported employment service options should be reviewed and considered as a component of an member's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the member. These services and supports should be designed to support successful employment outcomes consistent with the member's goals.

Personal care and assistance may be a component of prevocational services, but may not comprise the entirety of the service.

Members who receive prevocational services may also receive educational, supported employment, and day habilitation services. A member's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

Prevocational services may include volunteer work, such as learning and training activities that prepare a member for entry into the paid workforce.

Prevocational services may be furnished to any member who requires and chooses them through a person-centered planning process. They are not limited to persons with intellectual or developmental disabilities.

Example: Due to his chronic schizophrenia, John Doe has never been employed. He has difficulty getting up on time and dressing appropriately for a work setting. Provider staff come to his home for an hour each morning on Monday through Friday to help him in acquiring these skills. He then attends a sheltered workshop where he assembles widgets for four hours per day.

The hour of staff assistance each morning is an acceptable prevocational service and is reimbursable. Assembling widgets at the workshop is vocational, not prevocational, and is not reimbursable.



Example: Jane Doe attends a sheltered workshop where she works assembling widgets four hours per day. For two of those hours, provider staff work with her on maintaining concentration and task completion. For the other two hours, she works under staff supervision, but is not involved in any prevocational skills training activity.

The two hours that staff assist her are acceptable as a prevocational service and are reimbursable. The remaining time is not prevocational and not reimbursable.

The member cannot be paid from Medicaid funds for work performed while receiving prevocational services. If a provider chooses to compensate a member for such work, the provider must use non-Medicaid funding such as revenues from a third party contract to pay the member. The provider of prevocational services must be able to document the funding source of the member's wages from work performed.

Prevocational services are designed to be provided for a limited time in order to prepare a member for employment. If a member has been receiving prevocational services for more than one year and is not ready for regular employment, the interdisciplinary team should re-evaluate the necessity of prevocational services and explore other service options to meet the member's vocational needs, if necessary.

5. **Supported Employment Individual Employment (SEIE) Habilitation**

SEIE supports may be furnished to any member who requires and chooses them through a person-centered planning process. They are not limited to persons with intellectual or developmental disabilities.

SEIE support services are the ongoing supports to members who, because of their disabilities, need intensive ongoing support to obtain and maintain employment. Supports are provided to members employed in a competitive or customized job, or to members who are self-employed. Members shall be integrated into the general workforce and compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.



Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for members with mental illness, or customized employment for members with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.

SEIE supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services:

- ◆ Vocational or job-related discovery or assessment,
- ◆ Person-centered employment planning,
- ◆ Job placement,
- ◆ Job development,
- ◆ Negotiation with prospective employers,
- ◆ Job analysis,
- ◆ Job carving,
- ◆ Training and systematic instruction,
- ◆ Job coaching,
- ◆ Benefits support, training, and planning,
- ◆ Transportation,
- ◆ Asset development and career advancement services, and
- ◆ Other workplace support services including services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.

SEIE support is not intended for people working in mobile work crews of small groups of people with disabilities in the community. That type of work support is addressed in the core service definition for Supported Employment Small Group (Enclave) employment support.

SEIE support does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

Transportation between the member's place of residence and the employment site is a component part of SEIE support services and the cost of this transportation is included in the rate paid to providers of SEIE support services.



SEIE supports may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the providers of service.

Personal care and assistance may be a component of SEIE supports, but may not comprise the entirety of the service.

SEIE supports may include services and supports that assist the member in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include:

- ◆ Aid to the member in identifying potential business opportunities;
- ◆ Assistance in the development of a business plan, including potential sources of business financing and other assistance needed to develop and launch a business;
- ◆ Identification of the supports that are necessary in order for the member to operate the business; and
- ◆ Ongoing assistance, counseling, and guidance once the business has been launched.

Members receiving SEIE support services may also receive educational, prevocational or day habilitation services and career planning services. A member's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of time.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- ◆ Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- ◆ Payments that are passed through to users of supported employment services.



Exclusions

SEIE supports do not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.

SEIE supports do not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through prevocational services.

6. Supported Employment Small Group (Enclave)

Enclave employment support are services and training activities provided in regular business, industry, and community settings for groups of two to eight workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community.

Enclave employment support must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include vocational services provided in facility based work settings.

Enclave employment supports may include any combination of the following services:

- ◆ Vocational or job-related discovery or assessment,
- ◆ Person-centered employment planning,
- ◆ Job placement,
- ◆ Job development,
- ◆ Negotiation with prospective employers,
- ◆ Job analysis,
- ◆ Training and systematic instruction,
- ◆ Job coaching,
- ◆ Benefits support,
- ◆ Training and planning transportation,
- ◆ Career advancement services, and



- ◆ Other workplace support services may include services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Enclave employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the providers of service.

Personal care and assistance may be a component part of enclave employment support services, but may not comprise the entirety of the service.

All supported employment service options should be reviewed and considered as a component of an member's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the member. These services and supports should be designed to support successful employment outcomes consistent with the member's goals.

Members receiving enclave employment support services may also receive educational, prevocational, or day habilitation services and career planning services. A member's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of time.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- ◆ Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services, or
- ◆ Payments that are passed through to users of supported employment services.



Exclusions:

- ◆ Enclave employment support does not include vocational services provided in facility-based work settings or other similar types of vocational services furnished in specialized facilities that are not a part of general community workplaces.
- ◆ Enclave employment support does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Supported employment has two main components:

- ◆ [Activities to Obtain a Job](#), and
- ◆ [Supports to Maintain Employment](#)

a. Activities to Obtain a Job

Activities to obtain a job include the following service components provided to or on behalf of the member:

- ◆ **Job development** services are directed toward obtaining competitive employment. The activities provided to the member may include:
 - Job procurement training, including grooming and hygiene, application, resume development, interviewing skills, follow-up letters, and job search activities.
 - Job retention training, including promptness, co-worker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development specific to the consumer.

A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. A member may receive two units of job development services during a 12-month period.

Payment for job development may occur when the service has been authorized in the member's service plan. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid member is not eligible for funding through that agency.



- ◆ **Employer development** services are focused on supporting employers in hiring and retaining members in their workforce and to communicate expectations of the business with the interdisciplinary team. Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week.

The services provided may include:

- Developing relationships with employers and providing leads for members when appropriate.
- Job analysis for a specific job.
- Development of a customized training plan that identifies job-specific skill requirements, employer expectations, teaching strategies, timeframes, and responsibilities.
- Identifying and arranging reasonable accommodations with the employer.
- Providing disability awareness and training to the employer when it is deemed necessary.
- Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

Most members will receive this service through Iowa Vocational Rehabilitation Services. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid member is not eligible for funding through that agency.

A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development during a 12-month period.



- ◆ **Enhanced job search** activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days; or with assisting the member in changing jobs due to lay-off, termination, or personal choice.

The interdisciplinary team must review and update Iowa Vocational Rehabilitation Services form SES/RA-1, *Supported Employment Readiness Analysis*, to determine if this service remains appropriate for the member's employment goals. Click [here](#) to view the form online.

The services provided may include:

- Job opening identification with the member.
- Assistance with applying for a job, including completion of applications or interviews.
- Work site assessment and job accommodation evaluation.

A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid member is not eligible for their funding.

b. Supports to Maintain Employment

Supports to maintain employment includes the following services provided to or on behalf of the member or small group of members:

- ◆ Individual work-related behavioral management
- ◆ Job coaching (one member)
- ◆ Small group (enclave) (2 to 8 members)
- ◆ On-the-job or work-related crisis intervention
- ◆ Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety
- ◆ Assistance with time management
- ◆ Assistance with appropriate grooming
- ◆ Employment-related supportive contacts
- ◆ On-site vocational assessment after employment
- ◆ Employer consultation



Example: Due to his bi-polar disorder, John Doe has never been employed, but he would like to work. His provider finds that John has an interest and aptitude for working with animals.

The provider contacts local pet stores to explain John's situation and arranges for a job interview for John. These activities would be considered job procurement training and are reimbursable as "job development services."

The employer hires John to help take care of the animals. Provider staff work with John to assist him in learning his job duties. During the first two weeks, the provider works with John at the job site for an hour per day. For the next two weeks, staff assist him every other day.

Staff also makes periodic contact with the employer to check on John's performance and identify any trouble areas.

These activities are considered job coaching and employer consultation and would be reimbursable as "supports to maintain employment."

One day, John becomes agitated while at work and yells at another employee. Provider staff respond by coming to the job site and assisting John in regaining his composure. The staff finds that John was confused about some of his duties and became upset when his co-worker pointed out some things John had not done.

Provider staff then assists John in communicating about the problem with the employer and co-worker and in clarifying his duties.

These activities are considered work-related crisis intervention and assistance with communication skills and are reimbursable as "supports to maintain employment."

7. Exclusions Under State Plan HCBS

State plan HCBS habilitation services do not include any of the following:

- ◆ Respite services
- ◆ Room and board
- ◆ Family support services
- ◆ Inpatient hospital services



- ◆ Services that are solely educational in nature
- ◆ Services that are not in the member's comprehensive person-centered service plan
- ◆ Services provided before the approval of a member's plan by the Iowa Medicaid Enterprise or the Iowa Plan for Behavioral Health contractor
- ◆ Services to persons under 65 years of age who reside in institutions for mental diseases
- ◆ Services directed at a parent or family member to meet the protective, supportive, or preventive needs of a child. Services that are otherwise covered by the Iowa Medicaid program or that are an integral and inseparable part of another Medicaid-reimbursable service, including but not limited to:
 - Institutional services, such as in a nursing facility or ICF/ID.
 - Services under a behavioral health managed care program, such as Assertive Community Treatment (ACT).
- ◆ Non-emergency medical transportation (NEMT) services cannot be used for transportation to state plan HCBS habilitation services as that service is not included in the state plan approved for the transportation service.

8. Duplication

Members may be enrolled for state plan HCBS habilitation services while also enrolled in an HCBS waiver program under the following conditions:

- ◆ The member must meet all eligibility requirements for both programs.
- ◆ Services may not be duplicated between the two programs. When a needed service is available under both programs, it should be accessed through habilitation services rather than the waiver.
- ◆ Only one case manager is permitted per member. When case management is to be provided as an HCBS service, such as with the elderly waiver, the habilitation case manager must oversee both programs. When the member receives HCBS waiver service coordination from a service worker, the HCBS habilitation services and HCBS waiver services must be monitored and managed by a case manager meeting the provider qualifications outlined earlier in this manual.



9. Medical Necessity

To be payable by Medicaid as a habilitation service, a service must:

- ◆ Be reasonable and necessary.
- ◆ Be based on the member's needs as identified in the member's comprehensive service plan.
- ◆ Be delivered in the least restrictive environment appropriate to the needs of the member.
- ◆ Be provided at the most appropriate level for the member.
- ◆ Include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- ◆ Be consistent with professionally accepted guidelines and standards of practice for the service being provided.

10. Documentation

Providers must meet the documentation requirements set forth in 441 IAC 79.3(249A).

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.

Providers must maintain the 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 professionally recognized standards of care.

Each page of the medical record shall contain the member's first and last name. As part of the medical record, the member's medical assistance identification number and date of birth must be identified and associated with the member's first and last name.

The provider's file for each Medicaid member **must** include progress notes for **each** date of service that detail specific services rendered related to the covered habilitation service for which a claim is submitted to the Iowa Medicaid program.



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.
- ◆ The first and last name and title of provider staff actually rendering service, as well as that person's signature.
- ◆ The place of service (i.e., location where service was actually rendered).
- ◆ A description of the specific components of the Medicaid-payable habilitation service being provided (using service description terminology from the covered services section of this manual).
- ◆ The nature, extent, and number of units of the habilitation service that was rendered. The progress note **must** describe what specifically was done, and include the progress and barriers to achieving the goals and objectives as stated in the member's comprehensive service plan.
- ◆ The name, dosage, and route of administration of any medication administered, when it is a part of the service.

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

- ◆ The reason for discharge,
- ◆ The date of discharge,
- ◆ The recommended action or referrals upon discharge, and
- ◆ The treatment progress and outcomes.



E. PROCEDURE CODES AND NOMENCLATURE

These procedure codes may be used in submitting bills for habilitation services to Iowa Medicaid Enterprise:

Service Description	HCPCS Code	Modifier	HCPCS Code Description	Unit of Time
Home-based habilitation	H2015		Comprehensive community support	15 minutes
Home-based habilitation	H2016		Comprehensive community support	Per diem
Day habilitation	T2020		Day habilitation, waiver	Per diem
Day habilitation	T2021		Day habilitation, waiver	15 minutes
Prevocational service	T2014		Habilitation, prevocational waiver	Per diem
Prevocational service	T2015		Habilitation, prevocational waiver	Hourly
Support to maintain employment	H2025		Ongoing support to maintain employment	15 minutes
Enclave, support (groups of 2 to 8)	H2023		Supported employment	15 minutes
Job develop directed at develop skills	T2018	UC	Habilitation, supported employment, waiver	Flat fee per service
Employer development directed; support employers	H2024	UC	Supported employment	Flat fee per service
Enhanced job search activities	H2019		Therapeutic behavior services	15 minutes

Units of Service

The following rules are to be followed when applying units of services to a procedure code:

- ◆ A unit of case management is 15 minutes.
- ◆ A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month.
- ◆ Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 441 IAC 79.1(2).



- ◆ The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.
- ◆ The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.
- ◆ A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).
- ◆ A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours).
- ◆ A unit of supported employment habilitation for activities to obtain a job is:
 - One job placement for job development and employer development.
 - A 15-minute unit for enhanced job search.
 - A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

Submit bills for whole units of service only. Hourly services should be rounded as follows:

- ◆ Add all the minutes provided for a day.
- ◆ When the total minutes for the day is less than 60, round up to 1 whole unit.
- ◆ When the total minutes for the day is more than 60, divide the total by 60 to get the number of hours for the day. This should be rounded to the nearest whole unit, by rounding down for 1 through 30 minutes, and rounding up for 31 through 59 minutes.

F. BASIS OF PAYMENT

Providers shall be reimbursed for members enrolled in the Iowa Plan for Behavioral Health by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor.

Providers shall be reimbursed for members not enrolled in the Iowa Plan for Behavioral Health by the IME at the rate negotiated by the provider and the Iowa Plan for Behavioral Health contractor.

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G. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Habilitation Services 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>

NOTE: Claims for habilitation services submitted to the Iowa Plan for Behavioral Health contractor must be submitted in accordance with the instructions provided. Instructions for submitting claims to the Iowa Plan for Behavioral Health Contractor may be located at <http://www.magellanofiowa.com/for-providers-ia/additional-options/habilitation.aspx>.

Special Instructions for Habilitation Services Providers Billing the IME

A diagnosis code is required to be entered in field 21. In the event that a provider may not have documentation of the diagnosis code for a member, contact the member's case manager. The case manager or care coordinator should have the member's diagnosis on file. If the diagnosis code is not available from the case manager or care coordinator, the provider may ask the member to contact the member's primary mental health care physician and request the member's primary diagnosis code.

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at (800) 967-7902 or by email at edi@noridian.com.