



Iowa Department of Human Services

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For Human Services use only:

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Employees' Manual, Title 8
Medicaid Appendix

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COMMUNITY MENTAL HEALTH CENTERS MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **COMMUNITY MENTAL HEALTH CENTERS MANUAL**, Chapter III,
Provider-Specific Policies, pages 20 through 23, revised.

Summary

The **COMMUNITY MENTAL HEALTH CENTERS MANUAL** is revised to align with current IA Health Link policies, procedures, and terminology.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages from the **COMMUNITY MENTAL HEALTH CENTERS MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter III	
20, 21	May 1, 2014
22, 23	October 1, 2015

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/CMHC.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



C. BASIS OF PAYMENT

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

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

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

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



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

Reporting Requirements

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

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



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

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

D. PROCEDURE CODES AND NOMENCLATURE

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

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

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

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



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

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

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Community Mental Health Centers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click [here](#) to view a sample of the CMS-1500.

Click [here](#) to view billing instructions for the CMS-1500.

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

The Billing Manual can be located online at:

<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>