Iowa Medicaid B3 Provider Manual (Guide)

Last Updated: 6/11/2026

IOWA Health and Human Services

Contents

Section 1 - Overview

Overview & Purpose

Iowa Medicaid members enrolled with a Managed Care Organization (MCO) have access to an expanded array of mental health and substance use disorder services. These services are often referred to as “B3” services because they are authorized as a 1915(b)(3) waiver exemption by the Centers for Medicare and Medicaid Services (CMS).

Eligibility & Scope

Individuals not enrolled with an MCO do not have coverage for B3 mental health and substance use disorder services. Iowa Health and Wellness Not Medically Exempt and Healthy and Well Kids in Iowa (Hawki) members are not eligible for any B3 services.

The array of B3 Services is intended to support individuals with current mental health or substance use disorder with presenting symptoms. There is no standard functional impairment form that is required for members to access B3 services.

Reference: Iowa HHS document 519 “Comparison of Medicaid Basic Benefits Based on Eligibility Determination” Comm 519 - Comparison of Medicaid Basic Benefits

Section 2 - Provider Eligibility & Enrollment

Provider Eligibility

How To Enroll

- Verify your provider type is eligible to provide the service(s) you wish to provide
- Verify you are enrolled with Iowa Medicaid
- Contract with MCOs to set reimbursement rates for the B3 services you are eligible for and wish to provide. Individually contracted rates will be in place until or upon development of a State-wide fee schedule.

Iowa Medicaid Enrollment
Contact Provider Services Monday through Friday from 8 a.m. to 5 p.m. by
Phone (Toll Free): 800-338-7909
Phone (Des Moines): 515-256-4609
Email: imeproviderservices@hhs.iowa.gov

Iowa Total Care Contracting & Credentialing
Email: NetworkManagement@IowaTotalCare.com

Molina Health Care Contracting & Credentialing
Email: IAProviderContracts@MolinaHealthcare.com

Wellpoint Contracting & Credentialing
Email: providernetworkia@wellpoint.com

Section 3 – Service Definitions & Scope of Care

Covered Services Overview:

Detailed Definitions (one per subsection)

H0018TG

- Level III.7 Community-based Substance Use Disorder Treatment
- 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a licensed substance abuse facility

Provider Type	21, 23, 49, 62
Licensure	Provider must have an active license by Iowa Health and Human Services Substance Use Providers licensed under Iowa Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT See 'Iowa Administrative Code 641-Chapter 155'
Assessment Requirements	ASAM updated every 7 days See 'Iowa Administrative Code 641 Chapter 155.21(19)
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine See Iowa Administrative Code 641-Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0017TG

- Level III.7 Hospital-based Substance Use Disorder Treatment
- 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a licensed substance abuse facility

Provider Type	1, 26, 41
Licensure	Provider must have an active license by Iowa Health and Human Services Substance Use Providers licensed under Iowa Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT See 'Iowa Administrative Code 641-Chapter 155'
Assessment Requirements	ASAM updated every 7 days See 'Iowa Administrative Code 641 Chapter 155.21(19)
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine See Iowa Administrative Code 641-Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0018TF

- Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Substance Use Disorder Treatment – Community Based

- Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 is designed to treat people who have significant social and psychological problems. Services are based on a therapeutic treatment community. A step-down or alternative to Level III.7

Provider Type	**21, 23, 49, 62**
Licensure	Provider must have an active license by the Iowa Health and Human Services to provide the 3.3/3.5 Level of Care. Substance Use Providers licensed under Iowa Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT See Iowa Administrative Code 641 Chapter 155
Assessment Requirements	ASAM updated every 7 days See Iowa Administrative Code 641 Chapter 155.21(19)
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine See Iowa Administrative Code 641 Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0017TF

- Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Substance Use Disorder Treatment – Hospital Based

- Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 is designed to treat people who have significant social and psychological problems. Services are based on a therapeutic treatment community. A step-down or alternative to Level III.7

Provider Type	**1, 26, 41**
Licensure	Provider must have an active license by Iowa Health and Human Services. Substance Use Providers licensed under Iowa Administrative Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT See Iowa Administrative Code, 641-Chapter 155
Assessment Requirements	ASAM updated every 7 days See Iowa Administrative Code 641 Chapter 155.21(19)
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine See Iowa Administrative Code 641 Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H2034

- Level III.1 Clinically Managed Low Intensity Residential Substance Use Disorder Treatment

- Level III services offer organized treatment services that feature a planned regimen of care in a 24-hour residential setting. All Level III programs serve individuals who, because of their specific functional deficits, need a safe and stable environment to develop their recovery skills. The sublevels within Level III exist on a continuum ranging from the least intensive to the most intensive medically monitored intensive inpatient services. Level III.1 – at least 5 hours/week of treatment plus the structured recovery environment

Provider Type	**21, 23, 49, 62**
Licensure	Provider must have an active license by Iowa Health and Human Services. Substance Use Providers licensed under Iowa Administrative Code Chapter 125
Training/Education	CADC, IADC, LMHC, LISW, LMSW, LMFT See Iowa Administrative Code, 641 Chapter 155
Assessment Requirements	ASAM updated every 30 days. See Iowa Administrative Code 641 Chapter 155.21(19)
Documentation Requirements	Requirements for this level of care as described by the American Society of Addiction Medicine See Iowa Administrative Code 641 Chapter 155.21 on Treatment Plans and Progress Notes'
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

Outpatient Services

H2017U1-U5

- Intensive Psychiatric Rehabilitation
- Modifiers
    - U1: Readiness Assessment
    - U2: Readiness Development
    - U3: Goal Setting
    - U4: Goal Achieving
    - U5: Goal Keeping

Intensive Psychiatric Rehabilitation or Outpatient Psychiatric Rehabilitation Services are comprehensive outpatient services based in the individual's home or residence and/or community setting. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are directed primarily to individuals with severe and persisting mental disorders, and/or complex symptoms who require multiple mental health and psychosocial support services. Such services are active and rehabilitative in focus, and are initiated and continued when there is a reasonable likelihood that such services will lead to specific observable improvements in the individual's functioning

Provider Type	**1, 13, 21, 49, 59, 62, 63**
Licensure/Accreditation	Community Mental Health Centers (CMHCs) and accredited organizations under Iowa Administrative Code 441Chapter 24
Service Settings & Exclusions	Adult only service for members 18+
Training/Education	State recognized training program See "Intensive psychiatric rehabilitation practitioner" Iowa Administrative Code 441 Chapter. 24 Definitions)
Assessment Requirements	See Iowa Administrative Code 441 Chapter 24.4.11
Documentation Requirements	See Iowa Administrative Code 441 Chapter 24.4.11
Frequency, Duration, Limits	4-10 hours per week = 16 to 40 billable units per week See Chapter 24.4.11
Unit Type	1 unit = 15 minutes
Rates	Rates Negotiated between Provider and MCO

H0037 Low or H0037TF High

- Community Support Services
- Community Support Services (CSS) are provided to adults with a severe and persistent mental illness. These services are designed to support individuals as they live and work in the community. These services address mental and functional disabilities that negatively affect integration and stability in the community. CSS staff attempt to reduce or manage symptoms/reduced functioning that result from a mental illness. CSS providers are expected to have knowledge and experience working with this population. Staff should have the ability to create relationships with this population that provide a balance between support of the mental illness and allow for maximum individual independence. Community support program components include all the following:
    - Monitoring of mental health symptoms and functioning/reality orientation
    - Transportation
    - Supportive relationship
    - Communication with other providers
    - Ensuring individual attends appointments/obtains medications
    - Crisis intervention/developing crisis plan
    - Coordination and development of natural support systems for mental health support

CSS Service Levels

There are two levels of Community Support Services. Each level is described below. The level of CSS provided must be consistent with the member's assessed need at a certain point in time or across a time period. While minimum contact requirements are included in the descriptions below, CSS providers should see each member at a frequency consistent with that member's assessed needs. At both levels, CSS staff must plan CSS service components in conjunction with a Mental Health Professional such as the member's individual therapist.

High Intensity CSS Criteria for Admission

High Intensity CSS is for members who:

- Experience increased psychiatric symptoms that require increased support and close follow-up to continue living in the community.
- ***Or***
- Have persistent psychiatric symptoms and a pattern of community living that require long-term support and close follow-up to assist in living in the community.

Frequency of Contact/Service Provision

High Intensity CSS is provided through 5-12 member contacts per month. Contacts may be face-to-face or by telephone.

- A minimum of 4 face-to-face contacts required per month between CSS staff and member.
- CSS staff must have at least 2 monthly contacts with a Mental Health Professional who is working with the member. These contacts do not count towards the 5-12 member contacts.
    - Examples include calling Mental Health Professional's office to confirm member's appointment attendance or emailing provider with key monthly updates on member.
- All contacts with the member and the mental health professional must be documented in the CSS progress notes.

Low Intensity CSS Criteria for Admission

Low Intensity CSS is for members who require periodic supportive services to maintain their level of independent functioning in the community. Without Low Intensity CSS, these members may become socially isolated and may exhibit increased symptoms of mental illness and associated functioning disabilities that put them at risk for a more restrictive level of care than their normal community environment.

- **Frequency of Contact/Service Provision** - Low Intensity CSS is provided through 2-4 member contacts per month, with episodes of increased frequency, as needed. Contacts may be face-to-face or by telephone.
    - A minimum of 1 face-to-face contact required per month.
    - CSS staff must have at least 1 contact monthly with a Mental Health professional who is working with the member. This contact does not count towards the 2-4 member contacts per month.
    - Examples include calling Mental Health Professional's office to confirm member's appointment attendance, or emailing provider with key monthly updates on member
    - All contacts with the member and the mental health professional must be documented in the CSS progress notes.

- **Community Support Services (H0037)** identifies low and high intensity needs. Members who are low intensity will be billed using no modifier. Members who are high intensity will be billed using the TF modifier. High intensity members will receive 5-12 contacts per month.

Provider Type	1, 13, 21, 49, 59, 62, 63
Licensure/Accreditation	Community Mental Health Centers and accredited organizations under Iowa Administrative Code 441.24
Training/Education	The following staff qualifications shall be met: a. Have knowledge and experience in working with the target population. 2. Have the ability to create relationships with the individuals served that balance support of the mental illness and the need to allow for maximum individual independence. 3. Have a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field, including but not limited to psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy.
Assessment Requirements	An assessment should outline that there is medical necessity for the service and be completed every 12 months.
Documentation Requirements	Documentation should clearly outline the interventions and member reactions. It should clearly outline the need for services in the provider care plan/treatment plan.
Frequency, Duration, Limits	This service cannot be provided when a member is already accessing home-based habilitation or ACT services.
Unit Type	1 unit = 1 month
Rates	Rates Negotiated between Provider and MCO

H0045

- Respite
- Modifiers:
    - No modifier: Standard/most typical – all ages
    - U4: For members in Therapeutic Foster Care Program - Ages 6 through 11
    - U5: For members in Therapeutic Foster Care Program - Ages 12 through 17

- In-/Out-of-Home Respite consists of community- and home-based services that can be provided in a variety of settings. Respite care is a brief period of rest and support for individuals and/or families. Respite care is intended to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current issues related to a mental health diagnosis. Respite may be provided for up to 72 hours and can be planned or in response to a crisis. A comprehensive respite program must provide or ensure linkages to a variety of residential alternatives for stabilizing and maintaining individuals who require short-term respite in a safe, secure environment with 24-hour supervision outside a hospital setting. Respite is a community-based alternative to inpatient hospitalization that provides a temporary, safe, and secure environment with a flexible level of supervision and structure. These services are designed to divert individuals from an acute hospitalization to a safe environment where medical and psychiatric symptoms can be monitored. Respite services can be planned or unplanned. Therapeutic foster care providers may utilize this service, by accessing another therapeutic foster care provider. If a member is receiving a Home and Community Based (HCBS) waiver, this service must be utilized through waiver prior to accessing B3 respite services.

Provider Type	1, 9, 13, 21, 23, 25, 26, 27, 41, 59, 62, 63, 64, 80, 81, 99
Licensure	Hospitals, agencies, Community Mental Health Centers contracted using MCO credentialing standards and holding national accreditation (JCAHO, CARF, COA, AOA, or AAAHC) or under Iowa Administrative Code Chapter 24) *HCBS Waiver respite agencies may contract to deliver B3 respite when they meet one of the above qualifications.
Training/Education	Providers should have knowledge and experience working with adults and children with mental illness
Assessment Requirements	See Iowa Administrative Code
Documentation Requirements	See Iowa Administrative Code Chapter 77.30(5)
Frequency, Duration, Limits	This service cannot be provided when a member is already accessing home-based habilitation or ACT services.
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

H0038

- Peer Support, Family Peer Support, and Recovery Coach
- Modifiers used for members in Therapeutic Foster Care
    - U4: Ages 6 through 11
    - U5: Ages 12 through 17
- The services are provided to eligible individuals by people with lived experience with mental health and substance use and who are specifically trained to provide peer support services (adult peer, recovery coach and family peer support). Services are targeted toward the support of persons with a serious and persistent mental illness, families with a child who has serious emotional disturbance or substance use disorder. Peer support services focus on individual support from the perspective of a trained peer support specialist and may also include service coordination and advocacy activities as well as rehabilitative services. Peer support services are initiated when there is a reasonable likelihood that such services will benefit an eligible person's functioning and assist them in maintaining community tenure. Peer Support and Family Parent Peer Support services may be provided to members who are receiving therapeutic foster care services.
- There are no minimums or caps/limits on the number of units a member can receive. Medical necessity always applies.
- The service/code is for individuals or families, not groups of members nor groups of families.
- If a member is receiving inpatient (i.e. Hospital) or residential services (i.e. SUD treatment, PMIC) the provider cannot bill additionally for Peer Support. Outpatient providers (i.e. Intensive Outpatient Programs, Partial Hospitalization Programs) may provide and bill for Peer Support services to occur outside of the outpatient program timeframe.

Provider Type	1, 13, 21, 49, 59, 62, 63, 88
Licensure/Certification	Certification is optional through the Iowa Board of Certification.
Service Settings & Exclusions	Individual Peer Support, Family Peer Support or Recovery Coaching can be performed via telehealth or in person. • For Telehealth: audio-only is not allowed according to https://hhs.iowa.gov/media/13025/download?inline Exclusion: Group Setting
Training/Education	To provide Peer Support, Family Peer Support, and Recovery Coach services, an individual must be trained by a state approved entity. Training must be completed within six months of hire date. The training required is facilitated by the Iowa Peer Workforce Collaborative for adult and family peer support and Connecticut Community for Addiction Recovery (CCAR) for recovery coaching. To bill Peer Support, Family Peer Support, and Recovery Coach Services, an individual must receive a training certification upon course completion. The Iowa Board of Certification is an option and not required by the state for Medicaid reimbursement.
Assessment Requirements	An assessment should outline that there is medical necessity for the service and be completed every 12 months.
Documentation Requirements	If the Peer Support Specialist, Family Peer Support Specialist or Recovery Coach is in their first 6 months of employment and are not yet trained, then their documentation will be reviewed and co-signed by a trained Peer Support Specialist, Family Peer Support Specialist or Recovery Coach. Documentation should also include care plan/treatment plan guidelines as well.
Unit Type	1 unit = 15 minutes
Rates	Rates Negotiated between Provider and MCO

H2022 (X1-X5)

- Integrated Services and Supports
- Modifiers
    - X1: 1:1 Supervision will be utilized in cases where a member needs increased supervision due to safety concerns. The intent of this service is to help members stay in the least restrictive environment possible while putting supports in place to improve and maintain their safety. This modifier covers increased supervision for 1 - 8 hours per day.

    - X2: 1:1 Supervision will be utilized in cases where a member needs increased supervision due to safety concerns. The intent of this service is to help the member stay in the least restrictive environment possible while putting supports in place to improve and maintain their safety. This modifier covers increased supervision for 8.25 – 16 hours per day.

    - X3: 1:1 Supervision will be utilized in cases where a member needs increased supervision due to safety concerns. The intent of this service is to help members stay in the least restrictive environment possible while putting supports in place to improve and maintain their safety. This modifier covers increased supervision for 16.25 - 24 per day.

    - X4: Mentoring is centered around improving members' well-being by providing a positive role model who can support them through growth, struggles, and life transitions. Mentoring allows members to participate in activities such as going to a movie, shopping, going out to eat, or favorite sporting event. Because mentoring is focused on building a healthy attachment to an adult, mentoring is not dependent on the treatment progress.

    - X5: Other services and supports cover a broad array of services. Examples of these services include transportation for treatment, and hotel costs related to visiting a member in treatment.
- Service available to eligible adults and children.
- Integrated Services & Supports are informal services/supports offered by providers, family/friends, and other members of the natural support community. These interventions help individuals to remain in or return to their homes and limit the need for more intensive out-of-home mental health treatment. Integrated services and supports are specifically tailored to an individual consumer’s needs at a particular point in time and are not a set menu of services.

  A joint treatment planning process may identify the need for integrated services/supports. The consumer/family member must lead the planning process,

and other members of the team must give their input as well. Individual contacts with the individual/family may also identify the need. Ideally, this provides more flexibility to individuals with unique services to address mental health needs and augment and complement those provided through other funders and systems. The services/supports must be integrated into the treatment plan. Integrated Services and Supports may have natural support involvement that requires reimbursement and, at other times, be part of the family process.

Provider Type	1, 9, 13, 21, 23, 25, 26, 27, 41, 59, 62, 63, 64, 80, 81, 99
Licensure	Hospitals, agencies, Community Mental Health Centers contracted using MCO credentialing standards and holding national accreditation (JCAHO, CARF, COA, AOA, or AAAHC) or under Iowa Administrative Code 441 Chapter 24) *HCBS Waiver respite agencies may contract to deliver B3 respite when they meet one of the above qualifications.
Training/Education	Providers should have knowledge and experience working with adults and children with mental illness.
Assessment Requirements	An assessment should outline that there is medical necessity for the service.
Documentation Requirements	An active mental health treatment plan exists and indicates how H2022 would address the member's current need.
Unit Type	Per Diem Unit
Rates	Rates Negotiated between Provider and MCO

Section IV: Person-Centered Planning

Providers will embrace:

- Person-Centered thinking helps to establish the means for a person to live a life that they and the people who care about them have good reason to value.
- Person-Centered planning is a way to assist people who need supports to construct and describe what they want and need to bring purpose to their life.
- Person-Centered practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

Section V: Authorization of Services & Referral

Prior Authorization Steps

- Verify Member has full Medicaid, if members have Iowa Health & Wellness Not Medically Exempt or Hawk-I they are not eligible for B3 services.
- Verify the Managed Care Organization (MCO) the member is assigned to. Members who are assigned to Fee for Service (FFS) are not eligible to receive these services.
- Complete Medicaid Outpatient Prior Authorization Form
- Complete B3 Request Template and attach with Medicaid Outpatient Prior Authorization form for Integrated Services and Supports (H2022), or respite (H0045), with no modifier.
- Submit to MCO per their identified process

Section V: Billing, Claims, & Reimbursement

Fee Schedule & Rates

Providers and MCOs negotiate the reimbursement rates for all B3 services. The Provider must contact their Provider Representative at each of the MCOs.

Codes & Modifiers

Where applicable, claims must be billed using procedure code and modifier combination Select B3 services are allowed to be billed on the UB-04 Claim form, please see Info Letter 2156 for detailed information

Ensure the member receiving the services and for which the claim is submitted, is eligible for services (i.e. not Iowa Health & Wellness – not Medically Exempt, and not Hawki)

Claims Submission Process

- Please see the provider manual for detailed information about claims submissions.
- No paper claims submissions accepted; electronic claims only accepted.

Timely Filing & Frequency

- Please see the provider manual for detailed information about claims timely filing requirements. Standard timely filing requirements apply.

Denials, Corrections, Recoupments, and Appeals

- Please see provider manual for detailed information about claims denials, corrections, recoupments and appeals. Standard processes apply.

MCO Contacts for Billing and Claims Questions

Wellpoint Iowa, Inc.
Phone: 1-833-731-2143
Email: ProviderSolutionsIA@wellpoint.com
Website: https://www.provider.wellpoint.com/iowa-provider/home

Molina Healthcare of Iowa
Phone 1-844-236-1464
Email: IAProviderContracts@MolinaHealthcare.com
Website: www.molinahealthcare.com/providers/ia/medicaid/home

Iowa Total Care of Iowa
Phone: 1-833-404-1061
Email:NetworkManagement@IowaTotalCare.com
Website: www.iowatotalcare.com/providers.html

Provider Type

Key	
1	Hospital
9	Home Health Agency
13	Rural Health Clinics
21	CMHC
23	Residential Care Facility
25	ICF/ID State
26	Mental Hospital
27	ICF/ID Community-Based
41	PMIC
49	FQHC
59	Indian Health Service
62	Behavioral Health
63	Remedial Services/BHIS
64	Habilitation
72	Public Health Agencies
80	Crisis Response
81	Sub-acute facilities
88	CCBHC
99	Waiver Providers

Appendix A – B3 Menu of Services / Codes

Service	Claim Form Type	HCPCS/CPT Code	Revenue Code	Modifier(s)	Bill Type	Service Unit
Integrated Services & Supports	CMS-1500	H2022	N/A	X1-X5	N/A	1 Unit = 1 Day
Peer Support, Family Peer Support & Recovery Coaching	CMS-1500	H0038	N/A	No modifier required unless provider is Therapeutic Foster Care	N/A	1 Unit = 15 minutes
Respite	CMS-1500	H0045	N/A	No modifier required unless provider is Therapeutic Foster Care	N/A	1 Unit = 1 Day
Community Support Services	CMS-1500	H0037	N/A	*Low:* No Modifier *High:* TF Modifier	N/A	1 Unit = 1 Month
Intensive Psychiatric Rehabilitation	CMS-1500	H2017	N/A	U1-U5	N/A	1 Unit = 15 minutes
Residential SUD Services (ASAM 3.1)	CMS-1450	H2034	906	None	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Hospital Based) (ASAM 3.3/3.5)	CMS-1450	H0017	906	TF	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Community Based) (ASAM 3.3/3.5)	CMS-1450	H0018	906	TF	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Community Based) (ASAM 3.7)	CMS-1450	H0017	906	TG	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day
Residential SUD Services (Community Based) (ASAM 3.7)	CMS-1450	H0018	906	TG	Outpatient (13x, 74x, 76x, 89x)	1 Unit = 1 Day

Appendix B – Frequently Asked Questions (FAQ)

Question	Answer
How will providers be notified of changes to the manual?	Providers can access the most recent updates through the Medicaid Provider General Letters on the Health & Human Services website Medicaid Provider General Letters | Health & Human Services. We are also in the process of developing a more direct mechanism for sharing updates and will provide additional information as it becomes available
Until clarified, should we follow the new manual monthly contact expectations or June's letter that states quarterly contact?	The B3 Manual supersedes previous Informational Letters (ILs).
When we apply to provide B3 services, how long does it take to hear back? Do you have any information regarding the back log at Medicaid Enrollment?	HHS provider enrollment recommends contacting provider enrollment and copy in Sabrina Johnson, Sabrina.Johnson@hhs.iowa.gov if greater than 30 days.
I am a Medicaid provider as Psychiatric Mental Health Nurse Practitioner (PMHNP). Do I need to apply again as B3?	If already enrolled as NP and provider type is eligible for B3 services, no new Medicaid enrollment type needed
Can H0038 be provided in a member's home when receiving H2016 U9 or U7 services?	H2016 U7 is a 24-hour service and should not be authorized for any additional Medicaid services at the same time.
If a member remains fully covered while incarcerated, can H0038 be provided within corrections? If a member remains enrolled with full Medicaid coverage still while incarcerated, can H0038 billable Peer Support services be provided within the correctional setting during that incarceration period?	If member is incarcerated, they should not be assigned to a MCO. They should flip to FFS, therefore, H0038 (or any B3 service) cannot be provided.
Is there a 3-hour time cap on billing for Peer Support per month still?	There is no cap and no limit on billing for Peer Support.

Question	Answer
Are there limitations to where CSS services can occur? If someone is living in a halfway house, sometimes their Medicaid can show as incarceration status. It would be beneficial if CSS could bill for CSS services when a client is hospitalized to help with coordination of discharge planning due to no IHH anymore	CSS services require a member to have Medicaid and be enrolled with an MCO. If a member is in a halfway house, they are technically incarcerated and on FFS, not with a MCO and not eligible for B3 Services.
Can you clarify in the manual if CSS services are able to work on vocational goals? Work and school related goals	These services are designed to support individuals as they live and work in the community. If vocational and school goals offer that support, then “yes”.
Face to face meetings are supposed to be away from the office to my understanding. Community-based is the key.	Ideally, yes. CSS staff should meet at locations preferred by clients, hence the name of the service – Community Support Services
How can we bill 1:1 support for youth in shelter care, H2022?	Be a provider with Iowa Medicaid Contract with the MCO Connect with care/case management with the MCO to coordinate.
Will BHIS be an option as a service under B3 services?	No, BHIS is currently a Medicaid service.
Will H0015 be added to the manual?	No, this is a covered benefit with Medicaid.
What does telehealth services look like for B3 services?	The list of approved telehealth services is found on the HHS Fee Schedule webpage.
What will future monthly trainings look like that you have scheduled? Will you be presenting new content? Will it be more like an "open office hours"?	ITC will host monthly sessions every third Wednesday as informal office hours and updates. Molina and Wellpoint representatives will also join the call.
Where should we direct additional questions that we may have after this call?	To MCO provider reps listed on slides. Any door is fine; teams will compile for FAQ.
What is non par?	Non-par means not participating in the MCO network. Non-par services require authorization.

Question	Answer
Clarify billing primary insurance for B3. Medicare and Commercial COB expectations.	If Medicare does not cover, bill MCO with denial or policy reference. For commercial, bill primary first unless excluded; attach EOB.
The commercial insurances we have tried submitting to do not recognize the H0037 code, and when we have attempted to bill to get a denial, they deny the claim with a contractual adjustment code (CO), which typically means the MCO won't pay either. We are unclear on how to proceed with these claims.	Medicare as primary: If Medicare does not cover the service/code, Medicaid may pay in its usual manner. For services Medicaid covers but Medicare does not, submit directly to the Medicaid MCO and note "Medicare non-covered" with your Medicare denial or policy reference. Iowa's billing manual states Medicaid pays for services it covers that Medicare does not. Health & Human Services. Commercial insurance as primary. When there is other insurance on file, providers generally must bill that insurer first and attach the primary EOB when billing Medicaid, except for specific federal exceptions Health & Human Services.
SCAs are done with the MCO, not IME, is that correct?	SCAs are completed with MCOs.
Will there be recoupments if we do not follow the guide?	Yes, recoupment is standard practice for found billing errors.
Does CSS need to bill primary?	The CSS code is a Medicaid only service, primary does not need to be billed.
Is a client having IOP or EOP double dipping to have CSS as well?	IOP/EOP is billed per diem and CSS is billed monthly. Services are not duplicative if both demonstrate medical necessity.
Any limits on where CSS can occur? Halfway house sometimes shows incarceration. Can CSS support hospital discharge planning with IHH ended?	Setting-of-service and eligibility flags need guidance. It depends on the member's eligibility status. CSS will not be paid if member is not eligible nor if another provider is billing a per diem, like hospital. Also, there shouldn't be a service that is considered duplicative.
Can ICF-ID providers bill H2022?	ICF-ID is an approved provider type
Do the monthly contacts include collateral with MHP?	No
Face-to-face should be community-based away from office?	Yes, it must be away from the office
Do CSS and MHP staff need to be from the same agency?	CSS and MHP staff do not have to be from the same agency
Is CSS still only for adults?	Yes

Question	Answer
Looking for clarification on the contacts needed with an MHP for CSS. What should that look like as far as documentation in our progress notes?	Follow Medicaid Documentation Expectations
Which Iowa Administrative Code definition is used for Mental health professional for the CSS services section? Does this include MD, NP, PA, DO, LMSW, LMFT-t, LMHC-t? We weren't sure if it included temporary licensed therapists.	Iowa Administrative Code definition applies for CSS-Iowa Code 228.1 (MH professional definition). CSS does NOT require every staff person to be a MH professional. There are two staffing roles: A MH professional=clinical oversight role and CSS staff= service delivery role. Does the Iowa Code definition include these listed providers in question-YES. Temporary licenses are legally allowed to practice under supervision, counted as qualified staff for service delivery, NOT treated as independent MH professionals for oversight authority, dependent on supervision structure for clinical authority including signing and submitting all documentation.
Will non-Chapter 24 accredited providers need to follow chapter 24 rules for CSS and IPR B3 services? As there are specifics for training and service components for them	Yes, they do need to follow the Chapter 24 rules regardless of provider type.
Can H2022 be authorized or billed as an add-on service for members who are currently receiving H2016 U9 or H2016 U7 services or does this continue to be a single case agreement?	No, because they are both stand-alone service types. Both require separate service components, and would otherwise risk being considered duplicative.
Do we have to use new H2022 X1–X5 modifiers now?	Yes, required immediately or auth/claims will reject. Modifier X5 likely via SCA.
For H2022 services, is this service eligible to children?	Yes, if criteria is met for this service.
Can we bill for family expenses to visit youth in residential SUD treatment?	Yes, in-state travel and hotel can be reimbursed under H2022 X5 modifier when applicable. Prior auth is required.
If a Provider is offering IOP services for Mental health, not substance abuse and the provider is enrolled in Iowa Medicaid, am I understanding correctly that the provider is not required to enroll in B3?	Enrollment in B3 services is not required before providing mental health PHP or IOP.

Question	Answer
Can you pay/bill for peer led support groups?	Not currently. This is currently being explored to see if this could be done in the future.
Is peer support billable for 3.1 Recovery House programs or as group services?	Individual peer support only currently. Group billing not available. 2/11/2026 -- need to clarify what 3.1 Recovery House is. Kevin: ASAM Level of Care 3.1 is paid as a daily rate/per diem, so Peer Support cannot be billed on top of that by the same or different provider. 3/13/26: Wellpoint is in agreement with Kevin as this cannot be billed on top of that by the same provider.
Who to contact to renegotiate peer support rates?	ITC: providerrelations@iowatotalcare.com Molina: IAProviderContracts@MolinaHealthcare.com Wellpoint: Provider.Inquiry@carelon.com
Many of the peer support programs and peer support specialists were originally trained several years ago. Will the possibility of "grandfathering" these PSS specialists be considered vs taking NEW training when they have already been practiciing as a certified PSS? And how often?	Iowa does recognize prior experience and initial training, but it does not exempt PSS from ongoing continuing education. Certification is maintained through renewal and CE, not repeated full training. Updates to Medicaid or peer workforce standards may require targeted retraining, but not full recertification.
Will the state or the Iowa Peer Workforce Collaborative be providing training in the Appalachian Consulting Group model?	The State is not launching a new separate ACG model training program. The ACG model is already a required foundational standard in Iowa peer support certification rules. The Iowa Peer Workforce Collaborative delivers training that incorporates those standards. Existing PSS staff maintain competency through CE and agency training, not re-certification in ACG. See HHS website for further information on peer support training information.
If they require authorizations, how long are the authorizations for?	Length of authorization varies based on the service being requested.
For CSS - Is a Treatment Plan required?	Yes, each client should have an individualized treatment plan that supports their treatment.

Question	Answer
Can a member get Peer Services at the same time they reside in a RCF?	Peer services can occur while a member lives in an RCF. They may be billable if they are distinct, individualized, and properly documented, but they cannot duplicate RCF provided supervision, programming or support. Documentation and service separation are critical for audit compliance. Peer services should be in alignment of acuity/tier.
Does the state consider PSS and CSS services duplication? Can a client be enrolled and receive both services?	A member can receive both services concurrently. They cannot provide the same function, same time, for the same goal. Documentation and role separation are what determines compliance, not just service codes.
Page 3 – “current mental health diagnosis or a substance use disorder diagnosis” – what timeframe is considered current?	A client must have been given a diagnosis by a provider licensed to diagnose within the past 12 months. Preference would be current mental health diagnosis or substance use disorder diagnosis within the last 60 days.
Is RCF an appropriate place of service to receive H0038?	The RCF cannot provide the service, but can be an appropriate place of service.