

**441—88.65 (249A) Covered services.**

**88.65(1) Amount, duration, and scope of services.** The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

**88.65(2) Enrollee use of Iowa Plan services.** Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

**88.65(3) Covered, required and optional mental health services.**

*a.* The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

- (1) Ambulance services for psychiatric conditions.
- (2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.
- (3) Inpatient hospital care for psychiatric conditions.
- (4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.
- (5) Partial hospitalization.
- (6) Day treatment.
- (7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.
- (8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.
- (9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.
- (10) Services provided through a community mental health center.
- (11) Targeted case management services to persons with chronic mental illness.
- (12) Medication management.
- (13) Psychiatric nursing services by a home health agency.
- (14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.
- (15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- (16) Behavioral health intervention as set forth in rule 441—78.12(249A).
- (17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.
- (18) Home- and community-based habilitation services as described at rule 441—78.27(249A).

*b.* The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

- (1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.
- (2) Services of a licensed social worker for treatment of mental illness.
- (3) Mobile crisis services.
- (4) Mobile counseling services.
- (5) Integrated mental health services and supports.
- (6) Psychiatric rehabilitation services.

- (7) Peer support services for persons with chronic mental illness.
- (8) Community support services.
- (9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.
- (10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

**88.65(4) Covered and required substance abuse services.** The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

- a. Outpatient services (all Level I services according to the ASAM-PPC-2R).
- b. Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).
- c. Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).
- d. Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).
- e. Detoxification.
- f. PMIC substance abuse treatment services.
- g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.
- h. Ambulance services for substance abuse conditions.
- i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

**88.65(5) Covered diagnoses.** Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no Axis I diagnosis. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.
2. Substance abuse: 303-305.9.

**88.65(6) Excluded services.** Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

**88.65(7) Iowa wellness plan service benefits.** Services described in 441—Chapter 74 that otherwise constitute covered services pursuant to this rule shall be included in Iowa Plan services for members enrolled in the Iowa Plan who are also Iowa wellness plan members.