Clinical Policy: Integrated Services & Supports (ISS)

Reference Number: IA.CP.BH.501 Coding Implications
Date of Last Revision: 07/26 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Integrated Services & Supports (ISS) are individualized, non-discrete support services intended to help the member/enrollee remain in or return to their home and community and reduce the need for more intensive out-of-home mental health treatment. Services are tailored to a member/enrollee's needs at a specific point in time and must be integrated into an active behavioral health treatment plan.[1]

Policy/Criteria

I. It is the policy of Iowa Total Care that requests for Integrated Services & Supports (ISS) are considered **medically necessary** when all of the following are met:

A. Member/enrollee has a current DSM-5-TR mental health disorder or substance use disorder diagnosis;
B. Member/enrollee is engaged in, or has an active plan to engage in, behavioral health treatment;
C. Requested service supplements, but does not replace medically necessary clinical services;
D. Documentation demonstrates a behavioral health-related need that cannot be adequately addressed through standard outpatient or community-based services alone;
E. The service supports the member/enrollee's ability to remain in/or transition to a home or community-based setting as a reasonable alternative to a more restrictive level of care;
F. Member/enrollee and/or family has participated in treatment planning;
G. Requested service is not solely intended to address social, educational, vocational, housing, legal, or custodial needs in the absence of a behavioral health-related clinical need;
H. The treatment plan clearly documents all of the following:
    1. The mental health or substance use disorder diagnosis;
    2. The purpose of integrating ISS and how it integrates with the member/enrollee's overall treatment plan;
    3. Clinical rationale supporting the frequency, duration, and intensity of services;
    4. The identified behavioral health needs and corresponding interventions;
    5. Measurable goals and expected outcomes;
    6. A plan to reduce, transition, or discontinue services, when clinically appropriate;
I. Documentation requirements include all the following:
    1. Completed Medicaid Outpatient Prior Authorization Form;
    2. Completed B3 service request template form;
    3. Appropriate H2022 modifier (X-1- X-5), as applicable;
    4. Current treatment plan;
    5. Clinical rational for intensity and duration;
    6. Transition or step-down planning or discharge planning for continued stay request;
J. Service request meets one of the following:

1. *Initial request* meets one of the following applicable modifier-specific criteria for the requested level of service:
   a. H2022X1: 1:1 Supervision, (1 to 8 hours/day), meets the following:
      i. Member/enrollee has a documented safety concern related to mental health, behavioral health, or psychosocial functioning;
      ii. Increased supervision is required to reduce the risk of harm to self or others;
      iii. Lower-intensity interventions are insufficient to safely manage the identified risk;
      iv. Supervision supports treatment goals and community stabilization;
   b. H2022X2: 1:1 Supervision, (8.25 to16 hours/day), meets the following:
      i. Member/enrollee has a documented, ongoing, or pervasive safety concern related to mental health, behavioral health, or psychosocial functioning requiring extended daily supervision;
      ii. Increased supervision is required to reduce the risk of harm to self or others;
      iii. Supervision supports treatment goals and community stabilization;
      iv. Documentation supports that lower-intensity interventions, including H2022X1, are insufficient to safely manage the identified risk;
   c. H2022X3: 1:1 Supervision, (16.25 to 24 hours/day), meets the following:
      i. Member/enrollee has a documented, severe, and persistent safety risks related to mental health, behavioral health, or psychosocial functioning requiring near-continuous supervision;
      ii. Increased supervision is required to reduce the risk of harm to self or others;
      iii. Supervision supports treatment goals and community stabilization;
      iv. Documentation supports that lower-intensity interventions, including H2022X2, are insufficient to safely manage the identified risk;
      v. The service is intended to prevent immediate transition to a more restrictive level of care;
   d. H2022X4: Therapeutic Mentoring/Skill Building Support, meets the following:
      i. Member/enrollee has a behavioral health condition resulting in functional impairment;
      ii. Mentoring or skill-building activities are linked to specific treatment plan goals;
      iii. Services are rehabilitative and are not primarily custodial, recreational, or supervision-only;
      iv. Services are coordinated with the member/enrollee's clinical treatment;
   e. H2022X5: Other services and support meets the following:
      i. The requested service addresses a documented barrier to accessing or participating in medically necessary treatment;
      ii. Without the service the member/enrollee is at risk of treatment disruption, functional deterioration, or loss of community stability;
      iii. The barrier cannot be adequately addressed through routine benefits, natural support, or other available resources;
      iv. The service directly supports treatment participation, continuity of care, or discharge planning;
2. *Continued stay request* meets all the following:

a. Member/enrollee continues to meet the applicable modifier-specific criteria for the requested level of service;
b. Documentation demonstrates at least one of the following:
    i. Measurable progress toward treatment goals;
    ii. Maintenance or stabilization of symptoms or functioning that would be expected to deteriorate without continued services;
    iii. Modification of treatment plan to address documented barriers to progress when progress is limited;
c. Member/enrollee and/or family remain engaged in treatment planning and service delivery;
d. Continued services remain the least restrictive and most appropriate intervention;
e. Documentation includes an updated transition, step-down, or discharge plan appropriate to the member/enrollee's current needs.

II. It is the policy of Iowa Total Care that Integrated Services & Supports (ISS) **no longer meets medical necessity** criteria and *discharge* from treatment is medically appropriate when any of the following is met:
A. Safety concerns or functional impairments have resolved or significantly improved;
B. Member/enrollee can maintain stability with less intensive support;
C. Continued services are not expected to provide additional clinical benefit;
D. Services are no longer consistent with the least restrictive environment;
E. Member/enrollee no longer meets the applicable modifier-specific criteria.

III. It is the policy of Iowa Total Care that Integrated Services & Supports (ISS) **are not medically necessary** for any of the following:
A. Member/enrollee is enrolled in the Iowa Health and Wellness Plan and is not medically exempt;
B. Member/enrollee is enrolled in the Healthy and Well Kids in Iowa (Hawki) program, which are not eligible for B3 services;
C. Member/enrollee is incarcerated;
D. Requested services duplicate the purpose, scope, or expected outcomes of another reimbursable service, including but not limited to Home-Based Habilitation or Residential-Based Supported Community Living;
E. Services are primarily intended for:
    1. Childcare, recreation, respite, or general supervision;
    2. Social activities without linkage to treatment goals;
    3. Convenience or visitation;
    4. Needs unrelated to treatment access, participation, or continuity of care.

Background

Iowa Medicaid member/enrollees, 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).[1]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description
H2022	Integrated Services & Supports (X1-X5), per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	07/26	

References

1. Iowa Health and Human Services. Iowa Medicaid B3 Provider Manual (Guide). https://hhs.iowa.gov/about/policy-manuals/medicaid-provider. Updated January 15, 2026. Accessed July 13, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment by providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.