Acute Hospital Services

Provider Manual

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HHS

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. Hospitals Eligible to Participate – Acute Hospital Services

1. Certification of Hospitals

All Iowa hospitals that are certified as eligible to participate in the Medicare program are eligible to participate in the Iowa Medicaid program (441 Iowa Administrative Code (IAC) 641-78.3(3)(249A.)). Hospitals in other states are eligible to participate in Iowa Medicaid, providing they have been certified as eligible to participate in Medicare in that state. [Iowa Code Section 249A.4]

a. Certification of Special Units

Certification by Iowa Medicaid is required for Medicaid reimbursement (IAC 78.31(3)) as a neonatal intensive care unit, a psychiatric unit, a physical rehabilitation hospital or unit, or a substance abuse unit.

Hospitals should submit requests for certification to:

Iowa Medicaid
Attn: Provider Services Unit PO Box 36450
Des Moines, IA 50315

The request needs to include documentation demonstrating the certification requirements are met. The Provider Services Unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which Iowa Medicaid received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(1) Criteria for Neonatal Intensive Care Units

A neonatal intensive care unit receives categorization and verification based on national recommendations set forth by American Academy of Pediatrics for newborn care (IAC 641-150.9(135)). The neonatal intensive care unit may then be certified for Iowa Medicaid reimbursement if it is verified as a level II (IAC 641 -159(2)), level III (IAC 641-159(3)) or Level IV (IAC 641-159(4)) neonatal unit and the hospital where it is located is accredited by The Joint Commission or the American Osteopathic Association as per the Iowa Department of Health and Human Services, Iowa Code 150.11(135)

Iowa Medicaid shall verify the neonatal unit's certification level.

Neonatal units in Iowa shall be certified by the Iowa Department of Health and Human Services according to IAC 641 Chapter 150. Out-of-state units shall submit proof of level II or level III certification from their respective states.

(2) Criteria for Physical Rehabilitation Hospitals and Units

A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement if:

- it receives Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), and
- the hospital is accredited by The Joint Commission or the American Osteopathic Association.

(3) Criteria for Psychiatric Units

A psychiatric unit may be certified for Medicaid reimbursement if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 as amended to August 1, 2002, and 42 Code of Federal Regulations, Sections 412.25 as amended to August 1, 2002 with Change Request 11062 December 14, 2018.

Inpatient Psychiatric Units must also meet the requirements related to admission, medical records, personnel, psychological services, social services, and therapeutic activities as Outlined in Medicare Benefit Policy Manual Chapter 2 Inpatient Psychiatric Hospital Services Rev. 253, Issued 12-14-2018 (R253 (cms.gov))

Any hospital operating as an acute psychiatric hospital or unit will be engaged in providing services for the diagnosis and treatment of persons with psychiatric illness/disorders (IAC 481-51.36(1)a.)

While operating under the supervision of a doctor of medicine or osteopathy, the policies and procedures of the psychiatric hospital/psychiatric unit will identify (IAC 481-51.36(1)a.b.c.d.):

- how the general and specialized rules pertaining to general hospital are met
- if the medical and surgical diagnostic treatment services are not available within the institution, the agreement with an outside source of these services explaining the immediately availability.
- how the patient is informed of their rights and responsibilities and ensuring the availability of a patient advocate

- sufficient qualified professionals and support staff to:
  i. evaluate patients
  ii. formulate written individualized comprehensive treatment plan
  iii. provide active treatment measures
  iv. and engage in discharge planning

(4) Criteria for Substance Abuse Units Chapter 155

An in-state substance abuse unit may be certified for Medicaid reimbursement if the unit's program is licensed by the Iowa Department of Health and Human Services as a substance abuse treatment program in accordance with IAC 641 Chapters 125 and 155. (IAC 641-155.2)

In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served. (IAC 641-155.3(3) and IAC 641-155.5)

(5) Criteria for Transplant Certification

Hospitals performing transplants must meet criteria in IAC 441 -78.3(10) as determined by Iowa Medicaid. Iowa Medicaid Provider Services can provide a copy of the rules. Iowa Medicaid Provider Services must approve the provisions of other services that are reimbursed on a special basis.

2. Cost Reporting Requirements

Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles and in accordance with Medicare Provider Cost Reporting subject to the exceptions and limitations provided in this rule.

- The hospital's Medicare cost report (form CMS-2552, *Hospitals and Healthcare Complex Cost Report*);
- Either:
  - *Hospital Supplemental Cost Report*, form 470-4514 (click here), or
  - *Critical Access Hospital Supplemental Cost Report*, form 470-4515, (click here); and

A copy of the revenue code crosswalk used to prepare the Medicare Cost Report.The cost reports and supporting documentation shall be sent to:

Iowa Medicaid
Provider Cost Audit and Rate Setting Unit,
PO Box 36450
Des Moines, IA 50315

The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

3. Incentives for Efficient Operation

Payment to hospitals using diagnosis-related group (DRG) methodology extends incentives for efficiency of operations. These systems encourage providers to control their operating costs and hence, lower their actual overall costs for Medicaid.

When the covered charge is lower than the hospital's prospective reimbursement rate, the hospital may keep the difference. When the reverse is true, the hospital will not experience additional payment for that service.

Under 42 CFR 447.321, upper payment limit tests are required to ensure that Medicaid payments made under this plan do not exceed what would be paid for the services furnished by the group of facilities under Medicare payment principles. This applies to rates paid for outpatient services furnished by hospitals within the following categories:

- State government-owned or operated,
- Non-state-government-owned or operated, and
- Privately owned and operated.

Iowa Medicaid performs these tests on a yearly basis, after receipt of finalized cost reports from the Medicare fiscal intermediaries.

Additionally, under 42 CFR 447.325, Medicaid may not pay more than the prevailing charges, in aggregate, in a locality for comparable services under comparable circumstances. This test is performed on a yearly basis.

4. Audits

Legal reference: IAC 441 78.3

All cost reports are subject to desk review audit and, if necessary, a field audit.

- All Cases are subject to random retrospective review.
- Cases may receive a more intensive retrospective review if abuse is suspected.
- Each participating hospital is subject to a periodic audit of its fiscal and statistical records.
- Selected admission and procedure are subject to a 100% review before services are provided
- The Department has agreements for the exchange of Medicare and Medicaid information with the Medicare intermediaries in Iowa and surrounding areas.
- Transfers, outliers, and readmissions within 31 days are subject to random review.

5. Provider Appeals

In accordance with 42 CFR 447.253(e), providers have appeal rights for rate setting in the inpatient setting. A hospital that is dissatisfied with a diagnosis-related group (DRG) rate determination may file a written appeal. The appeal must clearly state the nature of the appeal and be supported with all relevant data.

The Department of Health and Human Services contracts with the Department of Inspections and Appeals to conduct appeal hearings. Based upon a proposed decision by the Department of Inspections and Appeals, the Department of Health and Human Services makes a final decision and advises the provider accordingly within 120 days.

6. Rate Adjustment for Hospital Mergers

When one or more hospitals merge to form a distinctly different legal entity, the base rates and add-ons are revised to reflect this new operation. Financial information from the original cost reports and the original rate calculations is added together and averaged to form the new rate for the merged entity.

7. Recovery of Overpayments

When the Department determines that a hospital has been overpaid for inpatient, a notice of overpayment and request for refund is sent to the hospital. The notice states that if the hospital fails to submit a refund or an acceptable response within 30 days, the amount of the overpayment will be withheld from weekly payments to the hospital.

B. Coverage of Inpatient Services

Payment is made for inpatient hospital care as medically necessary.

Iowa Medicaid reimburses hospitals for inpatient care based on diagnosis-related groups (DRG) (IAC 78.3(249A)). There are no specific limits on the number of days of inpatient care for which DRG payment will be approved, as long as Iowa Medicaid Medical Services determines that the care is medically necessary in the individual case, subject to the limitations in this chapter.

1. Certification of Inpatient Care

Review activities are completed to ensure that Medicaid beneficiaries receive care that is medically necessary and of an appropriate quality. These activities may include prior authorization procedures or retrospective reviews regarding medical necessity or payment accuracy.

Medicaid adopts most Medicare peer review organization regulations to control increased admissions or reduced services. The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification (441 Iowa Administrative Code Chapter 78.1 (15)).

Payment can be denied if either admissions or discharges are performed without medical justification, as determined by Iowa Medicaid Medical Services.

Inpatient services that require preadmission approval by Iowa Medicaid Medical Services are updated periodically by the Department. Once the preadmission approval is granted, an authorization number is given. Provide the authorization number on the UB-04 claim form to receive payment. Claims submitted without this authorization number will be denied.

To safeguard against these and other inappropriate practices, Iowa Medicaid Medical Services will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations on peer review organizations.

2. Pre-Procedure Review

To ensure that procedures are medically necessary, Iowa Medicaid Medical Services conducts a pre-procedure review program for the Medicaid program. (IAC 441 – 79.11, 78.1(19), 78.3(18), and 78.26(3).Approval by Iowa Medicaid medical services will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department.

Pre-procedure review is performed for all heart, lung, liver, stem cell,pancreas, and bone marrow transplants and for all bariatric procedures. (IAC–441 78.3(10), 78.1(20))

a. Review Process

- The Provider must submit a request to Iowa Medicaid Medical Services.
- Iowa Medicaid Medical Services will issue a validation number for each request, which includes if the payment for the procedure will be approved or denied.
- Medicaid adopts most Medicare Quality Improvement Organizational regulations to control increased admissions or reduced services. Payment can be denied if either admissions or discharges are performed without medical justification as determined by Iowa Medicaid Medical Services. To safeguard against this or any other inappropriate practices, Iowa Medicaid Medical Services will monitor admission practices and quality of care.
- Inpatient services which require preadmission or pre-procedure approval by Iowa Medicaid Medical Services are updated each year.
- The request must provide the following information from the physician, on which Iowa Medicaid Medical Services will base its decision: (IAC 441-78.28(f))
    - Procedure planned
    - Proposed admission date
    - Proposed date of procedure
    - Hospital or location of intended procedure
    - Member’s name and address
    - Member’s age
    - Member’s Medicaid identification number
    - Attending physician’s name
    - Tentative diagnosis
    - Orders
    - History and chief complaint (include symptoms and duration of problem)
    - Other medical history or problem
    - Preadmission treatment
    - Outpatient studies performed
    - Medication

Pre-procedure review is conducted using criteria that have been developed by the applicable physician categories. (IAC 441- 79.1(2)) Questionable cases are referred to a physician reviewer for determination of the medical necessity of the procedure. Denial letters are issued if the procedure is determined not to be medically necessary.

Iowa Medicaid provides validation numbers on all approved pre-procedure reviews. (IAC 441-79.11(2)) Claims sent to Iowa Medicaid without a validation prior authorization number will be denied. Iowa Medicaid will not provide medical payment to the physician, other medical personnel, and/or the facility without approval (IAC 441-79.11 (3)). The hospital must notify Iowa Medicaid to request a retrospective review to determine the appropriateness of the procedure before receiving payment.

A sample of cases reviewed on a pre-procedure basis are selected for retrospective review. The information provided during the pre-procedure review is validated during the retrospective review process. A denial may be issued if the information provided during precertification review is not supported by medical record documentation.

b. Procedure Review Obtained Following Discharge

If the provider discovers that pre-procedure review was not obtained with Iowa Medicaid before or immediately following the procedure and the member was discharged, the provider must request Iowa Medicaid review to determine the appropriateness of the procedure before receiving payment.

In addition, the hospital must send a copy of the complete medical record with the completed form, identifying the procedure, to Iowa Medicaid for a retrospective review.

3. Specific Diagnostic Situation Information

a. Abortion

Information Legislation enacted by the Iowa General Assembly limits payment for abortions (a termination of pregnancy of a woman known to be pregnant with the intent other than to produce a live birth or to remove a dead fetus (Iowa Code 2022 Vital Statistics, 144.29A. 7.b.) through the Medicaid program to the following situations: (IAC 441: 78.1(17)

- The attending physician shall certify in writing via Form 470-0836, on the basis of professional judgment, that continuing the pregnancy would endanger the life of the pregnant woman. (IAC 441: 78.1(17)a.) Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed. A copy of *Certification Regarding Abortion*, form 470-0836, must be attached to the physician's claim if payment is to be made for an abortion (Title 42/Chapter IV/Subchapter C/ Part 441/Subpart E 441-206). Click here to view the form online. (IAC 441 Chapter 78.1(17))

Payment cannot be made to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if the required certification is not submitted with the claim for payment.

- The attending provider shall certify in writing, on the basis of the provider's professional judgment, that the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition ((IAC 441: 78.1(17)b.)).
- If the pregnancy is the result of rape that (IAC 441: 78.1(17)c.):
  - Was this reported to a law enforcement agency or public or private health agency, which may include a family physician, and
  - Was this reported within 45 days of the date of the incident, and does the report contain the name, address and signature of the person making the report. An official of the agency must so certify in writing. In the case of a pregnancy resulting from rape, a certification from a law enforcement agency, public or private health agency, or family physician is required (IAC 441 Chapter 78.1(17)c.d.) It is the responsibility of the member, someone acting on their behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.
- If the pregnancy is the result of incest:(IAC 441: 78.1(17)d.):
  - Was this reported to a law enforcement agency or public or private health agency, which may include a family physician, and
  - Was this reported within 150 days of the incident, and
  - Does the report contains the name, address, and signature of the person making the report. An official of the agency or physician must so certify in writing via Form 470-0836 of a pregnancy resulting from rape, a certification from a law enforcement agency, public or private health agency, or family physician is required, (IAC 441 Chapter 78.1(17)c.d.). It is the responsibility of the member, someone acting in her behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.

(1) Certification Regarding Abortion, 470-0836

- It is the responsibility of the physician to make a copy of form 470-0836 available to the hospital, other physicians, certified registered nurse anesthetists, anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other physicians on abortion claims (IAC 441 Chapter 78.1(17))
- All abortion claims must be billed with the appropriate ICD 10 diagnosis and procedure code indicating the abortion on the hospital claim and the appropriate ICD 10 diagnosis and CPT abortion procedure code on the practitioner claim.

- The health care provider who induces the termination of the pregnancy, will complete and submit the form within thirty days of the occurrence. A documented good faith effort will make note of completing the information with respect to the termination of the pregnancy (Iowa Code 2022 Vital Statistics, 144.29A. 2.a.b.c.). The intent is to collect the data while protecting the confidentiality/anonymity of the patient. The data will be shared in acceptable format, to facilitate funding and public health research.

The reason for the abortion must be identified on the *Certification Regarding Abortion* form. This form must be attached to the claim for payment, along with the following documentation:

- The operative report
- The pathology report
- Lab reports
- The ultrasound report
- The physician's progress notes
- Other documents that support the diagnosis identified on the claim

The 'spontaneous termination of pregnancy' means the occurrence of any unintended termination of pregnancy at any time during the period from conception to twenty weeks gestation. (Iowa Code 2022 Vital Statistics, 144.29A.7.c.). A fetal death is reported as a spontaneous termination of pregnancy at any time during the period of twenty weeks gestation or greater (Iowa Code 2022 Vital Statistics, 144.29A.7.c.).

(2) Covered Services Associated with Non-Covered Abortions

The following services are covered even if performed in connection with an abortion that is not covered:

- Services that would have been performed on a pregnant woman regardless of whether she was seeking an abortion, including:
  - Pregnancy tests.
  - Tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis).
  - Laboratory tests routinely performed on a pregnant member, such as Pap smear, urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B, and blood typing.
- Charges for all services, tests, and procedures performed post abortion for complications of a non-covered therapeutic abortion, including:
  - Charges for services following a septic abortion.
  - Charges for a hospital stay beyond the normal length of stay for abortions.

NOTE: Family planning or sterilization services must not be billed on the same claim with an abortion service. These services must be billed separately.

(3) Non-Covered Services Associated with Non-Covered Abortions

- Physician and surgical charges for performing the abortion. These charges include the usual, uncomplicated preoperative and postoperative care and visits related to performing the abortion.
- Hospital or clinic charges associated with the abortion. This includes:
  - The facility fee for use of the operating room.
  - Supplies and drugs necessary to perform the abortion.
- Charges associated with routine, uncomplicated preoperative and postoperative visits by the member.
- Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- Charges for laboratory tests performed before performing the non-covered abortion to determine the anesthetic or surgical risk of the member (e.g., CBC, electrolytes, blood typing).
- Drug charges for medication usually provided to or prescribed for a member who undergoes an uncomplicated abortion. This includes:
  - Routinely provided oral analgesics.
  - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH-negative women who have an abortion).
- Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- Uterine ultrasounds performed immediately following an abortion.

b. Cosmetic Surgery

Cosmetic, reconstructive, plastic surgery, or expenses incurred in connection with such surgeries is not covered under the Medicaid program *except when* required for the (IAC 441 Chapter 78.6(5)d.):

- Prompt (i.e., as soon as medically feasible) repair of accidental injury,
- Improvement of or return to the original functioning of a congenitally malformed body member, or
- Revision of disfiguring and extensive scarring related to neoplastic surgery.

In such latter cases, such surgery becomes primarily reconstructive, as opposed to merely cosmetic.

For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which:

- Can be expected primarily to improve physical appearance,
- Is performed primarily for psychological purposes, or
- Restores form but which does not correct or materially improve bodily function.

However, when a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions of this policy.

When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded. However, an important distinction in this regard is that if a given member incurs some medical condition, such as an infection (or similar condition) following cosmetic surgery, then payment would be made for treating the infection or similar condition.

While coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- Correction of a congenital anomaly
- Restoration of body form following an accidental injury
- Revision of disfiguring and extensive scars resulting from neoplastic surgery

Generally, coverage is limited to those cosmetic, reconstructive or plastic surgery procedures provided no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration or exception will be given to cases involving children who may require a growth period or for other medically necessary and appropriate reasons involving adults.

Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
- Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.
- Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

Following is a partial list of cosmetic, reconstructive, or plastic surgery **procedures which are not covered** under the program (this list is for example purposes only and is not considered all inclusive) (IAC 441-78.1(4).:

- Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the member's age or ethnic or racial background
- Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need
- Augmentation mammoplasties
- Face lifts and other procedures related to the aging process
- Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts
- Panniculectomy and body sculpture procedures, unless there is medical documentation of chronic back or abdominal pain, intertriginous skin infections or dermatitis, impaired ambulation, or difficulty with activities of daily living not amenable to at least six months of conservative treatment
- Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision
- Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing
- Chemical peeling for facial wrinkles
- Dermabrasion of the face
- Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery
- Removal of tattoos
- Hair transplants
- Electrolysis
- Sex reassignment
- Penile implant procedures
- Insertion of prosthetic testicles

c. Diagnosis and Treatment Tests

Payment for inpatient hospital tests for the purposes of diagnosis or treatment shall be made only when the tests are specifically ordered for the diagnosis or treatment of a particular member's condition (IAC 441 chapter 78.3(7). The attending physician or other licensed practitioner who is responsible for the member's diagnosis or treatment must order the test, acting within the scope of practice as defined by law.

d. Fertility Services

Iowa Medicaid does not cover fertility services (IAC 441 Chapter 78.2(4)b.(8)).

e. Hysterectomies

Payment will be made only for a medically necessary hysterectomy that is performed for a purpose other than sterilization and only when one or more of the following conditions are met (IAC 441 Chapter 78.1(16)a.(2) and IAC 441 Chapter 78.1(16).(4)j.):

- A member or her representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the member permanently incapable of reproducing (IAC 441 Chapter 78.1(16)j.(1)):.

This statement may be added to either the surgery consent form, written on the claim form, or on a separate sheet of paper. The person who receives the explanation must sign the statement. The following language is satisfactory for such a statement:

> *"Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.*
>
> *(Date)* *(Signature of member or person acting on her behalf)"*

The vehicle for transmitting the acknowledgement that the member received the explanation before the surgery should **not** be the *Consent for Sterilization*, form 470-0835 or 470-0835S.

This statement must be submitted to Iowa Medicaid with the related Medicaid claims.

- When the member was already sterile before the hysterectomy (IAC 441 Chapter 78.1(16.j.(2)), the physician must certify in writing that the member was already sterile at the time of the hysterectomy and must state the cause of the sterility. The following language is satisfactory for such a statement:

> *"Before the surgery, this patient was sterile and the cause of that sterility was __________________.*
>
> *(Physician's signature)* *(Date)"*

This statement may be added to either the surgery consent form, written on the claim form, or a separate sheet of paper. A physician must sign any document stating the cause of sterility. This includes a history and physical, operative report, or claim form.

The statement must be submitted to Iowa Medicaid with the related Medicaid claims.

- If the hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible (441 Chapter 78.1(16j.(3))), the physician must include a description of the nature of the emergency.

  If the physician certifies that the hysterectomy was performed for a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis. Payment will be permitted only in extreme emergencies.

- Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus could be a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information. This includes C-sections when there is a reasonable expectation a hysterectomy will be performed, such as in the event of a placental accreta.

f. Medicare-Covered Services

Medicaid will pay the Medicare coinsurance and deductible for members who are eligible for both Medicare and Medicaid (IAC 441–75.1(29))

g. Organ Transplants

Payment will be made only for the following organ and tissue transplant services when medically necessary (IAC 441 Ch.78.1(20))

- Kidney, cornea, skin, and bone transplants. (IAC 441 Ch.78.1(20a.(1))
- Allogeneic bone marrow transplants for the treatment of (IAC 441 78.3(10); Ch.78.1(20a.(2)):
  - Aplastic anemia,
  - Severe combined immunodeficiency disease (SCID),
  - Wiskott-Aldrich syndrome,
  - Follicular lymphoma,
  - Fanconi anemia,
  - Paroxysmal nocturnal hemoglobinuria,
  - Pure red cell aplasia,
  - Amegakaryocytosis/congenital thrombocytopenia,
  - Beta thalassemia major,
  - Sickle cell disease,
  - Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]),
  - Adrenoleukodystrophy,
  - Metachromatic leukodystrophy,
  - Refractory anemia,
  - Agnogenic myeloid metaplasia (myelofibrosis),
  - Familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders,
  - Acute myelofibrosis,
  - Diamond-Blackfan anemia,

- Epidermolysis bullosa, or the following types of leukemia:
  - Acute myelocytic leukemia,
  - Chronic myelogenous leukemia,
  - Juvenile myelomonocytic leukemia,
  - Chronic myelomonocytic leukemia,
  - Acute myelogenous leukemia, and
  - Acute lymphocytic leukemia.

- Autologous bone marrow transplants for treatment of the following conditions (IAC 441 78.3(10); Ch.78.1(20a.(3)):
  - Acute leukemia,
  - Chronic lymphocytic leukemia,
  - Plasma cell leukemia,
  - Non-Hodgkin's lymphomas,
  - Hodgkin's lymphoma,
  - Relapsed Hodgkin's lymphoma,
  - Lymphomas presenting poor prognostic features,
  - Follicular lymphoma,
  - Neuroblastoma,
  - Medulloblastoma,
  - Advanced Hodgkin's disease,
  - Primitive neuroendocrine tumor (PNET),
  - Atypical/rhabdoid tumor (ATRT),
  - Wilms' tumor; Ewing's sarcoma,
  - Metastatic germ cell tumor, or
  - Multiple myeloma.

- Liver transplants for members with extrahepatic biliary atresia or any other form of end-stage liver disease. **EXCEPTION:** Coverage is not provided for members with a malignancy extending beyond the margins of the liver or those with persistent viremia. (IAC 441 Ch.78.1(20a.(4)):

  Liver transplants require pre-procedure review by Iowa Medicaid Medical Services and are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10).

- Heart transplants (IAC 441 Ch.78.1(20a.(5)): for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered.

  Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated. Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require pre-procedure review by Iowa Medicaid Medical Services Prior Authorization Unit. Heart-lung transplants are covered consistent with the criteria listed above under heart transplants.

Covered heart transplants are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10).

- Lung transplants (IAC 441 Ch.78.1(20a.(6)) for members having end-stage pulmonary disease. Lung transplants require pre-procedure review by Iowa Medicaid Medical Services Unit and are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10).

- Pancreas transplants (IAC 441 Ch.78.1(20a.(7)) for person with type I diabetes mellitus, as follows:

  - Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

  - Pancreas transplants alone are covered for persons exhibiting any of the following:

    - A history of frequent, acute and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

    - Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

    - Consistent failure of insulin-based management to prevent acute complications.

  Pancreas transplants require pre-procedure review by Iowa Medicaid Medical Services.

NOTE: See current rules 441 IAC 78.1(20) for complete listing of currently covered transplants, related provision.

Donor expenses (IAC 441 Ch.78.1(20a.(7)) incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

h. Inpatient Dental treatment

Payment is only approved for inpatient hospital care, when the mental, physical, or emotional condition of the patient prevents the dentist from providing the care in the office (IAC 441-78.3(11)).

i. Respite Care

A hospital choosing to provide respite care to (HCBS) Home and Community Bases Services waiver consumers must enroll with Medicaid as a waiver provider (Title 42 Chapter IV Subchapter C Part 440.181 b(6))

j. Sterilizations

Federal regulations provide that payment shall not be made through the Medicaid program for sterilization of a member under the age of 21 at the time of consent or who is legally mentally incompetent or institutionalized.

"Sterilization" means (IAC441-78.1(16)a.(1)) any medical procedure, treatment, or operation for the purpose of rendering a person incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment to an operation of the genital urinary tract.

For purposes of this definition, mental illness or intellectual disability is not considered an illness or injury.

A "legally mentally incompetent" person (IAC441-78.1(16)a.(3)) is one who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the court declares the member competent for purposes that include the ability to consent to sterilization.

An "institutionalized" person (IAC441-78.1 (16a. (4)) is a person who is Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness or confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

Requirements for sterilization include the following conditions (Title 42 Chapter IV Part 441.253) and (IAC441-78.1 (16)):

- The member to be sterilized must voluntarily request the services (IAC 441-78.1(16)b.).
- The member to be sterilized must be advised that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization, without prejudicing the member's future care or loss of other project or program benefits to which the member might otherwise be entitled. (IAC441-78.1(16)d.)
- The member to be sterilized must be given an explanation of the procedures to be performed by a knowledgeable informant upon which the member can base the consent for sterilization. An "informed consent" is required (IAC441-78.1(16)e.).

"Informed consent" means the voluntary knowing permission from the member on whom the sterilization is to be performed, after the member has been given a complete explanation of what is involved and has signed a written document to that effect.

If the member is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The member to be sterilized may be accompanied by a witness of the member's choice (IAC441-78.1 (16)g.).

The informed consent shall not be obtained while the member to be sterilized is (IAC441-78.1 (16)f.):

- In labor or childbirth,
- Seeking to obtain or obtaining an abortion, or
- Under the influence of alcohol or other substance that affects the member's state of awareness.

The elements of explanation which must be provided are (IAC441-78.1 (16)e.):

- A thorough explanation of the procedures to be followed and the benefits to be expected. (IAC441-78.1 (16)e.(2))
- A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used (IAC441-78.1 (16)e.(3))
- Counseling concerning alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure (IAC441-78.1 (16)e.(1))
- An offer to answer any questions concerning the proposed procedure (IAC441-78.1 (16)e.(4))
- The member must give "informed consent" at least 30 days, but not more than 180 days, before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs (IAC441-78.1 (16)f.)

For an exception to be approved when emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent was obtained (IAC441-78.1(16)f.)

For an exception to be approved when a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained. Documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed (IAC441-78.1(16)f.)

(1) Consent for Sterilization, Forms 470-0835 and 470-0835S:

The "informed consent" shall be obtained on form 470-0385, *Consent for Sterilization*, or the Spanish version, form 470-0835S, *Formulario de Consentimiento Requerido*. The individual must be 21 years of age or older at the time of consent. An equivalent Medicaid form from another state is acceptable ((IAC441-78.1 (16)b.(1).(2)):

- Click here to view the English consent form online.
- Click here to view the Spanish consent form online.

The physician's copy of the consent must be completely executed in all aspects (no substitute form is accepted) according to the above directions and attached to the claim in order to receive payment.

When a claim for physician's services for sterilization is denied either due to the failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided, or failure to use the official consent form, 470-0835 or 470-0835S, any claim submitted by the ambulatory surgical center, hospital, anesthesiologists, assistant surgeon, or associated providers for the same operation or procedure will also be denied. (IAC441-78.1(16)f.)

- It is the responsibility of the ambulatory surgical center, hospital, and other providers associated with the sterilization services to obtain a photocopy of the completed consent form which must be attached to their claim when submitted to the Iowa Medicaid for payment. (IAC 441-78.1(16)h.)
- All names, signatures, and dates on the consent form must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:
  - The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the member to be sterilized.
  - The information requested pertaining to race ethnicity designation is to be supplied voluntarily on the part of the member,but is not required.

It is the responsibility of the provider obtaining the consent form to verify that the member requesting the sterilization is at least 21 years of age on the date that the member signs the form. If there is any question pertaining to the true age of the member, the member's birthdate must be verified (IAC 441-78.1(16)).

The "Statement of Person Obtaining Consent" may be completed by any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control which are available to the member.

The "Physician's Statement" must be completed fully and signed by the **physician performing the sterilization** and dated when signed. It is important that one of the paragraphs at the bottom of this statement, which is not used, be crossed out as per instructions.

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization for which a claim will be submitted; i.e., ambulatory surgical center, hospital, anesthetist, assistant surgeons, etc.

It is the responsibility of all other providers associated with the sterilization to obtain a photocopy of the fully completed consent form from the physician performing the sterilization, to be attached to the provider claim which is submitted to Iowa Medicaid for payment. (IAC 441-78.1 (16)h.)

The only signatures which should be on the completed consent form are those of the member, interpreter (if interpreter services were provided), the person who provided the information and the physician performing the sterilization. (IAC 441-78.1 (16)h.(1)(2)(3)(4))

k. Substance Abuse Rehabilitation

Payment will be made for the medically necessary treatment of rehabilitation for substance abuse. Substance abuse rehabilitation shall be performed only in Medicaid-certified substance abuse units. Medically necessary detoxification treatment may be performed in any acute care hospital.

l. Vaccinations

Hospitals that wish to administer vaccines to Medicaid children that are available through the Vaccines for Children (VFC) program shall enroll in the VFC program (IAC 441-78.23(4)). Obtain information about immunizations by contacting (800) 232-4636 or (800) 831-6293.

Vaccines available through the VFC program are found in the Iowa Department of Health and Human Services. Click here to access the list of Available Vaccines and Covered Age ranges, or call (800) 831-6293. When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

C. Basis of Payment for Inpatient Services

1. Basis of Payment

The basis of payment for inpatient hospital care is similar to that in the Medicare program. Except for care in critical-access hospitals, the Iowa Medicaid program reimburses inpatient hospital care based on the diagnosis-related group (DRG) principle, as explained in 42 Code of Federal Regulations Part 412.

a. Definitions

Iowa Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system, except as indicated. The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification (441 Iowa Administrative Code Chapter 78.1 (15).

As a result, combined billing for physician services is eliminated, unless the hospital has approval from Medicare to combine bill the physician and hospital services.

b. Services provided by certified nurse anesthetists

Services provided by certified nurse anesthetists employed by a physician are covered by the physician reimbursement(441-78.1(13)). Services provided by certified nurse anesthetists employed by the hospital are billed on the CMS-1500, *Health Insurance Claim Form*.

c. Inpatient Admission

A member may be admitted as an inpatient after receiving outpatient services. If the admission is within three days of the day the outpatient services were provided, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes (IAC 441 - 79.1(5)q.). The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. This does not apply to critical-access hospitals.

d. Emergency Medical Hospital Care

Payment may be approved for an assessment fee to determine if the medical emergency exists. This is based on the patient presenting with unforeseen conditions combined with the health history at which the symptoms indicate a substantial risk to the persons health,
(IAC 441-78.3(12), IAC 441-79.1(16)a.r.).

e. Acute Care Hospital Bed Occupied by patient requiring Skilled Nursing Level of Care

Payment for patients in acute hospital beds who are determined by Iowa Medicaid Medical Services unit to require nursing facility level of care, are to be adjusted. This rate is effective as of the date noted by Iowa Medicaid Medical Services Unit at the lower level of care. This payment structure is also used in an outlier review for the days the Iowa Medicaid medical services unit determines, in an outlier review, that the lower level of care was required.
(IAC 441-78.3(14); 441-81.6(16).f.(1))

f. Inpatient charges for a normally billed outpatient surgical procedure

Random claim reviews are pulled monthly and reviewed by Iowa Medicaid Medical Services Unit acute retrospective review team. If the claim information included does not support the appropriateness of an inpatient level of care that claim is sent to Iowa Medicaid Medical Director for review. If the Medical Director approves, claim is paid. If the Medical Director determines the care could have been rendered at the lower level of care, the hospital and attending physician are notified. If the Hospital agrees with the finding, the hospital submits a new clam, if the hospital disagrees, the hospital can submit additional documentation. (IAC 441-78.3(15)

g. Critical-Access Hospitals (Chapter 135B Licensure and Regulation of Hospitals

The basis of payment for critical-access hospitals is reasonable cost achieved through retrospective cost settlement. Critical-access hospitals must submit a *Critical Access Hospital Supplemental Cost Report*, form 470-4515, to furnish the date for cost settlement. Click here to view this form online.

Critical-access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. (IAC 441-79.1(g).

The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received.

Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)"*aa*" and 79.1(16)"*h*..

h. Diagnosis-Related Group Payments (DRG)

DRG are a group of similar diagnoses combined based on the patient age, procedure coding comorbidity and complications.

(1) Medicaid DRGs

Medicaid DRGs cover services provided in acute care general hospitals, (IAC 441 79.1(5)d.) with the exception of physical rehabilitation hospitals, special units such as substance abuse units, neonatal intensive care units, and psychiatric units (IAC 441-79.1(5)r.) which have an annual calculated per-diem rate. The DRG payment covers acute-care hospital services, including:

- **Ambulance services**. The cost for hospital-based ambulance transportation that results in inpatient admission and hospital-based ambulance services performed while the beneficiary is an inpatient is covered by the DRG payment, in addition to all other inpatient services (IAC 411-79.1(5)j.)
- **Treatment by another provider**. If, during an inpatient stay, it becomes necessary to transport (but not transfer) the member to another hospital or provider for treatment, with the member remaining an inpatient at the originating hospital after the treatment (IAC 411-79.1(5)j.):
  - The originating hospital shall bear all costs incurred by that member for the medical treatment or the ambulance transportation between the originating hospital and the other provider.

- The services furnished to the member by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment.

Under the DRG payment system, the "final payment rate" for each hospital (IAC 441 79.1(5)h.) is the aggregate sum of the two components (the blended base amount and capital costs) when added together form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

The rate table is a schedule of rate payments for each provider. The rate table listing is the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight (IAC 441 79.1(5)a.).

The DRG Weight (IAC 441 79.1(5)a) is a number that reflects relative resource consumption, measured by the relative charges by hospitals for cases associated with each DRG.

- Iowa Medicaid uses trimmed claims which is completed by:
  - Using all normal inlier claims
  - Discarding short stay outliers
  - Discarding transfers where the final payment is less that the full DRG payment
  - Include transfers where the full payment is greater than or equal to the full DRG payment, and
  - Use only the estimated charge for the inlier portion of the long stay outliers and cost outliers for weighting calculations
- Iowa-specific DRG weights (IAC 441 79.1(5)c.(1)) reflect the Medicaid charge data from the Medicaid claim set using the trimmed claims. One weight is determined for each DRG with noted exceptions. (IAC 441 79.1(5)c) Weights are based on calculations of:
  - the determined statewide geometric mean charge for all cases classified in each DRG
  - computing the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG
  - taking the sum of the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs
  - dividing the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG
  - normalizing the weights so that the average case has a weight of one.

- The hospital-specific case-mix index is computed (IAC 441 79.1(5)c.(2)) by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period.
- With the blended base amount, (IAC 441 79.1(5)d.) the DRG reflects a 50/50 blend of statewide and hospital-specific base amounts. To identify the blended base amount the statewide average cost per discharge is calculated:
  - by subtracting from the statewide total Iowa Medicaid inpatient expenditures
  - the total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
  - the actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services
- The remaining case-mix adjusted amount is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system less an actual number of non-full DRG transfers and short stay outliers.
- Cost report data for Critical Access Hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge.

i. Inpatient readmissions

Inpatient readmissions within 30 days for same condition (IAC 441 79.1(5)g.(5)) will be under a single DRG for both stays. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

The readmission policy does **not apply** to the following:

- Scheduled readmissions that are part of repetitive or periodic treatments
- Critical access hospitals
- Hospitals that normally submit claims for DRG reimbursement to the Iowa
- Medicaid enterprise after a patient's discharge.

j. Capital Cost Add-on to the base amount

One compensation is added, for capital expenditures, (IAC 441 79.1(5)e.) to the blended base amount before setting the final payment rate. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical-access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per-discharge capital cost to the statewide average case-mix-adjusted per-discharge capital costs and dividing by two.

Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate are subject to a reduction in their capital add-on to equal the greatest amount of the first standard deviation. For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs will be calculated for any hospital that qualifies for payment only as a children's hospital based on a distinct area or areas serving children. This cost will be calculated using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid members in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

k. Outlier Review

Additional payment may be approved for cases meeting or exceeding the Medicaid criteria for day and cost outliers of a DRG. (IAC 441 79.1(5)f.) Iowa Medicaid Medical Services completes a retrospective review of outliers.

- Long stay outliers (IAC 441-79.1(5)f.(1))occur when a patient's stay exceeds the upper day limit threshold. This upper day limit is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.
- Short stay outliers (IAC 441-79.1(5)f.(2)) occur when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to Iowa Medicaid Medical review and payment may be denied for inappropriate admissions.
- Cost outlier cases (IAC 441-79.1(5)f(3)) are identified when charges exceed a fixed multiple of the applicable DRG rate or a fixed dollar amount, whichever is greater. These rates are predetermined. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

- Cases are reviewed to ensure that services were not a duplicative bill, to determine whether services were rendered, and to determine whether all services were ordered by a physician.
- Iowa Medicaid Medical Services Unit review the case and perform admission review, quality review, discharge review, DRG validation, and invasive procedure review. Questionable cases are referred to Iowa Medicaid Quality Improvement physician review to determine whether the services were medically necessary and appropriate. If services are found to be unnecessary, a denial letter is issued to all parties.
- Those hospitals that are notified of any outlier review initiated by the Medicaid Medical Services unit must submit all requested supporting data to the Medicaid Medical Services within 60 days of the receipt of outlier review notification. If this submission of supporting data is not timely received, the outlier payment will be forfeited and recouped.
- Any hospital may request review for additional outlier payment by submitting the medical record, the UB-04, and a copy of the remittance statement within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.
- The Iowa Medicaid Medical Services Unit reviews a random sample of all outlier claims. Any outlier that is not found to be medically necessary for inpatient hospital care may qualify for payment as a lower level of care payment or payment may be denied for inappropriate admissions.
- The Iowa Medicaid Medical Services unit notifies the member, the attending physician, and the hospital of decisions regarding the following reviews:
  - Preadmission, including DRG validation
  - Admission
  - Readmission
  - Transfer
  - Pre-procedure
  - Invasive procedure
  - Outlier

A redetermination that affects payment may be requested within 60 days after receipt of notification. A reconsideration request will be in writing.

Reconsiderations will be completed within three working days after the receipt of the request for preadmission, pre-procedure, or continued stay reviews in an acute rehabilitation unit, swing-bed, or lower level of care provided in an acute facility. Reconsiderations requested following discharge will be completed within 30 working days.

Day outliers (IAC 441-79.1(5)f.(4)) are cases in which the number of days in a stay exceeds the average length of stay by a fixed number of days or a standard deviation from the average length of stay, whichever is less. These thresholds are predetermined. Any days that are determined to be medically unnecessary are "carved out" in determining the qualifying outlier days. A denial letter is issued to all parties identifying the total number of unnecessary days.

Retrospective review may be performed on any hospital service (IAC 441-78.28(6)b.). Review focuses on quality of care, appropriateness of admission, appropriateness of discharge, coding validation, and appropriateness of invasive procedures. Cases identified as readmissions or transfers may be included in the sample. The Iowa Medicaid Medical Services Unit will grant approval per patient condition and established criteria.7Disproportionate-Share Payment

The disproportionate share fund is an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the costs associated with the treatment of a disproportionate share of poor, indigent, non-reimbursed or nominally reimbursed patients for inpatient services. (IAC 441-79.1(5)a.2.)This compensation is made directly from the "graduate medical education and disproportionate share fund." The disproportionate share fun is a part of the "graduate medical education and disproportionate share fund" (GME/DSH fund). (IAC 441-79.1(5)y.).

Hospitals qualify for disproportionate share payments from the fund when:

- The hospital's low-income utilization rate exceeds 25 percent,
- The hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or
- The hospital is defined as a children's hospital

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to members under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age (IAC 441-79.1(5)a.)

To qualify as a children's hospital, a hospital must provide its available base year submitted Medicare cost report to Iowa Medicaid Provider Cost Audits and Rate Setting Unit within 20 business days of a request by the Department. The costs to be reported are those attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

- And as a qualified Children's hospital
  - Provides services predominantly to children under age 18 or includes a distinct area or areas that provide services predominantly to children under 18, **and**
  - Is a voting member of the National Association of Children's Hospitals and Related Institutions, **and**
  - Has low-income and Medicaid inpatient utilization rates for children under 18 at the time of admission of 1 percent or greater in all distinct areas of the hospital where services are provided predominantly to children under 18.

The graduate medical education fund is a part of the "graduate medical education and disproportionate share fund." The graduate medical education fund reimburses qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs. (IAC 441-79.1(5)a.2.).

Iowa hospitals qualify for direct medical education payments (IAC 441-79.1(5)y.(1)) if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

Direct medical education costs are directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The direct medical education rate is calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552).

The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate.

Iowa hospitals qualify for indirect medical education payments when they qualify for indirect medical education payments from Medicare.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualified.

Allocation of the disproportionate share is based on the state fiscal year used as the source of DRG weights in this formula. If a hospital fails to qualify for the disproportionate share payments for the fund the amount of money that would have been paid to that hospital shall be removed from the fund.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

For hospitals that qualify for disproportionate share under **both** the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be the greater of:

- 2.5 percent, or
- The product of 2.5 percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do **not** qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage is 2.5 percent.

For hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition only, the disproportionate share percentage is the product of 2.5 percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage is the greater of:

- 2.5 percent, or
- The product of 2.5 percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

A qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Hospitals receiving reimbursement as critical-access hospitals do not qualify for disproportionate share payments from the fund.

Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

- Multiply the total of all DRG weights for claims paid during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value.
- Sum the dollar values for each hospital.
- Divide each hospital's dollar value by the total dollar value, resulting in a percentage.
- Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate-share payments from the fund and supplemental disproportionate share payments cannot exceed the amount of the federal cap under Public Law 102-234, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments.

2. Inpatient Psychiatric Units

To be operating as hospital psychiatric hospital or unit, the hospital needs to:

- be under the supervision of a Doctor of Medicine or Doctor of Osteopathy
- primarily engaged in providing psychiatric services for the diagnosis and treatment of persons with psychiatric illnesses/disorders
- have medical and surgical diagnostic treatment services available in the facility; if not the has an agreement with an outside source of these services to ensure they are immediately available
- have policies and procedures for informing patients of their rights and responsibilities and for ensuring the availability of a patient advocate; and
- Have sufficient numbers of qualified professionals and support staff to evaluate patients, formulate written individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning. (IAC 481-51.36) and (IAC 481-51.36(2))
- Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)"i" if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002

Medicaid-certified inpatient psychiatric units will be paid a per diem rate based on historical costs. The per diem rate effective October 1, 2008, will be based upon the hospital's cost report with a fiscal year ending on or after January 1, 2007, and before January 1, 2008. The per diem rate will be rebased every three years thereafter. In non-rebasing years, the per diem rate will be trended forward based on legislative appropriations.

The inpatient psychiatric per diem rate is calculated as total Medicaid inpatient psychiatric unit cost divided by inpatient psychiatric unit discharges. Medicaid inpatient psychiatric per diem cost is determined based upon Medicare principles of cost reimbursement is identified through the step-down cost apportionment process on the CMS-2552 using inpatient psychiatric unit patient days and cost to charge ration.

Hospitals are required to submit with the CMS-2552 Medicaid supplemental cost report schedules detailing Medicaid patient days and Medicaid charges by line item. In addition, Medicaid charges are available from the Medicaid cost report.

Medicaid inpatient psychiatric routine service cost is calculated based on patient days by multiplying Medicaid inpatient psychiatric days times the inpatient psychiatric routine per diem. Inpatient psychiatric routine per diem is total hospital inpatient psychiatric routine operating costs divided by total hospital inpatient psychiatric patient days.

Medicaid inpatient psychiatric ancillary service cost is determined by multiplying Medicaid charges per Medicaid cost report line item, by the ancillary Medicaid cost to charge ratio for each Medicare ancillary service cost center.

3. Substance Use disorder

A detailed specific direction is available is the Iowa Administrative Code 155. This section is a highlight only.

The Substance Use Disorder program will have a license attained from the department (Iowa Code 125.13 and IAC 641-155.2). For inpatient substance use disorder programs the license will identify the medical management involved in the unit/facility (IAC 641-155.2 h.i.j.) The program must be approved either by The Joint Commission or the Iowa Substance Abuse Commission.

The Substance Use Disorder hospital/unit will have a governing body that has the ultimate authority for the program operations. The explanation is all inclusive in IAC 641-155.21.

Initial Assessment: The program's policies and procedures address the screening, assessment, referral admission and documentation in the patient record (ICA 155.21(11). An assessment is completed prior to admission unless the condition of the patient requires immediate admission (IAC 155.21(11)a.).

Treatment Plan: The program's policies and procedures will address a uniform process of the individualized treatment plan (IAC 155.21(12)). The treatment plan includes (IAC 155.21) the entire inpatient stay including but not limited to the therapeutic environment, dietary intake, medications, visitors, drug screening, as well as a plan for discharge (established with admission), (IAC 155.21(19)(3)d.). The discharge plan ensures the development for ongoing needs post-discharge.

4. Members Eligible for Only Part of the Hospital Stay

When a member is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days.

When a member is eligible for Medicaid for greater than the average length of stay but less than the entire stay, then payment is treated as if the patient was eligible for the entire length of stay.

Long-stay outlier days are determined as the number of Medicaid-eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

5. Out-of-State Hospitals Reimbursement

Out-of-State Hospitals Reimbursement to out-of-state hospitals for the provision of medical care to Iowa Medicaid members will be based on either:

- The Iowa statewide average blended base amount plus the Iowa statewide average capital cost add-on, multiplied by the DRG weight, or
- Blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs.

Hospitals that submit a cost report no later than May 31 in a rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge or the blended capital rate computed by using submitted cost report data.

Out-of-state hospitals serving Iowa Medicaid members qualify for disproportionate share payments from the graduate medical education and disproportionate share fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate.

The disproportionate-share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014. Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph IAC 41- 79.1(5)"y."

Psychiatric units in out-of-state hospitals may receive Medicaid-certified unit status when the unit qualifies as a DRG-exempt unit under the Medicare prospective payment system. The hospital must submit a copy of the Medicare exemption notice to Iowa Medicaid Provider Cost Audits and Rate Setting Unit in order to receive special payment as a Medicaid-certified psychiatric unit.

Out-of-state hospitals are not recognized as having special units for substance abuse or physical rehabilitation treatment and may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

6. Physical Rehabilitation Units

Medicaid-certified physical rehabilitation payment is prospective based on a per diem rate calculated for each hospital by establishing a base year per diem rate to which an annual index is applied.(IAC 441-79.1g.(3))

The base rate effective October 1, 2008, shall be the Medicaid per diem rate as determined by the individual hospital's cost report with a fiscal year ending on or after January 1, 2007, and before January 1, 2008. The per diem rate will be rebased every three years thereafter. In non-rebasing years, the per diem rate will be trended forward based on legislative appropriations.

The base year cost report and resulting per diem rate shall be updated every three years. No recognition is given to the professional component of hospital-based physicians, except in the case of hospitals that have approval from Medicare to combine bill the physician and hospital services.

Hospitals are reimbursed the lower of actual charges or the Medicaid cost per diem rate. The applicable rate is determined based on the hospital fiscal year aggregate of actual charges and Medicaid cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

When Medicaid-certified physical rehabilitation units are reimbursed by a per diem, payment will be approved for the day of admission but not the day of discharge or death.

7. Transfers and Readmissions

The following chart lists the payment provisions for the transferring and receiving facilities when a Medicaid member is transferred. (IAC 441-79.1g.(1)(2)(3)(4)(5))

NOTE: Payment to a Medicaid-certified unit is made only when care is medical necessity.

Transferred from:	To:
Acute-care hospital Paid 100 percent of the hospital's average daily rate for each day care, up to 100 percent of the DRG payment.	Another acute-care hospital Paid 100 percent of the DRG payment.
Acute-care hospital Paid 100 percent of the DRG payment.	Substance abuse unit, Paid 100 percent of the DRG payment.
Acute-care hospital Paid 100 percent of the DRG payment.	Physical rehabilitation unit, Paid through a per diem rate.
Acute-care hospital Paid 100 percent of the DRG payment.	Inpatient psychiatric unit Paid through a per diem rate.

Transferred from:	To:
Facility other than acute care hospital Paid according to rules governing that facility.	Physical rehabilitation unit, Paid through a per diem rate.
Facility other than acute care hospital Paid according to rules governing that facility.	Inpatient psychiatric unit Paid through a per diem rate.
Inpatient psychiatric unit Paid through a per diem rate.	Acute care hospital Paid 100 percent of the DRG payment.
Inpatient psychiatric unit Paid through a per diem rate.	Facility other than acute care hospital Paid according to rules governing that facility.
Physical rehabilitation unit Paid a per diem rate.	Acute care hospital Paid 100 percent of the DRG payment.
Physical rehabilitation unit Paid through a per diem rate.	Facility other than acute care hospital Paid according to rules governing that facility.

Readmissions to the same hospital within seven days of discharge, same member, same diagnosis or condition (IAC 441-79.1g(5))**:**

Pursuant to a 2012 Iowa Legislative mandate (2012 Iowa Acts, Senate File 2336, section 12), a member's readmission within seven days of discharge from a hospital to the that same hospital, and for the same diagnosis or condition, will be treated and paid as one admission.

D. Coverage of Outpatient Services

Payment will be approved only for the following hospital services and medical services provided by hospitals on an outpatient basis (IAC 441-79.1c.(4))

- Services limited by medical necessity:
  - Emergency service
  - Follow-up or after-care specialty clinics
  - General or family medicine
  - Laboratory, x-ray, and other diagnostic services
  - Outpatient surgery
  - Physical medicine and rehabilitation
- Services with additional criteria (non-inpatient programs or NIPs):
  - Alcoholism or substance abuse treatment
  - Cardiac rehabilitation
  - Diabetic education
  - Eating disorders treatment
  - Mental health treatment
  - Nutritional counseling (technically not a NIP, but paid similarly)
  - Pain management
  - Pulmonary rehabilitation

Inpatient or outpatient services that require preadmission or pre-procedure approval by Iowa Medicaid are updated yearly. A list of these procedures is available from Iowa Medicaid Provider Services.. (IAC 441-78.11)

The hospital shall provide Iowa Medicaid with an authorization number on the claim form to receive payment. Claims for services requiring preadmission or pre-procedure approval that are submitted without this authorization number will be denied. .

1. Covered Outpatient Services

Payment will be approved for medically necessary hospital outpatient medical services. Inpatient policies apply to similar services performed on an outpatient basis. (IAC 441-79.1(16)c.(1) and (2)).

Outpatient rehabilitation services performed by rehabilitation agencies under contract to the hospital must meet the Medicare definition of rehabilitation services. Hospitals that do not have approved mental health programs may provide a one-time evaluation or test. Iowa Medicaid Medical Services reviews outpatient services on a random, retrospective basis.

a. Ambulance

Hospitals must enroll their ambulance service as ambulance providers. (IAC 441-79.1(16)b.(2)) Ambulance transport to the nearest hospital with the patient's condition requiring emergency treatment. Must be medically necessary and not merely for the convenience of the patient (IAC 441-78.11). Iowa Medicaid Medical Services Unit will determine that the ambulance transportation was medically necessary based on the person was admitted as a hospital inpatient, in an emergent situation, or previous information on file related to the patient's condition clearly indicates ambulance service was necessary (IAC 441-78.11(2)a.b.) .

Ambulance transport may be at a partial payment status when the transportation is beyond destination specified (IAC 441-78.11(1)) (EXAMPLE: not nearest institution).

Ambulance transport to patient's home may have partial payment equal to the nearest institution with appropriate facilities (IAC 441-78.11(1)).

Ambulance transfer for a patient residing in a Nursing Facility, may be paid in full even though it may not be the nearest facility (IAC 441-78.11(1)).

Ambulance transportation of a hospital inpatient to a provider and returns to the initial hospital, the ambulance services bills the hospital's DRG reimbursement system to include all associated costs (IAC 441-78.11(4))

b. Dental Services

A variety of dental benefits are available to patients within the dental provider office. These may include but are not limited to: diagnostic and preventive dental exams, cleaning, x-rays, fluoride treatments, fillings for cavities, root canal treatments, dentures and crowns.

Claims for dental services provided on an outpatient basis must include sufficient diagnosis to substantiate the fact that the care could not reasonably have been provided in the dentist's office. (IAC 441-79.1(20). Dental coding is using the D codes. The bill needs to present as 1 item per line.

Iowa Medicaid Dental Wellness Plan Codes Requiring Prior Authorization.

c. Drugs

Hospitals that fill prescriptions must follow the procedures in the ***Prescribed Drugs Manual***. Click here to view the manual online. Drug-only claims must be submitted using a pharmacy claim form.

Outpatient drugs include only take-home drugs and do not include those administered to or consumed by an outpatient during treatment in the hospital emergency room. Drugs administered or consumed in the emergency room should be billed on the UB-04 as an outpatient bill at the hospital's usual charge. Please see IL 2243-MC-FFS "Update- 340B Drug pricing Program" for more information.

Additional reimbursement information can be found in the ***Prescribed Drugs Manual***.

d. Emergency Services

Payment is always made for an assessment (IAC 411-78.4(11)) Payment for additional services will be approved in an emergency room providing at least one of the following conditions is met:

- The member is evaluated or treated for a medical emergency, accident, or injury.
- A physician refers the member. A physician referral must consist of actual instruction by the physician to the member directing the member to go to the hospital. Physicians employed by the hospital and assigned to the emergency room may not routinely be designated as referring physicians.
- The member is suffering from an acute allergic reaction.
- The member is experiencing acute, severe respiratory distress.

Effective for dates of service on or after September 1, 2011, the following emergency room payment policies are applicable. These changes are pursuant to a 2011 Iowa legislative mandate.

- **Copayment in the emergency room**. Medicaid members must pay a $3 copayment for each visit to a hospital emergency room for treatment of a non-emergent** medical condition. The $3 copayment does not apply if the visit to the emergency room is for an emergent condition or results in a hospital admission.

- **For Iowa Health and Wellness Plan members** a $10 copayment is required for each visit to a hospital emergency room for treatment of a non-emergent ** medical condition. The $10 copayment does not apply if the visit to the emergency room is for an emergent condition or results in a hospital admission.

  **A list of the diagnosis codes considered emergent is posted on the Iowa Medicaid website and updated annually, Please include a "Click here" to access this list.

  The exclusions applicable to all copayments still apply. The most common examples are members:

  - Under age 21,
  - Who are pregnant,
  - Presenting with an emergent condition, or
  - Receiving family planning services.

  See 441 IAC 79.1(13). The copayment amount (when applicable) will be deducted after the payment reductions have been applied.

- **Changes to reimbursement of non-emergent** emergency room services**. If the emergency room visit does not result in an inpatient hospital admission and does not involve any emergent** condition, the payment depends on the referral (if any).

- Payment is made at 75 percent of the usual APC amount:

  - For members who were referred to the emergency room by appropriate medical personnel (UB-04 form locator 76++), or
  - Payment is made at 50 percent of the usual APC amount for members who were not referred to the emergency room by appropriate medical personnel.

- If the emergency room visit results in an inpatient hospital admission, the visit continues to be paid as part of the inpatient claim. If the emergency room visit does not result in an inpatient hospital admission but involved an emergent** condition, the emergency room claim is still paid at the full APC. Triage and assessment codes for any Medicaid member in an emergency room also continue to reimburse at the full (100 percent) fee schedule amount in all cases.

- A medical record is to be developed for every patient given treatment in the emergency services (IAC 481-51.30(c)). This medical record at a minimum will note the services provided, services offered, any refusal of services from the patient, presences or absence of emergent condition, physician documentation of transfer or discharge, basis of transfer or discharge, where the transfer occurs, and means of transfer.

e. Inpatient Admission After Outpatient Service

A member may be admitted to the hospital as an inpatient after receiving outpatient services. (IAC 441-79.1(16)o.) If the member is admitted as an inpatient within three days of the day the outpatient services were rendered, all services are considered inpatient services for billing purposes. The day of admission as an inpatient is considered as the first day of hospital inpatient services.

When a member is expected to remain in a hospital for less than 24 consecutive hours, and this expectation is realized, the hospital is not precluded from characterizing that member as an outpatient.

However, if the hospital comes to expect that the member will remain in the hospital for 24 hours or more, the member is deemed to be admitted as an inpatient at the point that this expectation develops, even though a formal inpatient admission has not yet occurred.
(IAC 441-79.1(16)n.)

If there is no formal inpatient admission or prior expectation of an inpatient stay, a member is deemed admitted as an inpatient at the point when the member has remained in the hospital for at least 24 consecutive hours.

The above inpatient admission after outpatient service above does not apply to critical-access hospitals. Outpatient services before the date of admission must be billed as such and on a separate bill from inpatient services. Outpatient services rendered on the date of admission are still billed and paid separately as outpatient services. (IAC 441-79.1(16)o.)

f. Radiology Services

Hospitals must report HCPCS codes for all radiology services provided on an outpatient basis. (IAC 481-51.16) The codes for radiology are in the CPT-4 portion of HCPCS beginning with 70010 and ending at 79999.

g. Same-Day Surgery

Covered surgical procedures are those medically necessary that can safely be performed in an outpatient setting (IAC 441.78.26(1))

No payment will be made for inpatient hospital care for certain surgical procedures that can ordinarily be performed safely and effectively in the hospital outpatient department, physician's office, or other setting (IAC 441 78.1(1)g.). In the absence of justifying information submitted by the admitting physician, claims for inpatient care for those procedures **will** be denied.

An exception may be made if the admitting physician presents information to the hospital utilization review liaison justifying the medical necessity for inpatient care in the individual case.

If the member's physician believes that inpatient care is necessary for one of the listed procedures in view of the member's diagnosis and condition, the physician is responsible for advising the delegated hospital's utilization review liaison before admission in all cases, except where the emergency nature of the case makes this impossible.

If the hospital utilization review committee concurs that inpatient care is necessary, then payment for this care will be approved. If the physician does not present adequate justifying information before the member's admission or, for an emergency admission, if the hospital record does not justify the necessity of inpatient care, then payment of both the hospital claim for inpatient care and the physician's claim for the surgery will be denied.

The policy applies only to Medicaid members. It is the responsibility of the physician to advise the hospital that the member to be admitted for inpatient care is a Medicaid member and that one of the listed surgical procedures will be involved. Each participating physician has also been notified of this policy and provided with the list of procedures.

h. Take-Home Supplies and Medical Equipment

Reimbursement will not be made for take-home supplies or equipment billed on the UB-04 claim form.

To submit charges and be reimbursed for take-home supplies, hospitals must enroll as medical equipment dealers and follow all policies and procedures applicable to dealers. Direct requests for application for enrollment to the Iowa Medicaid Provider Services Unit. A separate billing number will be assigned for use in billing take-home items.

2. Alcoholism or Substance Abuse Outpatient Facility Programs

The outpatient facility is safe, clean, well ventilated, properly heated and in good repair. The services are to be accessible to people with disabilities. Smoking prohibited exceot in designated areas (IAC-641 155.25).

Administrative and procedural standards for alcoholism and substance abuse treatments match the inpatient facility standards (IAC 641—155.25 (20)).

The alcohol and substance abuse treatment services (IAC 641-78.31(4)) must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence. These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements. Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

a. Admission Criteria

Admission criteria include (IAC 641-78.31(4)a.):

- Alcohol or drugs taken in a longer period of time that the person intended
- Two or more unsuccessful efforts to cut down or control the use of alcohol or drugs
- Continued alcohol or drug use despite the knowledge of having a persistent or recurring family, social, occupational, psychological or physical problem that is caused or exacerbated by the use of alcohol of drugs
- Having a marked tolerance needing increased amounts of alcohol or drugs in order to achieve intoxication or desire effect of markedly diminished effect with continued us of the same amount
- Characteristic withdrawal symptoms
- Alcohol or drugs taken often to relieve or ovoid withdrawal symptoms.
- An initial comprehensive assessment including the biological, psychological, social, and spiritual orientation of the person, including, but not limited to:
  - history of use of alcohol and/or other drugs including the age of onset, duration, patterns, and consequences of use
  - use of alcohol and drugs by family member
  - responses to previous treatment (if applicable)
  - a comprehensive medical history
  - a comprehensive physical examination including the history of the physical problems associated with the dependence
  - Laboratory screening tests based on the historical and physical exam problems
  - History of abuse
  - A systematic mental status exam, particular focus on immediate recall and remote memory
  - Determination of current and past psychiatric and psychological abnormality
  - Determination of any degree of danger to self or others
  - Family history of alcoholism and/or other drug dependencies
  - Patient’s educational level, vocational status, and job performance history
  - Patient’s social support, including family and peer relationships
  - Patient’s perception of the patient’s strengths, problem area, and dependencies
  - Patient’s leisure, recreational, or vocational interests/hobbies

- Patient's ability to participate with peers, in programs, and social activities
- Patient's legal problems, if any
- If available, interview family members and significant others (patient needs to provide written permission

b. Plan of Treatment

Each patient is to have a written individualized comprehensive plan of treatment. This plan of treatment is based on the problems and needs identified in the initial assessment. The plan of treatment is specific to the regular times at which the plan is to be reassessed. The patient's participation in establishing the plan of treatment is documented. Each time a patient is reassessed, the plan of treatment is reassessed with updates and changes documented.

c. Discharge Planning

Discharge planning (IAC 441-78.31(4)a.(7)) is implemented in collaboration with the patient. The plan for discharge is designed to provide the appropriate continuity of care. The specifics of the discharge are in accordance to the current reassessed needs of the patient. The plan is implemented in a way so that the patient agrees and has confidentiality.

Medicaid payment for alcohol and drug treatment is reimbursed for a maximum of 28 treatment days, if the documentation indicate the patient has not reached the exit level, payment may be made beyond the 28 days (IAC 441-78.31(4)a.(8)).

d. Opioid Treatment Programs

Opioid treatment programs have specific standards (IAC 641-155.35). All programs that use methadone or other medications approved by the Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act and the state of Iowa for the use in the treatment of opioid addition shall comply with this rule and Part II, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 42 CFR Part 8, Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction, effective May 18, 2001.

- All programs are licensed or approved by the board and maintains all approvals required as explained in IAC 641-155.32(2).
- To prevent the patient of being enrolled in more than one program, the program will verify the patient is not registered in another program through the Central Registry System.
- Prior to admission to the opioid treatment program, a uniformed comprehensive assessment is completed to determine if the patient is appropriate for treatment (IAC 641-155.35(4)a.). The program physician determines and documents in the patient's record that the patient is physiologically dependent on narcotic substances and has been physiologically dependent for at least one year prior to the patient's admission.

- If the physiological addiction cannot be clearly documented, the program physician will make the final determination concerning a patient's physiologic dependence and history of addiction. The program physician signs, dates and records a statement acknowledging the physician has reviewed all the documented evidence to support the one-year history of addiction, the patient's current physiologic dependence status and in the physician's reasonable clinical judgment the patient fulfills the requires to the opioid treatment program (IAC 641-155.35(4)c.(1)).

- When a patient has voluntarily left an opioid treatment program in good standing, and seeks readmission within two years of discharge, the program documents the prior opioid treatment of six months or more and the program physician signs, dates and records a statement acknowledging the physician has reviewed all the documented evidence, the patient's current physiologic dependence status and in the physician's reasonable clinical judgment the patient fulfills the requires to the opioid treatment program (IAC 641-155.35(4)c.(2)).

- Detailed admission requirements to the opioid treatment program are covered in detail in IAC 441 Chapter 155 Section 35. An overview includes the requirement for collection of drug screening, attaining records from previous treatment programs if applicable, attempts of detoxification, insurance of voluntary participation in the program, and pregnancy provisions.

- Current written criteria, outlined in the Diagnostic and Statistical Manual for Mental Disorders (DSM IV), are maintained, and used to for the person is currently addicted to an opioid drug. The criteria guide the process for considering an individual for placement and admission to a program. The uniform processes define the types of information needed for all individuals, the acceptance of referrals, types of records kept, the psychosocial history uses for analysis and synthesis of the patient's status (IAC 441-155.35(5)). The items addressed in the assessment include, but are not limited to:

  - Complete medical history
  - Assessment of the current psychological and mental status
  - Physical examination of:
    - Pulmonary, liver, or cardiac abnormalities
    - Infectious diseases
    - Skin conditions which may be related to absorption of toxic substances
    - Lab testing for syphilis and drugs
    - Tuberculosis skin testing
    - EKG, chest x-ray, pap smear, pregnancy test, sickle cell screening, complete blood count, chemistry profiles, routine urine testing may be indicated based on the patient's condition.

A written individualized treatment plan (IAC 441 155.35(6)) is developed, documented, and identifies immediate needs with actions to meet the needs. The treatment plan is developed as soon a feasible, but no later than 30 days to an outpatient opioid treatment program. Minimal requirements:

- Clear concise statements of patient's current strengths and needs
- Short- and long- term goals the patient is attempting to reach
- Type and frequency of therapeutic activities in which to participate
- Staff person(s) responsible for the patient's treatment
- Developed with the patient
- Reviewed and Up-dated as often as necessary by the primary counselor, but no less than every 90 days
- Review consists of reassessment current status– - any accomplishments, changes and redefine the goals
- Reviewed by physician at least annually
- Documented with dates, changes, reviews, and individuals involved in the review
- Abstract terms or slang should be avoided, write in a manner for the average person to be readily understood
- Provided a copy to the patient
- Keep the plan culturally and environmentally specific to meet the individual

Uniform Progress Notes are to be entered in the patient's case record (IAC 441- 155.25(7)). The notes are:

- in chronological order
- dated with the date of the services provided
- entered by pen or by computer
- Subjective interpretation has descriptions of the actual behavior observation
- Avoid abstract terms, jargon, or slang unless quoting the individual

Rehabilitative services are to have policies and procedures for the minimum attendance of the rehabilitative services. This is to be relative to the individuals progress and length of involvement in treatment.

The minimum frequency of rehabilitative services occurs at the same frequency of on-site dosing for the individual receiving more than two take-home dosages a week in the first year.

The minimum frequency for rehabilitative services for individual receiving two or fewer take-home dosages is weekly.

The program provides rehabilitative services that are for the individual based on needs identified during the assessment process.

The program may provide rehabilitative services through collateral agreements with other service providers. If an individual is receiving services from outside resources, the program will attempt to attain a written copy of status reports from that resource.

A client/patient who does not comply with the program's rehabilitative service requirements is to be placed on a period of probation as defined by the program, or be required to immediately increase the frequency of clinic attendance for medication and rehabilitative services.

If, during a period of probation, the individual continues to be in noncompliance with rehabilitation services, the program continues to increase the attendance requirement until daily attendance is obtained or the individual complies with rehabilitative services. This requirement does not prevent the program's ability to discharge an individual if it is warranted for therapeutic reasons or program need (IAC 441-155.35(8)). Medication dispensing (initial dose, subsequent dose, clinic schedule) is determined by the program physician (IAC 441 155.35(9)). The Physician determines the individuals initial and subsequent doses of the medication. The physician's responsibility includes the narcotic drug administer, dispensed and records the date with the providers signature with each change in the dosage schedule. The program physician directly communicates to the registered or licensed staff supervising the medication dispensing. It is best to communicate this in writing but if giving verbal orders, the orders are placed in writing and countersigned within 72 hours by the program physician.

- The initial dose of medication is not to exceed 30 milligrams
- The total of the first day is not to exceed 40 milligrams
- An individual transferring into the program is to receive the last daily dosage authorized by the former program physician
- An individual receiving guest-dosing status is to receive the last daily dosage authorized by the primary program
- Medication is administered by a professional authorized by law
- No medication is administered unless the individual has completed the admission procedures or entered the program on a weekend with a clinical judgement from the program physician who determined an emergency situation and then will complete the admission procedure the following workday.
- A dispensing log is kept (IAC 441 155.35(9)) in the dispensing area. In the individual's case records, it is recorded the amount of medication dispensed with the signature of the staff member authorized to dispense the medication.
- No dose is dispensed until the individual has been positively identified and the dosage amount is compared with the currently ordered and documented dosage level.
- Ingestion is observed and verified by the staff person authorized to dispense the medication.

- Daily dosages of medications in excess of 100 milligrams are dispensed only with the approval of the program physician and are documented with justification in the client/patient's case record
- Take-home medication (IAC 441 155.35(10)) is labeled according to state and federal law and have childproof caps.
- Take-home or unsupervised medication use may be given to client/patients who demonstrate a need for a more flexible schedule in order to enhance and continue rehabilitative progress.
- For client/patients receiving take-home medication, the program documents the following requirements:
  - Absence of recent abuse of drugs (narcotic or nonnarcotic), including alcohol
  - Regular attendance at the clinic
  - Attendance at a licensed or approved treatment program for rehabilitative services
  - Absence of recent criminal activity
  - Stable home environment and social relationships
  - Active employment or participation in school, or similar responsible activities related to employment, education or vocatio– - AND
  - Assurance that medication can be safely transported and stored by the client/patient for the client/patient's own use

Prior to granting take-home privileges, the program physician documents in the client/patient's case record that all the above criteria have been considered and that, in the physician's professional judgment, the risk of diversion or abuse is outweighed by the rehabilitative benefits to be derived.

If the client/patient meets the above criteria, the client/patient may receive take-home medication according to the following guidelines:

- During the first 90 days of treatment, the take-home supply is limited to a single dose each week
- During the second 90 days of treatment, the take-home supply is limited to two doses per week
- In the remaining months of the first year, a patient may be given a maximum six-day supply of take-home medication
- After one year of continuous treatment, a patient may be given a maximum two-week supply of take-home medication
- After two years of continuous treatment, a patient may be given a maximum one-month supply of take-home medication

Take-home medications are not dispensed to patients in interim maintenance treatment or detoxification.

If a client/patient is unable to conform to the applicable mandatory schedule, a revised schedule may be permitted provided the program receives an exception to these rules from the division and SAMHSA, when applicable.

- A copy of the written exception is placed in the client/patient's case record. Exceptions are only in unusual circumstances. When a program is applying for less frequent pickups for client/patients, approval will be based on considerations in addition to distance when another program exists within 25 miles of the client/patient's residence.
- Should a patient receiving take-home medication provide a drug screen that is confirmed either positive for substances or negative for the prescribed medication, the program ensures the test results are from results that are definitive.

The program physician places the client/patient on three months' probation, as defined by the program, or increase the client/patient's frequency of clinic dosing after considering the client/patient's overall progress and length of involvement in the program.

Should the client/patient provide a drug screen that is positive for substances or negative for medication during a period of probation, the program physician shall increase the client/patient's frequency of clinic attendance for dosage pickup for at least three months. If after the three-month period the client/patient meets the eligibility criteria, the client/patient may return to the previous take-home schedule.

Drug testing and utilization of results is established by each programs policies and procedures.

- The program ensures that an initial drug-screening test or analysis is completed for each prospective client/patient.
- At least eight additional random tests or analyses are performed on each client/patient during the first year in maintenance treatment.
- At least quarterly random tests or analyses are performed on each client/patient in maintenance treatment for each subsequent year.
- When a sample is collected from each client/patient for drug testing, it is to be done in a manner that minimizes opportunity for falsification.
- Each test is to be analyzed for: opiates, methadone, amphetamines, cocaine, and barbiturates. The results are used as a guide to change treatment approaches and not the sole criteria to force a person out of treatment.

In addition, if any other drug(s) have been determined by a program to be abused in that program's area, each test or analysis must be analyzed for any of those drugs as well.

Individual case records are maintained, and the record includes:

- Entries in the client/patient case record are signed and dated
- Uniformity in Content and format of client/patient case records
- Confidentiality of alcohol and drug abuse client/patient case records is maintained by the program and is protected by the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations 42 CFR, Part 2, effective June 9, 1987.
- The Case record is retained for not less than seven years after the case is closed
- Appropriate records are readily accessible to those staff members providing services directly to the client/patient and other individuals specifically authorized
- The program is responsible for safeguarding and protecting the client/patient case records against loss, tampering, or unauthorized disclosure of information
- The program is responsible and has a written policy governing the disposal and maintenance of client/patient case records

The program provides adequate physical facilities for the storage, processing, and handling of client/patient case records. These facilities are suitably locked, secured rooms or file cabinets. Records should be kept in proximity to the area in which the client/patient normally receives

The program's written policies and procedures govern the compilation, storage and dissemination of individual client/patient case records (441- 155.35(12)).

The program is to have a diversion identification and prevention plan (441- 155.35(13)) that outlines the methods by which the program:

- implements proactive procedure to reduce the likelihood or possibility of diversion
- detects possible diversion of take-home medication
- the actions taken when diversion is identified or suspected

An approved program may offer interim maintenance treatment when, due to capacity, the program cannot place the client/patient in a program offering comprehensive services within 14 days of the client/patient's application for admission.

- An approved program may provide interim maintenance treatment only if the program also provides comprehensive maintenance treatment to which interim maintenance treatment client/ patients may be transferred.
- Before a public or nonprofit private narcotic treatment program provides interim maintenance treatment, the program must receive approval of both the U.S. Food and Drug Administration and the division of behavioral health and professional licensure and:
  - The program director must certify that the program seeking such authorization is unable to place client/patients in a public or private nonprofit program within a reasonable geographic area within 14 days of the client/patient's application for admission

- and that interim maintenance treatment will not reduce the capacity of the program's comprehensive maintenance treatment
- Client/patients admitted to interim maintenance treatment shall be transferred to comprehensive maintenance treatment within 120 days of admission (IAC 441-155.35(15))

Minimum standards for the program to admit a client/patient who is eligible for comprehensive maintenance treatment to interim maintenance treatment is if the client/patient cannot be placed in a public or private nonprofit comprehensive program within a reasonable geographic area and within 14 days of application for services:

- An initial drug screen, and at least two others, are taken from the client/patient during the maximum admission period of 120 days.
- The program establishes and follows reasonable criteria for determining the transfer of client/patients to comprehensive maintenance treatment.
  - The transfer criteria shall be in writing, available for inspection, and include at a minimum a preference for the transfer of pregnant client/patients.
  - Interim maintenance shall be conducted in accordance with all applicable federal regulations and state rules.
- The program documents in the client/patients case record, and notifies the division when:
  - a client/patient begins interim treatment
  - when a client/patient leaves interim treatment
  - and when a client/patient transfers to comprehensive maintenance treatment.

All requirements for comprehensive maintenance treatment apply to interim maintenance treatment with the following exceptions:

- The medication is required to be administered daily under observation
- Take-home medication is not allowed
- Initial and comprehensive treatment plans are not required
- A primary counselor is not required to be assigned to the client/patient
- Interim maintenance cannot be provided for longer than 120 days in any 12-month period

An ongoing written quality improvement process (441- 155.35(14)) is designed to:

- objectively and systematically monitor and evaluate the quality and appropriateness of client/patient care,
- pursue opportunities to improve client/patient care,
- and resolve identified problems
- have facility wide efforts in scope and include review of clinical and professional services.

The rules relating to complaints, investigation, suspension and revocation as outlined in 641 – 155.11(125) through 155.17(125) shall apply to opioid treatment programs (441-155.35(16)).

Deemed status is granted by the board shall to programs accredited either by a recognized national or not-for-profit accreditation body when the board determines that the accreditation is for the same services (441-155.35(17)) as national accreditation bodies. "Deemed status" means that the board and division recognize, in lieu of their own review, an outside body's review, assessment and accreditation of a hospital-based or freestanding community-based substance abuse program's operations, functioning, and services that correspond to those described in this chapter.

The national accreditation bodies currently recognized as meeting board criteria for possible deemed status are:

- The Joint Commission
- Council on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- American Osteopathic Association (AOA)

The accreditation credentials of the bodies shall specify the types of organizations, programs, and services the bodies accredit and targeted population groups, if appropriate.

When a program receives accreditation and is then granted licensure through deemed status, the program continues to be responsible for meeting all requirements in accordance with this chapter, IAC 441-155.35 and all applicable laws and regulations.

If a program that is nationally accredited requests deemed status for services not covered by the national accreditation body's standards, but covered by this chapter, IAC 441-155.35, the licensing for those services shall be conducted by the division.

Copies of the entire The Joint Commission, CARF, COA or AOA behavioral health accreditation survey/inspection report and certificate of accreditation is submitted to the division with the application for deemed status provided by the division.

- The program submits to the division the accreditation corrective plans or written conditions for the accreditation.
- The program is currently accredited by a board-approved national accreditation body for services that are outlined in this chapter.
- The program notifies the division of any changes in the program's accreditation status, address, executive director/CEO, facility locations, or any other changes to the program/organization within 30 days of such changes.
- All survey reports for the hospital-based or freestanding community-based substance abuse treatment program from the accrediting or licensing body are sent to the division.

- For a program granted deemed status, the period of deemed status shall coincide with the period of time that program is awarded accreditation by the national accreditation body. However, under no circumstances will it be longer than three years.
- The board and division shall retain the following responsibilities and rights when deemed status is granted to program/organizations:
  - The division may conduct focused or general on-site follow-up visits as determined appropriate.
  - The division investigates all complaints that are under the authority of this chapter and recommend and require corrective action or other sanctions in accordance with 641—155.16(125).
  - All complaints, findings and required corrective action may be reported to the accreditation body.
  - The board reviews and acts upon deemed status if necessary, when:
    - complaints have been founded
    - national accreditation bodies find instances of noncompliance with accreditation
    - the accreditation status of the program expires without renewal
    - the program's accreditation status is downgraded or withdrawn by the accreditation body
    - focused reviews find instances of noncompliance.

When the opioid treatment program has a continuation of deemed status, the program submits a copy of all CARF, JCAHO, COA or AOA behavioral health accreditation survey reports to the division.

3. Cardiac Rehabilitation Programs

A cardiac rehabilitation program (IAC 441- 78.31(4)c.) will:

- Provide a supportive educational environment in which to encourage behavior change with respect to the accepted cardiac risk factors.
- Initiate prescribed exercise as a mode of encouraging the return of the member to everyday activities by improving cardiovascular functional capacity and work performance.
- Promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

a. Admission Criteria

The attending physician must refer candidates for the program. Members who have had the following conditions are eligible for the program:

- Myocardial infarction (within three months post discharge).
- Cardiac surgery (within three months post discharge).
- Streptokinase.
- Percutaneous transluminal angioplasty (within three months post discharge).
- Severe angina being treated medically due to member or doctor preference or inoperable cardiac disease.

b. Treatment Staff

The following professionals must be represented on the treatment staff, either by full-time or part-time employment, by contract, or by referral:

- At least one physician responsible for responding to emergencies must be physically present in the hospital when the patients are receiving cardiac rehabilitation services. This physician must be trained and certified at least to the level of basic life support.
- **Medical consultant**. The medical consultant oversees the policies and procedures of the outpatient cardiac rehabilitation area. The consultant shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team. .
- **Registered nurse**. The cardiac rehabilitation nurse carries out the exercise prescription after assessment of the member. The nurse shall be able to interpret cardiac dysrhythmias and to initiate emergency action if necessary. The nurse assesses and implements a plan of care for cardiac risk-factor modification. The nurse should have at least one year of experience in a coronary care unit.
- **Physical therapist**. The physical therapist offers expertise in exercise prescriptions when a member has an unusual exercise problem.
- **Dietitian**. The dietitian assesses the dietary needs of members and appropriately instructs them on their prescribed diets.
- **Social worker**. The social worker provides counseling and facilitates the spouse support group.
- **Occupational therapist**. The licensed occupational therapist provides service as necessary.

c. Medical Records

Medical records for each cardiac rehabilitation member should consist of at least the following:

- Referral form
- Physician's orders
- Laboratory reports

- Electrocardiogram reports
- History and physical examination
- Angiogram report, if applicable
- Operative report, if applicable
- Preadmission interview
- Exercise prescription
- Rehabilitation plan, including participant's goals
- Documentation for exercise sessions and progress notes
- Nurse's progress reports
- Discharge instructions

d. Monitoring of Services

The program shall be monitored by the hospital on a periodic basis using measuring criteria for evaluating the cardiac rehabilitation services provided.

e. Physical Environment and Equipment

A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation.

The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

f. Restrictions

Payment shall be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the member has not reached an exit level.

g. Discharge Plan

The member shall be discharged from the program when:

- The physician, staff, and member agree that the member's work level is functional for the member and that little benefit could be derived from further continuation of the program, and
- Dysrhythmia disturbances are resolved, and
- Appropriate cardiovascular response to exercise is accomplished.

4. Diabetic Education Programs

An outpatient diabetes self-management education program shall provide instruction that will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes.

People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to:

- Self-treat insulin reactions,
- Protect feet that are numb and have seriously compromised circulation, and
- Accommodate their regimen to changes in blood glucose because of stress or infections.

In addition to certification for Medicaid, diabetic education programs must also be certified by the Iowa Department of Health and Human Services. See certification rules, 641 IAC Chapter 9.

a. Admission Criteria

Candidates for the program shall meet the following guidelines:

- The member must have Type I or Type II diabetes.
- The attending physician must refer the member.
- The member must demonstrate an ability to follow through with self-management.

b. Program Staff

Each person who provides services is to be competent by reason of education, training and experience with diabetes. Professional disciplines which must present as staff include a physician, registered nurse, registered dietitian, and licensed pharmacist. .

c. Health Assessment

Develop an individualized and documented assessment of needs is developed with the member's participation. Provide follow-up assessments, planning, and identification of problems.

d. Restrictions on Payment

Medicaid will pay for a diabetic self-management education program. Diabetic education programs shall include follow-up assessments at 3 and 12 months without charge.

5. Eating Disorders Programs

Eating disorders are characterized by gross disturbances in eating behavior. They include anorexia nervosa, bulimia, and bulimorexia. Compulsive overeaters are not acceptable for this program.

a. Admission Criteria

The members shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the current *Diagnostic and Statistical Manual of Mental Disorders*.

In addition, determine the need for treatment due to a demonstrable loss of control of eating behaviors and the member's failure in recent attempts at voluntary self-control of the problem. The member shall demonstrate impairment, dysfunction, disruption of or harm to:

- Physical health,
- Emotional health (e.g., significant depression, withdrawal, isolation, suicidal ideas),
- Vocational or educational functioning, or
- Interpersonal functioning (e.g., loss of relationships, legal difficulties).

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall be present for at least six months and three of the following symptoms must be present:

- Endocrine or metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, ketosis, hair loss, or abnormal cholesterol or triglyceride levels).
- Other cardiovascular factors, such as hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.
- Renal effects, such as diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.
- Gastrointestinal factors, e.g., sore throats, Mallery-Weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.
- Hematologic effects, such as anemia, leukopenia, or thrombocytopenia.
- Aspiration pneumonia.
- Ear, nose, or throat factors, such as headaches or dizziness.
- Skin considerations, such as lanugo or dry skin.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical and emotional stability.

b. Diagnostic and Treatment Staff

The number of such staff should all be appropriate to the patient load of the facility. Each person who provides diagnostic or treatment services shall be determined to be competent to provide such services through education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through full-time or part-time employment by a facility, contract, or referral, are:

- A doctor (of medicine or osteopathy),
- A licensed psychologist,
- A counselor with a bachelor's or master's degree and experience,
- A dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist.

c. Initial Assessment

Conduct a comprehensive assessment of the biological, psychological, social, and family orientation of the member. Include:

- A history of the member's weight and eating and dieting behavior, onset, patterns, and consequences, including:
  - Any history of purging behavior.
  - Frequency and history of vomiting.
  - Use of laxatives and diuretics.
  - Use of diet pills, ipecac, or any other weight control measures.
  - Frequency of eating normal meals without vomiting.
- A family history and the member's self-assessment regarding:
  - Chronic dieting, obesity, anorexia, or bulimia.
  - Drug abuse or alcohol problems.
  - History of other counseling experiences.
  - Depression or threatened or attempted suicide.
  - Hospitalization for psychiatric reasons.
- A history of exercise behavior, including type, frequency, and duration.
- The member's sexual history, including:
  - Sexual preference and activity.
  - History of physical or sexual abuse (incest or rape).
  - Current sexual interest as compared to before the eating disorder.
- The member's psychological orientation to the questions.
- A medical history, including a physical examination, covering the information under Eating Disorders Programs: Admission Criteria.

- Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The assessment shall also address:

- The member's social support networks, including family and peer relationships.
- The member's educational level, vocational status, and job or school performance history as appropriate.
- The member's leisure and recreational interests and hobbies.
- The member's ability to participate with peers and programs and social activities.
- Legal problems, if applicable.

Interview family members and significant others with the member's written or verbal permission.

d. Monitoring of Services

Monitor and evaluate program services to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing systematic process to identify problems in member care and opportunities to improve member care. Base the monitoring and evaluation of the services on the use of clinical indicators that reflect those components of member care most important to quality.

e. Plan of Treatment

Base the treatment plan on problems and needs identified in the assessments. Specify the regular times at which the plan will be reassessed. Seek and document the members' participation in the development of their treatment plans.

Document the members' perceptions of their needs and (when appropriate and available) the families' perceptions of the members' needs.

Reassess each member to determine current clinical problems, needs, and responses to treatment, and changes in treatment are documented.

f. Restrictions on Payment

Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the member has not reached an exit level.

Eating disorder programs shall include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorder program shall be covered in the overall treatment charge.

g. Discharge Plan

Develop a plan for discharge for each member before discharge. Design the plan to provide appropriate continuity of care. Describe and facilitate the transfer of the member and of the responsibility for the member's continuing care to another phase or modality of the program (e.g., aftercare), to other programs, agencies, individuals; or to the members and their personal support systems.

The plan shall be in accordance with the member's reassessed needs at the time of transfer. Develop the plan in collaboration with the member and (as appropriate and available, with the member's written or verbal permission) with family members.

Implement the plan in a manner acceptable to members and their needs for confidentiality. Include timely and direct communication with and transfer of information to the other programs, agencies, or individuals who will be providing continuing care.

6. Behavioral/Mental Health Programs

To be covered, behavioral/mental health services (IAC 441-78.12) must:

- Be prescribed by a physician or certified health service provider in psychology and provided under an individualized treatment plan, and
- Be reasonable and necessary for the diagnosis or treatment of the member's condition.

This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the member's condition.

a. Initial Assessment

A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the member must be conducted, which shall include (IAC441-78.31d.(6)):

- A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.
- A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.
- Any history of physical abuse.
- A systematic mental health examination, with special emphasis on any change in cognitive, social, or emotional functioning.
- A determination of current and past psychiatric and psychological abnormality.

- A determination of any degree of danger to self or others.
- The family's history of mental health problems.
- The member's educational level, vocational status, and job performance history.
- The member's social support network, including family and peer relationship.
- The member's perception of the member's strengths, problem areas, and dependencies.
- The member's leisure, recreational or vocational interests and hobbies.
- The member's ability to participate with peers in programs and social activities.
- Interview of family members and significant others, as available, with the member's written or verbal permission.
- Legal problems if applicable

b. Covered Services

Services covered for the treatment of psychiatric conditions (IAC441-78.31(4)d.(7)are:

- **Individual and group psychotherapy** with physicians, psychologists, social workers, counselors, or psychiatric nurses.
- **Drugs and biological products** furnished to outpatients for therapeutic purposes, but only if they are the type which cannot be self-administered and are not 'covered Part D drugs" for a 'Part D eligible individual as defined in 42 U.s.C.section 1395w-101(a)(3)(A) including an individual who is not enrolled in a Part D plan.
- **Family counseling** services, but only where the primary purpose of such counseling is the treatment of the member's condition.
- **Partial hospitalization** (IAC441-78.31(4)d.(7)6.)services designed to reduce or control a member's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the member's level of functioning, and minimize regression.

These services include all psychiatric services needed by the patient during the day.

"Partial hospitalization services" means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management, and medication management. Services are provided for a period of four to eight hours per day.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in member care or opportunities to improve member care.

The evaluation of the services shall be based on the use of clinical indicators that reflect those components of member care important to quality.

- **Occupational therapy** services, if the services require the skills of a qualified occupational therapist and are performed by or under the supervision of a qualified occupational therapist or by an occupational therapy assistant.
- **Activity therapies**, but only those that are individualized and essential for the treatment of the member's condition. The treatment plan must clearly justify the need for each particular therapy used and explain how it fits into the member's treatment.
- **Day treatment** services designed to assist in restoring, maintaining, or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability, and psychosocial interactions, and training in medication management. Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

c. Day Treatment or partial hospitalization for persons age 20or younger

Payment is made for day treatment services provided in an approved site. (IAC441-78.16(7)) Day treatment services shall be outpatient services provided to persons aged 20 or under who are not inpatients in a medical institution or residents of a licensed foster group care facility. Day treatment coverage is limited to a maximum of 15 hours per week. Partial hospitalization is limited to a maximum of 20 hours per week.(IAC441-78.31d.(7)6.)

Day treatment programs for persons aged 20 or under shall address:

- Documented need for day treatment services for children in the area served by the program, including studies, needs assessments, and consultations with other health care professionals (IAC441-78.16(7)a.(1)).
- Organization and staffing, including how the day treatment program for adults fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employees, contractual, or consultant (IAC441-78.16(7)a.(3)).
- Policies and procedures for the program, including admission criteria, patient-assessment, treatment plan, discharge plan, and post-discharge services, and the scope of services provided (IAC441-78.16(7)a.(4)).
- Goals and objectives of the day treatment program for persons aged 20 or under shall be established and shall meet the guidelines below (IAC441-78.16(7)a.(2)).

(1) Staffing

Day treatment programs for children shall meet the following staffing (IAC441-78.16(7)b.(1)). criteria:

- Staffing shall be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff member for each eight participants.

  Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals or persons employed for the purpose of providing offered services under the supervision of a mental health professional.

  Educational staff may be counted in the staff-to-patient ratio.

  All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative, clerical, or support activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns.

- Staffing shall reflect how program continuity will be provided.
- Staffing shall reflect an interdisciplinary team of professionals and paraprofessionals.
- The staff shall include a designated director who is a mental health professional. The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

(2) Supervision

Day treatment services shall be provided by or under the general supervision of a mental health professional. (IAC441-78.16(7)b.(1)5.). When services are provided by an employee or consultant of the hospital who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who:

- Gives direct professional direction and active guidance to the employee or consultant.
- Retains responsibility for consumer care.

The supervision shall be timely, regular, and documented. The employee or consultant shall have a minimum of:

- Either a bachelor's degree in a human services-related field from an accredited college or university **or** an Iowa license to practice as a registered nurse.
- Two years of experience in the delivery of nursing or human services.

(3) Hours of Operation

The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week. (IAC441-78.16(7)b.(3)).

Programming shall meet the individual needs of the member. A description of services provided for members shall be documented along with a schedule of when service activities are available including the days and hours of program availability. (IAC441-78.16(7)b.(5)).

There shall be a written plan for accessing emergency services 24 hours a day, seven days a week. (IAC441-78.16(7)b.(6)).

The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. (IAC441-78.16(7)b.(7)).

Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives.

Relationship with other entities, such as physicians, hospitals, private practitioners, halfway houses, the Department, juvenile justice system, community support groups, and child advocacy groups, are encouraged. The provider's program description shall describe how community links will be established and maintained.

Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification(IAC441-78.16(7)b.(8)).

(4) Admission Criteria

The admission criteria for day treatment for persons age 20 and younger are (IAC441-78.16(7)d.):

- The member is at risk for exclusion from normative community activities or residence; due to behavioral disturbance, chemical dependence, depression, etc.
- The member exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues.
- These symptoms are sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

- Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate, i.e., individual or group therapy services provided in a physician's office by the physician or by auxiliary staff, by a mental health professional employed by a community mental health center or by a psychologist.
- The member's principle caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the member, and to enable adequate control of the member's behavior.

  The caretaker must be involved in the member's treatment. If the principle caretaker is unable or unwilling to participate in the provision of services, the day treatment program shall document how services will benefit the child without caretaker involvement.

  Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.
- The member has the capacity to benefit from the interventions provided. Examples:
  - A member with an intellectual disability may not be appropriate for a day treatment program if the member is unable to participate and benefit from group milieu therapy.
  - A member exhibiting acute psychiatric symptoms such as hallucinations may be too ill to participate in the day treatment program.

(5) Individual Treatment Plan

The individualized treatment plan is prepared for each member receiving day treatment services (IAC441-78.16(7)e.). Formulate a preliminary treatment plan within three days of program participation after admission. Replace it within 30 calendar days with a comprehensive, formalized plan using the comprehensive assessment.

The treatment plan shall be developed or approved by one of the following:

- A board-eligible or board-certified psychiatrist
- A staff psychiatrist
- A physician
- A psychologist registered on the National Register of Health Service Providers in Psychology or the Iowa Register of Health Service Providers in Psychology

A signature of the physician or health service provider in psychology shall demonstrate approval.

This individual treatment plan should reflect the member's diagnosis and the member's strengths and weaknesses and identify areas of therapeutic focus.

Relate the treatment goals (general statements of consumer outcomes) to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives.

Outline the hours and frequency the member will participate in the program, the type of services the member will receive, and the expected duration of the program.

Relate objectives to the goal and have specific anticipated outcomes. Plan the methods that will be used to pursue the objectives.

Review and revise the treatment plan as needed, but at least every 30 calendar days.

(6) Programming

Day treatment services for persons age 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. (IAC441-78.16(7)c.).

"Time-limited" means that:

- The member is not expected to need services indefinitely or lifelong, and
- The primary goal of the program is to improve the behavioral functioning or emotional adjustment of the member in order that the service is no longer necessary.

Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family-focused. The overall expected outcome is clinically adaptive behavior on the part of the member and the family.

At a minimum, day treatment services will be expected to improve the member's condition, restore the condition to the level of functioning before the onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization.

Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive, and complimentary schedule of therapeutic activities, and shall have the capacity to treat a wide array of clinical conditions. The following services shall be available as components of the day treatment program:

- **Psychotherapeutic treatment services**, such as individual, group, and family therapy. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

- **Psychosocial rehabilitation services**. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as:

  - Communication skills
  - Assertiveness training
  - Other forms of community skills training
  - Stress management
  - Chemical dependency counseling
  - Education and prevention
  - Symptom recognition and reduction
  - Problem solving
  - Relaxation techniques
  - Victimization (sexual, emotional or physical abuse issues)

  Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

- **Evaluation services**. Evaluation services shall determine need for day treatment before program admission (IAC441-78.16(7)c.(3)).. An evaluation service may be performed for persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria.

  Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services.

  This service must be completed by a mental health professional. An evaluation from another source performed within the last 12 months may be substituted if there has not been a change. Medicaid will not make separate payment for these services under the day treatment program.

- **Assessment services**. All day treatment members shall receive a formal, comprehensive bio-psycho-social assessment of day treatment needs. If applicable, the assessment shall include a diagnostic impression based on the current *Diagnostic and Statistical Manual of Mental Disorders*. The assessment shall address whether medical causes for the child's behavior have been ruled out.

  An assessment from another source performed within the last 12 months may be used if the symptomatology is the same. If not, parts of the assessment that reflect current functioning may be used as an update.

  Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals.

Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

- **Educational component**. The day treatment program may include an educational component as an additional service. The member's educational needs shall be served without conflict from the day treatment program.

  Hours in which the member is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

  EXAMPLE:

  > The member attends the day treatment program from 9 a.m. to 3 p.m., and attends the educational component from 9 a.m. to noon. The hours the member attends the educational component are deducted from the day treatment hours. The billable day treatment hours for Medicaid are three hours.

  The day treatment program may wish to pursue funding of educational hours from local school districts.

(7) Discharge Criteria

The length of stay in a day treatment program for children shall not exceed 180 treatment days per episode of care. For members whose condition requires a length of stay exceeding 180 treatment days, document the rationale for continued stay in the member's case record and treatment plan every 30 calendar days after the first 180 treatment days.

Discharge criteria for the day treatment program for children shall incorporate at least the following indicators (IAC441-78.16(7)f.) :

- In the case of member improvement:
  - The member's clinical condition has improved, as shown by symptom relief, behavioral control, or indication of mastery of skills at the member's developmental level.
  - Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
  - Treatment goals in the individualized treatment plan have been achieved.
  - An aftercare plan has been developed that is appropriate to the member's needs and has been agreed to by the member and family, custodian, or guardian.

- If the member does not improve:
  - The member's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
  - Member, family, or custodian noncompliance with treatment or with program rules exists.

  Post-discharge services shall include a plan for discharge that provides appropriate continuity of care.

Programming services are provided in accordance with the individual treatment plan (IAC441-78.16(7)g.). Appropriate day treatment staff shall develop the plan in collaboration with the member and appropriate caretaker figure (parent, guardian, or principal caretaker). The services shall be under the supervision of the program director, coordinator, or supervisor.

Primary care staff of the hospital shall coordinate the program for each member. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies.

At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each member shall consist of active treatment components which are determined by the individual treatment plan based upon a comprehensive evaluation of member needs, as well as specifically addressing the targeted problems of the population served.

"Active treatment" has been defined as treatment in which the therapist assumes significant responsibility and often intervenes.

Involve the child's family, guardian, or principal caretaker with the program through family therapy sessions or scheduled family components of the program. Encourage them to adopt an active role in treatment.

Medicaid will not make separate payment for family therapy services. Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

Schedule therapeutic activities according to the needs of the members, both individually and as a group. Provide scheduled therapeutic activities, which may include other program components as described above, at least three hours per week, up to a maximum of 15 hours per week.

The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. Encourage this, in part, by scheduling attendance such that a stable core of members exists as much as possible.

Consider the developmental and social stage of the participants, such that no member will be significantly involved with other members who are likely to contribute to an intellectual disability or deterioration of the member's social and emotional functioning.

To help establish a sense of program identity, specifically identify the array of therapeutic interventions as the day treatment program. Hold program planning meetings at least quarterly to evaluate the effectiveness of the clinical program. In the program description, state how milieu stability will be provided.

A distinct clinical record for each member admitted should be maintained. (IAC441-78.16(7)a.) and (IAC441-78.31d.(10)) At a minimum, document:

- The specific services rendered,
- The date and actual time services were rendered,
- Who rendered the services,
- The setting in which the services were rendered,
- The amount of time it took to deliver the services,
- The relationship of the services to the treatment regimen described in the plan of care, and
- Updates describing the member's progress.
- For the services not specifically included in the patient's treatment plan, a detailed explanation of how the service being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan.

d. Diagnostic and Treatment Staff

The number of staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital or on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers, or counselors.

Each person who provides diagnostic or treatment services shall be determined to be competent to provide such services through education, training, and experience. (IAC441-78.31d.(5)) These staff must meet the qualifications for a "mental health professional," defined as a person who:

- Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing or social work; or is a doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.); and
- Holds a current Iowa license when required by the Iowa professional licensure laws; and

- Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

e. Length of Treatment

There are no specific limits on the length of time that services may be covered. Many factors affect the outcome of treatment, including the nature of the illness, prior history, the goals of treatment, and the member's response.

As long as the evidence shows that the member continues to show improvement in accordance with the individualized treatment plan, and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

If a member reaches a point in treatment where further improvement does not appear to be indicated, the case will be evaluated in terms of the criteria set forth under Service Requirements to determine whether with continued treatment there is a reasonable expectation of improvement.

f. Restrictions on Coverage

The following are generally not covered, except as indicated:

- **Activity therapies, group activities, or other services and programs** that are primarily recreational in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.
- **Geriatric day care programs** that provide social and recreational activities to older people who need some supervision during the day while other family members are away from home. Such programs are not covered, since they are not considered reasonable and necessary for a diagnosed psychiatric disorder.
- **Vocational training**. While occupational therapy may include vocational and prevocational assessment or training, when the services are related *solely* to specific employment opportunities, work skills, or work setting, they are not covered.

g. Service Requirements

(1) Prescription of Treatment

Services must be prescribed by a physician or certified health services provider in psychology.

Services must be provided under an individualized written plan of treatment established after consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnosis and anticipated goals.

A plan is not required if only a few brief services will be furnished. Day treatment and partial hospitalization for adults provided for more than five sessions require individualized treatment plans.

(2) Supervision and Evaluation

Services must be supervised and periodically evaluated by a physician or certified health services provider in psychology to determine the extent to which treatment goals are being realized.

Evaluation must include consultation between the certified health services provider and the attending physician within the scope of their respective practice if clinically indicated. The evaluation must be based on periodic consultation and conference with therapists and staff.

The physician or certified health services provider in psychology must also see the member periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(3) Reasonable Expectation of Improvement

Services must be for the purpose of diagnostic study or must reasonably be expected to improve the member's condition.

At a minimum, the treatment must be designed to reduce or control the member's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and to improve or maintain the member's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the member to the level of functioning exhibited before the onset of the illness, although this may be appropriate for some members.

For many other members, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.

"Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services are withdrawn, the member's condition will deteriorate, relapse further, or require hospitalization, this criterion is met.

7. Pain Management Programs

A chronic pain management program (IAC 441—78.31(e)) shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

In addition to certification by the Department, pain management programs must also be approved by the Commission on Accreditation of Rehabilitation Facilities (CARF).

a. Admission Criteria

Candidates for the program shall meet the following guidelines:

- The member must be experiencing chronic pain, usually defined as pain that persists six months or more following primary therapy for the disease process causing the pain.
- The member must have had adequate medical evaluation and treatment in the months preceding program admission, including an orthopedic or neurological consultation if the problem is back pain, or a neurological evaluation if the underlying problem is headaches.
- The member must be free of underlying psychosis or severe neurosis.
- The member cannot be toxic on any addictive drugs.
- The member must be capable of self-care, including being able to get to meals and to perform activities of daily living.

b. Plan of Treatment

For each member there shall be a written comprehensive and individualized description of treatment to be undertaken. Base the treatment plan on the problems and needs identified in the assessment and specify the times at which the plan will be reassessed.

Document the member's perception of needs and, when appropriate and available, the family's perception of the member's needs. Seek and document the member's participation in the development of the treatment plan.

Reassess each member to determine current clinical problems, needs, and responses to treatment. Document changes in treatment.

c. Restrictions on Payment

Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the member has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any member will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

d. Treatment Staff

The number of staff should be appropriate to the member load of the facility. Each person who provides treatment services shall be determined to be competent to provide the services through education, training, and experience.

Professional disciplines that must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist, and a licensed psychologist or psychiatrist.

e. Discharge Plan

For each member before discharge, design a plan for discharge to provide appropriate continuity of care. The plan shall:

- Describe and facilitate the transfer of the member and the responsibility for the member's continuing care to another phase or modality of the program, other programs, agencies, persons or to the member and the member's personal support system.
- Be in accordance with the member's reassessed needs at the time of transfer.
- Be developed in collaboration with the member and, as appropriate and available, with the member's written verbal permission with the family members.
- Be implemented in a manner acceptable to the member and the need for confidentiality. Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

8. Pulmonary Rehabilitation Programs

Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education (IAC 441—78.31(g)):

- Stabilize or reverse both the physiopathology and psychopathology of pulmonary diseases and
- Attempt to return the member to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

a. Admission Criteria

Admission criteria include a member's:

- Being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD);
- Having cardiac stability and social, family, and financial resources;
- Having ability to tolerate periods of sitting time; and
- Being a nonsmoker for six months, or if a smoker, being willing to quit and having a physician's order to participate anyway.

Factors that make a member ineligible include:

- Acute or chronic illness that may interfere with rehabilitation.
- Any illness or disease that affects comprehension or retention of information.
- A strong history of medical non-compliance.
- Unstable cardiac or cardiovascular problems.
- Orthopedic difficulties that would prohibit exercise.

b. Diagnostic and Treatment Staff

Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through full-time or part-time employment by the facility, contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

c. Initial Assessment

A comprehensive assessment must occur initially, including a diagnostic workup that entails:

- Proper identification of the member's specific respiratory ailment
- Appropriate pulmonary function studies
- A chest radiography
- An electrocardiogram

When indicated:

- Arterial blood gas measurements at rest and during exercise
- Sputum analysis
- Blood theophylline measurements

Behavioral considerations include:

- Emotional screening assessments and treatment or counseling when required:
- Estimating the member's learning skills and adjusting the program to the member's ability; and
- Assessing family and social support, potential employment skills, employment opportunities, and community resources.

d. Plan of Treatment

Develop individualized long- and short-term goals for each member. Base the treatment goals on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The members and their families need to help determine and fully understand the goals, so they realistically approach the treatment phase.

Reassess members to determine current clinical problems, needs, and responses to treatment. Document changes in treatment.

Components of pulmonary rehabilitation to be included are:

- Physical therapy and relaxation techniques
- Exercise conditioning or physical conditioning for those with exercise limitations
- Respiratory therapy
- Education
- An emphasis on the importance of smoking cessation
- Nutritional information

e. Restrictions on Payment

Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates the member has not reached an exit level.

f. Discharge Plan

Ongoing care is generally the responsibility of the primary care physician. Conduct periodic reassessment to evaluate progress and allow for educational reinforcement.

9. Special Non-Inpatient Programs (NIPs)

Hospital outpatient programs for alcoholism or substance abuse, cardiac rehabilitation, mental health, eating disorders, pain management, and diabetes education are called non-inpatient programs or NIPs and must meet additional requirements.

If any hospital wishes to add, delete, or change any services as described under the NIP units, a full program review may be necessary by Iowa Medicaid to ensure adequacy of the program, staffing levels, and settings. Medicaid will not certify any program that is found to be inconsistent with state, federal, or local restrictions.

No review is necessary to end any currently held Medicaid NIP certifications.

a. Application

A hospital that wants Medicaid payment for a special non-inpatient program must submit an application for certification to Iowa Mediciad Provider Services Unit before payment can be made.

The application shall consist of a narrative and supporting documents (table of organization, qualification of positions, treatment protocols, etc.) that provide the following information:

- The documented need for the program, including studies, needs assessments, and consultations with other health care professions.
- The goals and objectives of the program.
- A description of the organization and staffing, including how the program fits with the rest of the hospital, the number of staff, their credentials, and their relationship to the program, e.g., hospital employee, under contract, or consultant.
- Policies and procedures, including admission criteria, member assessment, treatment plan, discharge plan, and post-discharge services; and the scope of services provided, including treatment modalities.
- Any accreditation or other approvals from national or state organizations.
- A description of the physical facility and equipment, and whether the facility is part of the hospital license.

A letter of transmittal giving the following information must accompany the application:

- Name and address of the hospital
- Hospital provider number
- Name of the non-inpatient program
- Name and telephone number of a contact person

The Iowa Medicaid Provider Services Unit shall:

- Review the application against the general requirements and the requirements for the specific type of non-inpatient service; and
- Notify the provider whether certification has been approved.

b. Coding of Non-Inpatient Services

Hospitals billing for the following services must use one of the following condition codes to identify the special program:

Condition Codes	Service
84	Cardiac rehabilitation treatment
85	Treatment of eating disorders
86	Mental health treatment
87	Treatment for alcoholism or substance abuse
88	Pain management
89	Diabetic education
90	Pulmonary rehabilitation

The following HCPCS have been assigned for use when billing for normal treatment in outpatient programs. HCPCS are assigned based on one program treatment, which is defined as either one hour or treatment provided during one day.

- **Cardiac Rehabilitation**

Procedure	Description
S9472	Cardiac rehabilitation treatment, one day

One unit of cardiac rehabilitation treatment is defined as one treatment. Reimbursement for a treatment includes any stress tests or other diagnostic tests that are usually performed by the program.

- **Diabetic Education**

Procedure	Description
S9455	Diabetic education program

Diabetic education program is defined as one complete program for the education of diabetes treatment.

- **Eating Disorders**

Procedure	Description
H0017	Eating disorders treatment. Use this code whether the member participated in a full-day or half-day program.

- **Mental Health**

Procedure	Description
H2012	Behavioral health day treatment, per hour
S9480	Intensive outpatient psychiatric service, per 15 minutes (Use this code for group or individual psychotherapy, mental health occupational therapy, and psychometric testing.)
H0046	Mental health services, per hour (Use this code for partial hospitalization.)
90899	Unlisted psychiatric service (Use this code for brief encounter.)

- "**Day treatment**" is defined as one session consisting of three to five hours of service. Reimbursement for day treatment is through one-hour units not to exceed four hours per session, three or four times per week.
- "**Group psychotherapy**" is defined as one treatment provided by either a psychiatrist or a non-psychiatrist. One visit is defined as one hour of psychotherapy (i.e., any 15-minute combination of group or individual psychotherapy or occupational therapy).
- "**Individual psychotherapy**" is defined as one treatment provided by either a psychiatrist or a non-psychiatrist. One visit is defined as one hour of psychotherapy (i.e., any 15-minute combination of group or individual psychotherapy or occupational therapy).
- "**Occupational therapy**" is defined as one treatment provided by an occupational therapist. One visit is defined as one hour of treatment (i.e., any 15-minute combination of group or individual psychotherapy or occupational therapy).

- "**Psychometric testing**" is defined as diagnostic testing provided during a 15-minute interval. One visit is defined as one hour of treatment.
- "**Partial hospitalization**" is defined as one session consisting of four to eight hours of service. Reimbursement for partial hospitalization is through one-hour units not to exceed six hours per session.

Nutritional Counseling

Nutritional counseling for children from birth through age 20 is technically not a "non-inpatient" service, but is paid similarly. When billing the service, one unit equals 15 minutes The licensed dietitian is to be employed by or under contract with a hospital

Procedure	Description
97802	Medical nutrition therapy, per 15 minutes

Hospital Emergency Room Services

Procedure	Description
G0378	Hospital observation service, per hour
99211	Outpatient visit (Use this code for emergency room triage.)

Pain Management

Procedure	Description
97799	Unlisted physical medicine/rehabilitation service or procedure (Use this code for pain management treatment, one day.)

Pain management treatment is defined as one day's treatment in a multidisciplinary pain management program.

NOTE: When 97799 is billed with the "UC" modifier, it is intended that such be for the purpose of billing "outpatient pediatric intensive feeding" services. When used in this manner, such is not considered a "non-inpatient service."

Pulmonary Rehabilitation

Procedure	Description
S9473	Pulmonary rehabilitation treatment, one day

Pulmonary rehabilitation treatment is defined as one day's treatment in an approved program.

- **Substance Abuse**

  Reimbursement for a substance abuse treatment includes psychometric testing and the drugs Antabuse and Trexan.

Procedure	Description
H0047	Alcohol or other drug abuse services, full day (Use this code for billing one treatment provided for four or more consecutive hours.)
H2001	Rehabilitation per program, half day (one treatment provided for less than four consecutive hours)
H0034	Medication training and support. **NOTE:** Use this code only for members in one of the non-inpatient programs (cardiac rehabilitation, diabetic education, eating disorders, mental health, pain management, or pulmonary rehabilitation) on days when those services are not provided but the member must be seen for a medication check.

c. General Requirements for outpatient programs

All outpatient programs must meet the following requirements to be payable (IAC 441-78.31(2) and (3)) under the Medicaid program:

- It must be clearly established that the program meets a documented need in the area serviced by the hospital. There must be documentation of studies completed and of consultations with other health care facilities and health care professionals in the area and community leaders and organizations to determine the need for the service and to tailor the service to meet that particular need.
- The goals and objectives of the program must be clearly stated.
- The organization of the program must clearly facilitate attainment of its goals and objectives.
- The condition or disease that is proposed to be treated must be clearly stated. Any indications or contraindications for treatment must be set forth, together with criteria for determining the continued medical necessity of treatment.
- All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician.

  EXCEPTION: Mental health services may be provided under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.
- The program must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated and must contribute to the fulfillment of the stated goals and objectives.
- There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc. There must be a clear relationship between the length of the program and the stated goals and objectives.

- The services provided by the program must be monitored and evaluated to determine the degree to which members are receiving accurate assessments and effective treatment.
  - The service monitoring must be an ongoing plan and systematic process to identify problems in member care or opportunities to improve member care.
  - The service evaluation shall be based on the use of clinical indicators that reflect those components of member care important to quality.

d. Injected Medication

Additional reimbursement information can be found in the *Prescribed Drugs Manual*.

(1) Covered Services

Payment will be approved for injections, provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury or are for purposes of immunization. The following information must be provided when billing for injections:

- HCPCS code
- NDC
- Units of service

NOTE: When billing an "unlisted" J code (otherwise known as a "dump" code), in addition to the three bulleted items directly above, the provider should also indicate the charge for the injection.

When the above information is not provided, claims potentially will be denied. To the extent a hospital participates in the 340B program, proper billing is as per instruction in IL 699. The provider should include the NDC for the drug if billing under the 340B program where the UD modifier is appended. While this isn't required per IL 699, this is necessary information to price the drug, especially if billed under an unlisted HCPCS code.

(2) Non-Covered or Limited Services

For injections related to diagnosis or treatment of illness or injury, the following specific exclusions apply:

- **Injections not indicated for treatment of a particular condition**. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered. The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.

- **Injections not for a particular illness**. Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness or injury.

  NOTE: Obtain prior approval before employing an amphetamine or legend vitamin by injection. For additional information, see the ***Prescribed Drugs Manual***.

- **Method of injection not indicated**. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

- **Allergenic extract injection**. Claims from suppliers of allergenic extract materials provided the member for self-administration will be allowed according to coverage limits in effect for this service.

- **Excessive injections**. Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

  When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for injection given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.

If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for the purpose of administering drugs, it will be disallowed along with the non-covered injections. Outpatient hospital services that are not provided by critical-access hospitals and that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned.

For dates of services beginning on or after October 1, 2008, the Department adopts and incorporates by reference the OPPS APCs, relative weights and discount factors effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72 No. 227, page 66579.

E. Ambulatory Payment Classification (Apc) Payment

1. Calculation

The APC payment is calculated as follows:

a. The applicable APC relative weight is multiplied by the blended base APC rate determined according to Payment to Out-of-State Hospitals.

b. The resulting APC payment is multiplied by a discount factor percent and by units of service when applicable.

c. For a procedure started but discontinued before completion, the Department will pay a percent of the APC for the service.

The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under the OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ▪ Ambulance services ▪ Clinical diagnostic laboratory services ▪ Diagnostic mammography ▪ Screening mammography ▪ Non-implantable prosthetic and orthotic devises ▪ Physical, occupational, and speech therapy ▪ Erythropoietin for end state renal dialysis (ESRD) members ▪ Routine dialysis services for ESRD members provided in a certified dialysis unit of a hospital	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on Iowa Medicaid fee schedule for outpatient hospital services. If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).

Indicator	Item, Code, or Service	OPPS Payment Status
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC: ▪ May be paid when submitted on a bill type other than outpatient hospital. ▪ An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on Iowa Medicaid fee schedule for outpatient hospital services. If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the member and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes and services: ▪ That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ▪ That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ▪ That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ▪ For which separate payment is not provided by Medicare but maybe for Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on Iowa Medicaid fee schedule for outpatient hospital services. If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.

<table>
<tr><th>Indicator</th><th>Item, Code, or Service</th><th>OPPS Payment Status</th></tr>
<tr><td>F</td><td>Certified registered nurse anesthetists services
Corneal tissue acquisition
Hepatitis B vaccines</td><td rowspan="3">If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on Iowa Medicaid fee schedule for outpatient hospital services.
If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</td></tr>
<tr><td>G</td><td>Pass-through drugs and biologicals</td></tr>
<tr><td>H</td><td>Pass-through device categories</td></tr>
<tr><td>K</td><td>Non-pass-through drugs and biologicals
Therapeutic radiopharmaceuticals</td><td>If covered by Iowa Medicaid, the item is:
▪ Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.
▪ Paid based on Iowa Medicaid fee schedule for outpatient hospital services when either no APC or APC weight is established.
If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</td></tr>
<tr><td>L</td><td>Influenza vaccine
Pneumococcal pneumonia vaccine</td><td rowspan="2">If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on Iowa Medicaid fee schedule for outpatient hospital services.
If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</td></tr>
<tr><td>M</td><td>Items and services not billable to the Medicare fiscal intermediary</td></tr>
<tr><td>N</td><td>Packaged services not subject to separate payment under Medicare OPPS payment criteria</td><td>Paid under OPPS APC. Payment is included with payment for other services, including outliers; therefore, no separate payment is made.</td></tr>
<tr><td>P</td><td>Partial hospitalization</td><td>Not a covered service under Iowa Medicaid.</td></tr>
</table>

<table>
<tr><th>Indicator</th><th>Item, Code, or Service</th><th>OPPS Payment Status</th></tr>
<tr><td>Q1</td><td>STVX-packaged codes</td><td>Paid under OPPS APC:
▪ Packaged APC payment if billed on the same date of service as HCPS code assigned status indicator “S,” “T,” “V,” or “X.”
▪ In all other circumstances, payment is made through a separate APC payment.</td></tr>
<tr><td>Q2</td><td>T-packaged codes</td><td>Paid under OPPS APC:
▪ Packaged APC payment if billed on the same date of service as HCPS code assigned status indicator “T.”
▪ In all other circumstances, payment is made through a separate APC payment.</td></tr>
<tr><td>Q3</td><td>Codes that may be paid through a composite APC</td><td rowspan="3">If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.
If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</td></tr>
<tr><td>R</td><td>Blood and blood products</td></tr>
<tr><td>S</td><td>Significant procedure, not discounted when multiple</td></tr>
<tr><td>T</td><td>Significant procedure, multiple reduction applies</td><td rowspan="2">If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reductions.
If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</td></tr>
<tr><td>U</td><td>Brachytherapy sources</td></tr>
<tr><td>V</td><td>Clinic or emergency department visit</td><td rowspan="2">If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.
If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</td></tr>
<tr><td>X</td><td>Ancillary services</td></tr>
</table>

a. Calculation of Case-Mix Indices

Hospital-specific and state-wide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, and every three years thereafter.

- Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.
- The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services.
- Claims for hospitals receiving reimbursement as critical-access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

b. Calculation of the Hospital-Specific Base APC Rates

The base-year cost for the current rebasing is the hospital's cost report with fiscal year ending on or after January 1, 2006, and before January 1, 2007. The hospital-specific base APC rate will be rebased every three years thereafter. In non-rebasing years, the hospital-specific base APC rate will be trended forward based on legislative appropriations.

Rates of hospitals receiving reimbursement as critical-access hospitals are not trended forward using inflation indices.

Using the hospital's base year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, form CMS-2552.

The cost to charge ratios are applied to each line item charge reported on claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, and every three years thereafter, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

The following items are subtracted from the hospital's total outpatient Medicaid costs:

- The total calculated Medicaid direct medical education costs for interns and residents based on the hospital's base-year cost report. The reimbursement for direct medical education is allocated to the Graduate Medical Education and Disproportionate Share Fund and is not paid on a per-claim basis. See Direct Medical Education Payment for more information.
- The total calculated Medicaid cost for non-inpatient program services.
- The total calculated Medicaid cost for ambulance services.
- The total calculated Medicaid cost for services paid based on Iowa Medicaid fee schedule.

The remaining amount is multiplied by an inflation update factor, divided by the hospital-specific case-mix index, and divided by the total number of APC services for that hospital during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007, and every three years thereafter.

Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical-access hospitals during any of the period included in the base-year cost report.

c. Calculation of the Statewide Base APC Rates

The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

- The total calculated Medicaid direct medical education costs for interns and residents for all hospitals.
- The total calculated Medicaid cost for non-inpatient program services for all hospitals.
- The total calculated Medicaid cost for ambulance services for all hospitals.
- The total calculated Medicaid costs for services paid based on Iowa Medicaid fee schedule for all hospitals.

The resulting amount is multiplied by an inflation update factor, divided by the statewide case-mix index, and then divided by the statewide total number of APC services for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007, and every three years thereafter.

Data for hospitals receiving reimbursement as critical-access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

d. Rebasing

Effective January 1, 2009, and annually thereafter, the Department shall update the OPPS APC relative weights and discount factors using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

Effective January 1, 2009, and every three years thereafter, base APC rates shall be rebased. Data used for rebasing shall come from the hospital fiscal year-end form CMS-2552-10, *Hospital and Healthcare Complex Cost Report*, as submitted to Medicare as directed by Medicare cost report submission timelines for the hospital fiscal year ending during the preceding calendar year. Click here to access the form online.

If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to Iowa Medicaid Provider Cost Audits and Rate-Setting Unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using claims most nearly matching each hospital's fiscal year end.

NOTE: Once a hospital begins receiving reimbursement as a critical-access hospital, the prospective outpatient Medicaid cost-to-charge ratio is not subject to inflation factors or rebasing pursuant to this section.

In addition, any hospital may request review for outlier payment by submitting documentation to the quality improvement organization within 365 days of receipt of outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

Outlier cases are reviewed for medical necessity of all services provided, to ensure that services were not billed in duplicate, and to determine if services were actually provided and all services were ordered by a physician. Providers will be notified of all pending adverse decisions before the quality improvement organization makes a final determination.

On a quarterly basis, the quality improvement organization calculates denial rates for each facility based on completed reviews during the quarter. All reviewed outlier cases are included in the computation of error rates. Cases with denied charges exceeding $1,000 for inappropriate or non-medically necessary services are counted as errors.

Intensified review may be initiated for hospitals whose error rate reaches or exceeds the norm for similar cases in other hospitals. The error rate is determined based on the completed outlier reviews in a quarter per hospital and the number of those cases with denied charges exceeding $1,000. Intensified review will be discontinued when the error rate falls below the norm for a calendar quarter.

The number of cases sampled for hospitals under intensified review may change based on further professional review and the specific hospital's outlier denial history. Specific areas for review are identified based on prior outlier experience. When it is determined that a significant number of the errors identified for a hospital are attributable to one source, review efforts will be focused on the specific cause of the error.

If intensified review is required, hospitals will be notified in writing and provided with a list of the cases that met or exceeded the error rate threshold. When intensified review is no longer required, hospitals will also be notified in writing.

2. Direct Medical Education Payment

Payment to all hospitals qualifying for direct medical education is made directly from the graduate medical education and disproportionate share fund. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in:

- The hospital's base year cost report and
- The most recent cost report submitted before the start of the state fiscal year for which payments are being made.

a. Allocation to Fund for Direct Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is allocated by the Legislature. If a hospital fails to qualify for direct medical education payments related to outpatient services from the fund due to closure or any other reason, the amount of money that would have been paid to that hospital is removed from the fund.

This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

b. Distribution to Qualifying Hospitals

Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

- Multiply the total count of outpatient visits for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value. This is updated every three years.
- Sum the dollar values for each hospital.
- Divide each hospital's dollar value by the total dollar value, resulting in a percentage.
- Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

The state fiscal year used as the source of outpatient visits in this formula will be updated every three years by a three-year period.

3. Payment to Out-of-State Hospitals

Out-of-state hospitals providing care to Iowa Medicaid members shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state-hospital.

For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from Iowa Medicaid program for services to Iowa Medicaid members.

G. Billing Policies and Claim Form Instructions

Claims for hospitals are billed on federal form UB-04, *Health Insurance Claim Form*.

Click here to view a sample of the UB-04.

Click here to view billing instructions for the UB-04.

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