

Acute Hospital Services

Provider Manual



**Iowa Department
of Human Services**

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. HOSPITALS ELIGIBLE TO PARTICIPATE

All hospitals that are certified as eligible to participate in the Medicare program are eligible to participate in the Iowa Medicaid program. 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.

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

1. Audits

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

Each participating hospital is subject to a periodic audit of its fiscal and statistical records. The Department has agreements for the exchange of Medicare and Medicaid information with the Medicare intermediaries in Iowa and surrounding areas.

2. Certification of Special Units

Certification by the IME is required for Medicaid reimbursement as a substance abuse unit, a neonatal intensive care unit, a psychiatric unit or a physical rehabilitation hospital or unit.

Hospitals shall submit requests for certification to:

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

The request should include documentation that 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 the IME received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

a. Criteria for Neonatal Intensive Care Units

A neonatal intensive care unit may be certified for Medicaid reimbursement if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

The IME shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care.

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

b. Criteria for Physical Rehabilitation Hospitals and Units

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

- ◆ It receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and
- ◆ The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

c. 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 and 412.27 as amended to August 1, 2002.



d. Criteria for Substance Abuse Units

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

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.

An out-of-state substance abuse 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 and 412.27, as amended to September 1, 1994.

An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993.

All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

3. Cost Reporting Requirements

Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, 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 Enterprise
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 the IME.

4. Incentives for Efficient Operation

Payment to hospitals using diagnosis-related group (DRG) or ambulatory payment classification (APC) 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.

The IME 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.



5. Provider Appeals

In accordance with 42 CFR 447.253(e), providers have appeal rights for rate setting in the outpatient setting and in the inpatient setting. A hospital that is dissatisfied with a diagnosis-related group (DRG) or ambulatory payment classification (APC) 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 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 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 or outpatient services, 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.

The IME program reimburses hospitals for inpatient care based on diagnosis-related groups (DRG). There are no specific limits on the number of days of inpatient care for which DRG payment will be approved, as long as the IME Medical Services Unit 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. Payment can be denied if either admissions or discharges are performed without medical justification, as determined by the IME Medical Services Unit.

Inpatient or outpatient services that require preadmission or pre-procedure approval by the IME Medical Services Unit are updated periodically by the Department and are listed in this manual. 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, the IME Medical Services Unit 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

Surgical procedures affect health care expenditures significantly. To ensure that procedures are medically necessary, the IME Medical Services conducts a pre-procedure review program for the Medicaid program. This program entails reviewing selected high-quantity procedures when they are performed on an inpatient basis, in the outpatient unit of a hospital, or in a free-standing surgical unit.

Pre-procedure review is performed for all heart, lung, liver, stem cell, pancreas, and bone marrow transplants and for all bariatric procedures, as identified on the pre-procedure review list. Reviews are performed for members with traditional Medicaid and MediPASS coverage.



The following sections explain:

- ◆ [What procedures are reviewed](#)
- ◆ [How reviews are conducted](#)
- ◆ [What happens if the review is not obtained until after the member is discharged](#)

a. Procedures Subject to Review

The following is a list of the surgical procedures that are subject to pre-procedure review. Procedures for which approval must be obtained are listed with CPT and both ICD-9 and ICD-10 codes.

	Hospital Use Only: <u>ICD-9</u> (through 9/30/15)	Hospital Use Only: <u>ICD-10</u> (beginning 10/1/15)		Physician and Ambulatory Surgical Center Use Only: <u>CPT-4</u>
Bone marrow transplant	41.00 41.01 41.02 41.03	30230G0 30230G1 30233G0 30233G1 30240G0 30240G1 30243G0 30243G1 30250G0 30250G1 30253G0 30253G1	30260G0 30260G1 30263G0 3E03005 3E03305 3E04005 3E04305 3E05005 3E05305 3E06005 3E06305 30263G1	38240 38241



	Hospital Use Only: <u>ICD-9</u> (through 9/30/15)	Hospital Use Only: <u>ICD-10</u> (beginning 10/1/15)		Physician and Ambulatory Surgical Center Use Only: <u>CPT-4</u>
Stem cell transplant	41.04 41.05 41.06 41.07 41.08 41.09	30230AZ 30230Y0 30233AZ 30233Y0 30240AZ 30240Y0 30243AZ 30243Y0 30250Y0 30253Y0 30260Y0 30263Y0 30230Y1 30233Y1 30240Y1 30243Y1 30250Y1 30253Y1 30260Y1 30263Y1 30230X0 30230X1 30233X0 30233X1 30240X0 30240X1	30243X0 30243X1 30250X0 30250X1 30253X0 30253X1 30260X0 30260X1 30263X0 30263X1 3E03005 3E03305 3E04005 3E04305 3E05005 3E05305 3E06005 3E06305 30230G0 30233G0 30240G0 30243G0 30250G0 30253G0 30260G0 30263G0	38240 38241
Heart transplant	37.51	02YA0Z0 02YA0Z1 02YA0Z2		33945
Liver transplant auxiliary	50.51	0FY00Z0 0FY00Z1 0FY00Z2		47135
Other transplant of liver	50.59	0FY00Z0 0FY00Z1 0FY00Z2		47135 47136



	Hospital Use Only: <u>ICD-9</u> (through 9/30/15)	Hospital Use Only: <u>ICD-10</u> (beginning 10/1/15)		Physician and Ambulatory Surgical Center Use Only: <u>CPT-4</u>
Lung transplant: <ul style="list-style-type: none">• Unilateral transplant• Bilateral transplant	33.50 33.51 33.52	0BYK0Z0 0BYK0Z1 0BYK0Z2 0BYLOZ0 0BYLOZ1 0BYLOZ2 0BYFOZ0 0BYFOZ1 0BYFOZ2 0BYGOZ0 0BYGOZ1	0BYG0Z2 0BYH0Z0 0BYH0Z1 0BYH0Z2 0BYJ0Z0 0BYJ0Z1 0BYJ0Z2 0BYM0Z0 0BYM0Z1 0BYM0Z2	32851 32852 32853 32854
Pancreas	52.80 52.82	0FYG0Z0 0FYG0Z1 0FYG0Z2		48160 48554
Combined heart/lung	33.6	Requires two ICD-10 procedure codes. One from heart codes: 02YA0Z0 02YA0Z1 02YA0Z2 And one from respiratory codes: 0BYM0Z0 0BYM0Z1 0BYM0Z2		33935
Laparoscopic bariatric procedures	43.82 44.38 44.68 44.95	0DB64Z3 0D16479 0D1647A 0D164J9 0D164JA 0D164K9 0D164KA 0D164Z9 0D164ZA 0D1647B	0D1647L 0D164JB 0D164JL 0D164KB 0D164KL 0D164ZB 0D164ZL 0DQ64ZZ 0DV64CZ	43644 43645 43770 43772 43773 43774 43775



	Hospital Use Only: <u>ICD-9</u> (through 9/30/15)	Hospital Use Only: <u>ICD-10</u> (beginning 10/1/15)		Physician and Ambulatory Surgical Center Use Only: <u>CPT-4</u>
Bariatric procedures, other than laparoscopic	43.89 44.31 44.39 44.69 45.51 45.91	0DB60ZZ 0DB63ZZ 0DB67ZZ 0D1607A 0D160JA 0D160KA 0D160ZA 0D1687A 0D168JA 0D168KA 0D168ZA 0D160K9 0D160Z9 0D16879 0D168J9 0D168K9 0D168Z9 0DV63ZZ 0DV64DZ 0DV64ZZ 0DV67ZZ 0DV68ZZ 0DB90ZZ	0DBB0ZZ 0F190Z3 0TRB07Z 0D190Z9 0D190ZA 0D190ZB 0D194Z9 0D194ZA 0D194ZB 0D198Z9 0D198ZA 0D198ZB 0D1A0ZA 0D1A0ZB 0D1A4ZA 0D1A4ZB 0D1A8ZA 0D1A8ZB 0D1A8ZH 0D1B0ZB 0D1B4ZB 0D1B8ZB 0D1B8ZH	43842 43843 43845 43846 43847
Bariatric procedures, revisions/ removals	44.5 44.96 44.97 44.98	0DQ60ZZ 0DQ63ZZ 0DQ64ZZ 0DQ67ZZ 0DQ68ZZ 0DW643Z 0DW64CZ 0DP643Z 0DP64CZ 3E0G3GC		43771 43772 43774 43848 43860 43865 43886 43887 43888

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b. Review Process

The following review process applies to all pre-procedure review activities. Pre-procedure review is conducted to evaluate the appropriateness of the procedures identified on the pre-procedure review list. Requests for review of these elective procedures must be submitted in writing to:

Iowa Medicaid Enterprise
Attn: Medical Prior Authorization
PO Box 36478
Des Moines, IA 50315



The request must provide the following information from the physician, on which IME Medical Services will base its decision:

- ◆ 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 specialties. 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.

The IME provides validation numbers on all approved pre-procedure reviews. Claims sent to the IME without a validation prior authorization number will be denied. The hospital must notify the IME and request a retrospective review to determine the appropriateness of the procedure before receiving payment.

A sample of cases reviewed on a pre-procedure basis is 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.



c. Procedure Review Obtained Following Discharge

If the provider discovers that pre-procedure review was not obtained with the IME before or immediately following the procedure and the member was discharged, the provider must request the IME 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 to Iowa Medicaid Enterprise for a retrospective review. Hospital staff is reminded to identify the type of procedure review that is being requested (e.g., gastric stapling review).

3. Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

- ◆ The attending physician certifies in writing, on the basis of professional judgment, that continuing the pregnancy would endanger the life of the pregnant woman. 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.
- ◆ The attending provider certifies 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.
- ◆ The pregnancy is the result of rape that:
 - Was reported to a law enforcement agency or public or private health agency, which may include a family physician, and
 - Was reported within 45 days of the date of the incident, and
 - Report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.



- ◆ The pregnancy is the result of incest that:
 - Was reported to a law enforcement agency or public or private health agency, which may include a family physician, and
 - Was reported within 150 days of the incident, and
 - 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.

a. *Certification Regarding Abortion, 470-0836*

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. Click [here](#) to view the form online. 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.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required, as set forth above. 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.

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.

Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

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 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

b. 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 and 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.



c. Non-Covered Services

The following abortion-related services are **not** allowed when the abortion is not covered by federal or state criteria:

- ◆ 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.



4. **Cosmetic Surgery**

Cosmetic, reconstructive, or plastic surgery or expenses incurred in connection with such surgeries is not covered under the Medicaid program except when required for the:

- ◆ 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):

- ◆ 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

5. 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. 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.

6. Fertility Services

Iowa Medicaid does not cover fertility services.



7. 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:

- ◆ 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.

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 the IME with the related Medicaid claims.

- ◆ The member was already sterile before the hysterectomy. 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 the IME with the related Medicaid claims.



- ◆ The hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. 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 an acreta.

8. Medicare-Covered Services

Medicaid will pay the Medicare coinsurance and deductible for members who are eligible for both Medicare and Medicaid.

9. Organ Transplants

Payment will be made only for the following organ and tissue transplant services when medically necessary. For those transplants requiring preprocedure review/approval, such will be noted.

- ◆ Kidney, cornea, skin, and bone transplants.
- ◆ Allogeneic bone marrow transplants for the treatment of:
 - 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:
 - 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.

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



- ◆ Heart transplants 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 preprocedure review by the Iowa Medicaid Enterprise Medical Services Prior Authorization Unit. Covered heart transplants are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10).

- ◆ Lung transplants for members having end-stage pulmonary disease. Lung transplants require pre-procedure review by the IME Medical Services Unit and are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10). Heart-lung transplants are covered consistent with the criteria listed above under heart transplants.
- ◆ Pancreas transplants 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 the IME Medical Services Unit.

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



Donor expenses 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.

10. **Outlier Review**

Payment for long-stay and cost outliers is prospective (see [Cost Outlier Review](#)). Partial payment for outliers will be made when the hospital claim is originally filed.

The IME Medical Services Unit reviews a random sample of all outlier claims, as well as all claims for which outlier payment is in excess of \$20,000. The Medical Services Unit is responsible for notifying each hospital of cases that have been selected for day and cost outlier review.

Those hospitals must then submit the medical record, the paid UB-04 claim, and a copy of the remittance statement to Telligen (formerly IFMC) within 60 days of receipt of the outlier medical record request. If the documentation is not submitted timely, outlier payment will be recouped and forfeited.

Any hospital may request review for additional outlier payment by submitting the medical record, the UB-04, and a copy of the remittance statement to the IME Medical Services Unit within 365 days from the date of the remittance statement.

If the medical record is not submitted within 365 days, the provider loses the right to appeal or contest the payment. 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.

a. **Adverse Determinations**

The IME Medical Services Unit notifies the member, the attending physician, and the hospital of decisions regarding the following reviews:

- ◆ Preadmission
- ◆ Admission
- ◆ Readmission
- ◆ Transfer
- ◆ Pre-procedure
- ◆ Invasive procedure
- ◆ Outlier



The IME Medical Services Unit also notifies the attending physician and hospital of the adverse decisions resulting from DRG validation.

All parties to an adverse determination that affects payment may request reconsideration within 60 days after receipt of notification. A reconsideration request may 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.

b. Cost Outlier Review

Cost outliers are cases with charges that exceed a fixed multiple of the applicable DRG rate or a fixed dollar amount, whichever is greater. These rates are predetermined.

Cases are reviewed to ensure that services were not duplicatively billed, to determine whether services were actually rendered, and to determine whether all services were ordered by a physician.

IME Medical Services Unit staff review the case and perform admission review, quality review, discharge review, DRG validation, and invasive procedure review. Questionable cases are referred to a Telligen physician reviewer 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.

c. Day Outlier Review

Day outliers 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.

IME Medical Services Unit staff review the case and perform admission review, quality review, discharge review, DRG validation, and invasive procedure review. Questionable cases are referred to a physician reviewer.



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.

11. Respite Care

A hospital choosing to provide respite care to HCBS waiver consumers must enroll with Medicaid as a waiver provider.

12. Retrospective Reviews

The IME Medical Services Unit conducts the following retrospective reviews:

- ◆ **Focused review.** The Medical Services Unit performs intensive retrospective reviews on the inpatient hospital admissions for alcohol or drug abuse or dependence with detoxification or rehabilitation therapy, and for pediatric pneumonia and asthma.
- ◆ **Hospital-issued denial notice review.** The Medical Services Unit retrospectively reviews all hospital-issued notices of noncoverage and physician-requested denials. Hospital-issued denials are required before a member can be billed for service.
- ◆ **Random retrospective review.** All Medicaid discharges are subject to random retrospective review by the Medical Services Unit. 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.

Retrospective review includes a validation sample of preadmission and pre-procedure reviews and a sample of Cesarean section deliveries. This review does not include Medicare beneficiaries.

13. 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 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 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 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.

The same revision of federal regulations provide that payment may be made through the Medicaid program for the sterilization of a member aged 21 or over when the consent form is signed, who is mentally competent and not institutionalized, in accordance with the above definitions.

a. Requirements

The following conditions must be met:

- ◆ The member to be sterilized must voluntarily request the services.
- ◆ 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.



- ◆ 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.

“Informed consent” means the voluntary knowing assent 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.

The informed consent shall not be obtained while the member to be sterilized is:

- 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:

- A thorough explanation of the procedures to be followed and the benefits to be expected.
- A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- 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.
- An offer to answer any questions concerning the proposed procedure.

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.

For an exception to be approved when emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent was obtained.



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.

b. *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.

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.

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 IME for payment.

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.

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 the IME for payment.

The only signatures which should be on the completed consent form are those of the member, interpreter (if interpreter services were provided), the provider obtaining the consent form, and the physician performing the sterilization.

14. 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.

Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.



15. 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. 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 Public Health. 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

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

The IME adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system, except as indicated. 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.

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

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, and are covered by the DRG payment. This does not apply to critical-access hospitals. See also [BASIS OF PAYMENT FOR OUTPATIENT SERVICES](#).

Mother and newborn baby charges are considered two separate claims. They must be billed independently with each member's own Medicaid identification number on the claim. The baby's identification number is assigned as soon as the Department's local office receives verification of the baby's birth. Contact the local Department office to obtain the number.



Medicaid DRGs do **not** cover the following services:

- ◆ Inpatient services provided by a critical-access hospital to a Medicaid fee-for-service member are reimbursed on a reasonable cost basis, as described in [Critical-Access Hospitals](#).
- ◆ Physical rehabilitation performed in a certified unit is paid per diem. See [Physical Rehabilitation Units](#).
- ◆ Inpatient psychiatric services performed in a certified unit are paid per diem. See [Inpatient Psychiatric Units](#).

Teaching hospitals that have Medicare approval to receive reasonable cost reimbursement for physician services under 42 Code of Federal Regulations 415.55 are eligible for combined billing status if they have the Medicare approval notice on file with IME as verification. Reasonable cost settlement will be made during the year-end settlement process.

The graduate medical education and disproportionate share fund is a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for:

- ◆ The direct and indirect costs associated with the operation of graduate medical education programs and
- ◆ The costs associated with the treatment of a disproportionate share of poor, indigent, non-reimbursed or nominally reimbursed members for inpatient services.

The following sections explain:

- ◆ [Critical-Access Hospitals](#)
- ◆ [Diagnosis-Related Group Payments](#)
- ◆ [Disproportionate-Share Payment](#)
- ◆ [Inpatient Psychiatric Units](#)
- ◆ [Medical Education Costs – Direct](#)
- ◆ [Medical Education Costs – Indirect](#)
- ◆ [Members Eligible for Only Part of the Hospital Stay](#)
- ◆ [Out-of-State Hospitals](#)
- ◆ [Outliers](#)
- ◆ [Physical Rehabilitation Units](#)
- ◆ [Transfers and Readmissions](#)



1. Critical-Access 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 in the interim on an individually specific DRG basis for inpatient care and a percentage of charges for outpatient care, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year.

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 fee-for-service reimbursement received in the interim on the DRG basis. The Department will recover any interim payments made that exceed reasonable costs.

Once a hospital begins receiving reimbursement as a critical-access hospital, DRG basis payments are not subject to rebasing or recalibration. The individually specific base rate upon which the DRG payment is made is revised after any retrospective cost adjustment for the previous period to reflect the reasonable anticipated level of costs of providing covered services to eligible fee-for-service Medicaid members for the coming year.

2. Diagnosis-Related Group Payments

Under the DRG payment system, the "final payment rate" for each hospital is the aggregate sum of the blended base amount and capital costs for that hospital. These amounts are added together and multiplied by the set of Iowa-specific DRG weights to establish a final DRG payment rate for that hospital. Those dollar values are displayed on the rate table.

The direct and indirect medical education costs and the disproportionate share costs are directly reimbursed through the graduate medical education and disproportionate-share fund. They are not included in the final payment rate or displayed in the rate table.



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.
- ◆ **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:
 - 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.

a. Calculation of Blended Base Amount

The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

The statewide average case-mix-adjusted cost per discharge is calculated by subtracting from the statewide total IME inpatient expenditures the total calculated dollar expenditures, based on hospitals' base year cost reports, for:

- ◆ Capital costs
- ◆ Direct medical education costs
- ◆ Calculation of actual payments that will be made for:
 - Additional transfers
 - Outliers
 - Physical rehabilitation services (if included in total cost)
 - Inpatient psychiatric services (if included in total cost)
 - Indirect medical education

NOTE: The costs of hospitals receiving reimbursement as critical-access hospitals during any of the period included in the base-year cost report are not used in determining the statewide average case-mix-adjusted cost per discharge.



The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of IME discharges reported in the Medicaid management information system (MMIS) less an actual number of non-full DRG transfers and short stay outliers.

The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Medicaid costs or covered reasonable charges, as determined by the hospital's base year cost report or MMIS claims system, the actual dollar expenditures for:

- ◆ Capital costs,
- ◆ Direct medical education costs, or
- ◆ Calculation of actual payments that will be made for:
 - Non-full DRG transfers
 - Outliers
 - Physical rehabilitation services (if included above)
 - Inpatient psychiatric services (if included above)

The remaining amount is case-mix adjusted, adjusted to reflect inflation, and divided by the total number of IME discharges for that hospital during the applicable base year from the MMIS claims system or the cost report (whichever is greater), less the non-full DRG transfers and short stay outliers.

Using trimmed claims, the case-mix index is calculated by dividing the hospital's weighted sum of all DRG weights by the total number of Medicaid discharges in that hospital, excluding Medicaid managed care cases. Case-mix indices are not computed for hospitals receiving reimbursement as critical-access hospitals.

The hospital-specific case-mix-adjusted average cost per discharge is added to the case-mix-adjusted state-wide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

For purposes of calculating the disproportionate-share rate only, a separate hospital-specific case-mix-adjusted cost per discharge will be calculated for any hospital that qualifies for a disproportionate-share payment only as a children's hospital based on a distinct area or areas serving children.



The cost for a children's hospital will be calculated using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

Base amounts are rebased and weights recalibrated every three years.

NOTE: Hospitals receiving reimbursement as critical-access hospitals do not have base amounts rebased.

b. Calculation of Iowa-Specific Weights and Case-Mix Index

From the Medicaid claim set, the recalibration for rates effective October 1, 2008, and every three years thereafter, will:

- ◆ Use all normal inlier claims,
- ◆ Discard short stay outliers,
- ◆ Discard transfers where the final payment is less than 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 long stay outliers and cost outliers for weighting calculations.

These are referred to as trimmed claims.

Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical-access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

- ◆ Determine the statewide geometric mean charge for all cases classified in each DRG.
- ◆ Compute 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.



- ◆ Sum 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.
- ◆ Divide 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.
- ◆ Normalize the weights so that the average case has a weight of one.

The hospital-specific case-mix index is computed 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. Case-mix indices are not computed for hospitals receiving reimbursement as critical-access hospitals.

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.

Federal DRG definitions are adopted except as provided below:

- ◆ Hospitals with Medicaid-certified substance abuse units are reimbursed using the weight that reflects the age of each member. Three sets of DRG weights are developed.
 - One set for treating adults.
 - One set for treating adolescents in mixed-age units.
 - One set for treating adolescents to age 18 in designated adolescent-only units.
- ◆ For neonatal intensive care treatment, three sets of DRG weights are developed. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.
 - One set for treating neonates in a neonatal intensive care unit designated level III for some portion of their hospitalization.



- One set for treating neonates in a neonatal intensive care unit designated level II for some portion of their hospitalization.
- One set for treating neonates not treated in a setting designated level II or level III.

c. Capital Cost Add-on

Compensation for capital expenditures is added 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 IME members in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.



3. Disproportionate-Share Payment

Payment is made to all hospitals qualifying for disproportionate-share payments directly from the graduate medical education and disproportionate share fund. 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 and:
 - 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.

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

Information contained in the hospital's base year cost report submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's inpatient Medicaid utilization rate.

To qualify for disproportionate share payments as a children's hospital, a hospital must provide its available base year submitted Medicare cost report to the IME 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.



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 members who are in need of obstetric services.

For 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 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. Allocation to Fund for Disproportionate Share

The total amount of funding allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is allocated by the Legislature.

b. Distribution to Qualifying Hospitals for Disproportionate Share

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 July 1, 2008, through June 30, 2009, for each hospital that met the qualifications 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. This is updated every three years.

For a hospital that qualifies for payment only as a children's hospital, only the DRG weights for claims paid for members who were under 18 when admitted to an area of the hospital where services are provided predominantly to children are used in this formula.

The hospital must provide Medicaid claims data to the IME Provider Cost Audits and Rate Setting Unit within 20 business days of a Department request.

- ◆ 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.

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



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

If a hospital fails to qualify for disproportionate-share payments 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.

4. Inpatient Psychiatric Units

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.



5. Medical Education Payment – Direct

Payment is made to all hospitals qualifying for direct medical education payments 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 inpatient services is allocated by the Legislature. If a hospital fails to qualify for direct medical education payments related to inpatient 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 of all DRG weights for claims paid from July 1, 2008, through June 30, 2009, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program 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 DRG weights in this formula is updated every three years by a three-year period.

Effective September 1, 2011, out-of-state hospitals will no longer be able to receive direct medical education payments. This is based on a 2011 Iowa Legislative mandate eliminating such payments.

6. Medical Education Payment – Indirect

Payment is made to all hospitals qualifying for indirect medical education payments directly from the graduate medical education and disproportionate share fund. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from the IME and qualify for indirect medical education payments from Medicare.

Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

a. Allocation to Fund for Indirect Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education is allocated by the Legislature, unless a hospital fails to qualify for indirect medical education payments. If a hospital fails to qualify for indirect medical education payments related to inpatient 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 indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

- ◆ Multiply the total of all DRG weights for claims paid from July 1, 2008, through June 30, 2009, 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 indirect 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 indirect medical education to determine the payment to each hospital.

The state fiscal year used as the source of DRG weights in this formula is updated every three years by a three-year period.

Effective September 1, 2011, out-of-state hospitals will no longer be able to receive indirect medical education payments. This is based on a 2011 Iowa Legislative mandate eliminating such payments.

7. 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.



8. 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. If a hospital qualifies for direct medical education or indirect medical education under Medicare guidelines, it will qualify for these payments in Iowa.

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 the IME 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.



9. Outliers

Payment adjustments are made for member stays falling in these groups:

- ◆ [Cost outliers](#)
- ◆ [Long-stay outliers](#)
- ◆ [Short-stay outliers](#)

Cases qualifying as both cost and long-stay outliers are given additional payment as cost outliers only.

a. Cost Outliers

Cases qualify as cost outliers when costs of service (not including any add-on amounts for direct or indirect medical education or for disproportionate-share costs) exceed the cost threshold. This cost threshold is the greater of:

- ◆ Two times the statewide average DRG payment for that case, or
- ◆ The hospital's individual DRG payment for that case plus \$16,000.

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 for the case in question. Payment of the cost outlier amounts is at 100 percent of the calculated amount and is made when the claim is paid.

Hospitals that are notified of any outlier review initiated by the IME must submit all requested supporting data to the IME within 60 days of the receipt of review notification, or outlier payment will be forfeited and recouped.

Any hospital may also request a review for outlier payment by submitting documentation to the IME 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.



b. Long-Stay Outliers

Long-stay outliers are incurred when a member's length of stay exceeds the upper day threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the statewide average 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 threshold. Payment for long-stay outliers is made at 100 percent of the calculated amount when the claim is originally filed for DRG payment.

When a Medicaid member requires acute care in the same facility for an extraordinarily long length of stay (e.g., more than six months) the facility may request partial payment. The written request should include:

- ◆ The member's name and state identification number.
- ◆ The date of admission.
- ◆ A brief summary of the case.
- ◆ A list of charges.
- ◆ A doctor's statement that the member has been an inpatient for at least 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

Send requests to the IME Provider Services Unit. A representative of the Unit will assist in processing the interim claim.

c. Short-Stay Outliers

Short-stay outliers are incurred when a member's length of stay is greater than two standard deviations 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 is 200 percent of the average daily rate for each day the member qualifies, up to the full DRG payment. Short-stay outlier claims are subject to PRO review and payment denied for inappropriate admissions.



10. 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.

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.

11. Transfers and Readmissions

The following chart lists the payment provisions for the transferring and receiving facilities when a Medicaid member is transferred.

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.



Transferred from:	To:
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.
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:

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.

Before this change, when a hospital discharged a member too early and the member is subsequently readmitted for the same diagnosis or condition, the hospital receives two full “diagnosis-related group” (DRG) payments. The Legislature’s intent was that the original and readmission claims will be combined together, resulting in one DRG payment.



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:

- ◆ 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 the IME are updated yearly. A list of these procedures is available from the IME Provider Services Unit.

The hospital shall provide the IME 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.

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. The IME Medical Services Unit reviews outpatient services on a random, retrospective basis.



a. Ambulance

Hospitals must enroll their ambulance service as ambulance providers.

b. Dental Services

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.

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.

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

d. Emergency Room

Payment is always made for an assessment. 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.



Diagnosis codes used to determine emergency room payment are in Chapter I. [Exemptions](#). Other cases will be approved for the emergency room service if the IME Medical Services Unit evaluates not only the member's presenting diagnosis and condition, but also relevant medical history that may be available.

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.

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) and whether or not the member is participating in either the MediPASS or Lock-in programs.
- ◆ Payment is made at 75 percent of the usual APC amount:
 - For members not participating in the MediPASS or Lock-in program who were referred to the emergency room by appropriate medical personnel (UB-04 form locator 76++), or
 - For members participating in the MediPASS or Lock-in program referred to the emergency room by their MediPASS or Lock-in primary care physician (UB-04 form locator 79++).



- ◆ Payment is made at 50 percent of the usual APC amount for members not participating in the MediPASS or Lock-in program who were not referred to the emergency room by appropriate medical personnel.

No payment will be made for members participating in the MediPASS or Lock-in program who were not referred to the emergency room by their MediPASS or Lock-in primary care physician.

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 list of the diagnosis codes considered emergent is posted on the IME website and updated frequently. Click [here](#) to access the list of emergent diagnosis codes.

e. Inpatient Admission After Outpatient Service

A member may be admitted to the hospital as an inpatient after receiving outpatient services. 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.



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.

f. Radiology Services

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

g. Same-Day Surgery

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.

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 IME Provider Services Unit. A separate billing number will be assigned for use in billing take-home items.

2. Alcoholism or Substance Abuse Programs

Alcoholism or substance abuse services must be designed to identify and respond to the biological, psychological, and social antecedents, influences, and consequences associated with the member'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 members related to age, gender, sexual orientation, or ethnic origin shall be evaluated. Services for children and adolescents (as well as adults, if applicable) shall 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.



The program must be approved either by the Joint Commission on the Accreditation of Hospitals or the Iowa Substance Abuse Commission.

a. Admission Criteria

To be accepted for treatment, a member must have taken alcohol or drugs over a longer period than the member intended, and have made two or more unsuccessful efforts to control the use of alcohol or drugs. In addition, the member must exhibit at least one of the following:

- ◆ Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs; or
- ◆ Marked tolerance, meaning the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of same amount; or
- ◆ Characteristic withdrawal symptoms; or
- ◆ A pattern of taking alcohol or drugs often to relieve or avoid withdrawal symptoms.

b. Diagnostic and Treatment Staff

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 or treatment staff, either through full-time or part-time employment by the facility, through contract, or through referral, are physicians (doctor of medicine or osteopathy), psychologists, and counselors.

The number of professional staff should all be appropriate to the patient load of the facility. Psychiatric consultation must be available to the facility.

The psychologist must be licensed. The counselor must be certified by the Iowa Board of Substance Abuse Certification.



c. **Initial Assessment**

A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the member must be conducted. The assessment shall include:

- ◆ The history of the member's use of alcohol and other drugs that covers the:
 - Age of onset;
 - Duration, patterns, and consequences of use; and
 - Types of previous treatment and responses to it.
- ◆ A physical assessment. This shall include a physical examination and a comprehensive medical history, including the history of physical problems associated with dependence.
- ◆ Appropriate laboratory screening. Tests shall be carried out based on findings of the history and physical examination, including tests for communicable diseases when indicated.
- ◆ Any history of physical abuse.
- ◆ A systematic mental status examination, with special emphasis on immediate recall and recent and remote memory.
- ◆ A determination of current and past psychiatric or psychological abnormality.
- ◆ A determination of the degree of danger to self or others.
- ◆ The family's history of alcoholism and other drug dependencies.
- ◆ The member's educational level, vocational status, and job performance history.
- ◆ The member's social support networks, including family and peer relationships.
- ◆ The member's perception of the member's strengths and needs.
- ◆ The member's leisure and recreational interests and hobbies.
- ◆ The member's perception of the member's dependencies.
- ◆ The member's ability to participate with peers and programs and social activities.
- ◆ Interviews of family members and significant others, as available with the member's written or verbal permission.
- ◆ Legal problems, if applicable.



d. Plan of Treatment

Undertake a written comprehensive and individualized description of the treatment for each member. Base the treatment plan on the problems and needs identified in the assessments. Specify the regular 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.

e. Restrictions on Payment

Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the member has not reached an exit level and needs continued intensive treatment.

If a member has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification.

The program shall include an aftercare component meeting weekly for at least one year without charge to Medicaid.

f. Discharge Plan

Design a plan for discharge for each member before discharge to provide appropriate continuity of care.

The plan for continuing care must 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, or individuals;
- ◆ The member and the member's personal support system.



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 verbal permission) with family members whenever possible.

Implement the plan in a manner acceptable to the member and the need for confidentiality. Implementation of the plan includes timely and direct communication with the transfer of information to the other programs, agencies or individuals who will be providing continuing care.

3. Cardiac Rehabilitation Programs

A cardiac rehabilitation program shall:

- ◆ 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 life style 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:

- ◆ **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. The consultant shall be available for care of a member in the event of an emergency if staff is unable to locate the primary physician.
- ◆ **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 occupational therapist provides service in terms of arts and crafts as required.

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. Physician Coverage

At least one physician responsible for responding to emergencies must be physically present in the hospital when members are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

g. 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.



h. 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 Public Health. 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

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

Professional disciplines that must be represented on the 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 registered dietitian, and a licensed pharmacist.

c. Health Assessment

Develop an individualized and documented assessment of needs 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. A complete diabetic education program is payable once in the lifetime of a member.

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, retosis, 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, Mallory-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. Mental Health Programs

To be covered, mental health services 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. Covered Services

Services covered for the treatment of psychiatric conditions 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.
- ◆ **Family counseling** services, but only where the primary purpose of such counseling is the treatment of the member's condition.
- ◆ **Partial hospitalization** 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.

"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.

Although partial hospitalization is available to any Medicaid member for whom the service is appropriate, that is, the service is reasonable and necessary for the treatment of the member's condition, it is likely that the primary users of the service will be persons with chronic mental illness due to the nature of the service.



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 placement in a more restrictive setting, i.e., 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.

Although day treatment is available to any Medicaid member for whom the service is appropriate, that is, the service is reasonable and necessary for the treatment of the member's condition, it is likely that the primary users of the service will be persons with chronic mental illness due to the nature of the service.

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



b. Day Treatment for Children

Payment is made for day treatment services provided in an approved site. 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.

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.
- ◆ 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.
- ◆ 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.
- ◆ Goals and objectives of the day treatment program for persons aged 20 or under shall be established and shall meet the guidelines below.

(1) Staffing

Day treatment programs for children shall meet the following staffing 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 six 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. 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) Program Requirements

The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

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.

There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

The program shall maintain a community liaison with other psychiatric, mental health, and human service providers.

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.

(4) Admission Criteria

The admission criteria for day treatment for children are:

- ◆ 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

Prepare a treatment plan for each member receiving day treatment services. 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.



“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. 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:

- ◆ 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.

(8) Coordination of Services

Provide programming services in accordance with the individual treatment plan. 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.

(9) Stable Milieu

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.



(10) Documentation

Maintain a distinct clinical record for each member admitted. 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.

c. 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. 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.



d. Frequency and Duration of Services

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.

e. Initial Assessment

A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the member must be conducted, which shall include:

- ◆ 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.

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. Nutritional Counseling Programs

Nutritional counseling services provided by licensed dietitians for members age 20 and under are covered when a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

Diagnoses that may be appropriate for nutritional counseling are:

- ◆ Chronic gastrointestinal tract problems, such as chronic constipation, colitis, liver dysfunction, ulcers, tumors, gastroesophageal reflux, malabsorption disorders or chronic diarrhea associated with nutrient loss, short bowel syndrome, or celiac disease.
- ◆ Chronic cardiovascular problems and blood and renal diseases, such as kidney failure, heart disease, or hypertension.



- ◆ Metabolic disorders, such as diabetes, electrolyte imbalance, and errors of metabolism, such as phenylketonuria (PKU).
- ◆ Malnutrition problems, such as protein, mineral, vitamin, and energy deficiencies; failure to thrive; anorexia nervosa; or bulimia.
- ◆ Autoimmune disease.
- ◆ Other problems and conditions, such as food allergy or intolerance, anemias, pregnancy, drug-induced dietary problems, nursing-bottle mouth syndrome, obesity, inadequate or inappropriate techniques of feeding, inadequate or excessive weight gain, neoplasms, cleft palate, or cleft lip.

This is not an all-inclusive list. Other diagnosis may be appropriate.

Members eligible for nutritional counseling through the Supplemental Food Program for Women, Infants, and Children (WIC) must provide a statement that the need for nutritional counseling exceeds the services available through WIC. Submit a copy of this statement with the claim.

8. Pain Management Programs

A chronic pain management program 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.

9. **Pulmonary Rehabilitation Programs**

Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education:

- ◆ 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.

10. Special Non-Inpatient Programs

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 the IME 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 the IME 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 IME 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.

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

All outpatient programs must meet the following requirements to be payable 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.

Specific requirements for each type of program are described in the sections that follow.

d. Injected Medication

Additional reimbursement information can be found in the ***Prescribed Drugs Manual***. Click [here](#) to view the manual online.

(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 Informational Letter 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.

E. CONTENT OF WELL CHILD EXAMINATION

A well child examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
 - A developmental assessment.
 - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
 - Physical growth.
 - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.
- ◆ Appropriate laboratory tests. These shall include:
 - Hematocrit or hemoglobin
 - Lead toxicity screening for all children ages 12 to 72 months
 - Tuberculin test, when appropriate
 - Hemoglobinopathy, when appropriate
 - Serology, when appropriate
- ◆ Oral health assessment with dental referral for children over age 12 months and older based on risk assessment.

Click [here](#) to view the Iowa Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) Care for Kids Health Maintenance Recommendations for additional details.



1. History and Guidance

a. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the member's medical history. It includes an assessment of both physical and mental health development. Take the member's medical history from the member, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the member's history.

Complete or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- ◆ Identification of specific concerns
- ◆ Family history of illnesses
- ◆ The member's history of illnesses, diseases, allergies, and accidents
- ◆ Information about the member's social or physical environment that may affect the member's overall health
- ◆ Information on current medications or adverse reaction or responses due to medications
- ◆ Immunization history
- ◆ Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background
- ◆ Identification of health resources currently used

b. Developmental Screening

Screening is a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment." The primary purpose of developmental screening is to identify children who may need more comprehensive evaluation.

The use of validated screening tools improves detection of problems at the earliest possible age. Each developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). Any interventions or referrals based on abnormal findings should be documented as well.



Developmental screening for young children should include the following four areas:

- ◆ Speech and language
- ◆ Fine and gross motor skills
- ◆ Cognitive skills
- ◆ Social and emotional behavior

In screening children from birth to six years of age, it is recommended that recognized instruments are selected. The best instruments have good psychometric properties, including adequate sensitivity, specificity, validity, and reliability, and have been standardized on diverse populations.

Parents report instruments such as the *Parents' Evaluation of Developmental Status (PEDS)*, *Ages and Stages Questionnaires*, and the *Child Development Review* have excellent psychometric properties and require a minimum of time.

No list of specific instruments is required for identifying developmental problems of older children and adolescents. However, the following principles should be considered in developmental screening:

- ◆ Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional or other familiar person.
- ◆ Incorporate and review this information in conjunction with other information gathered during the physical examination.
- ◆ Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of the child as a component of overall health and well-being, given the child's age and culture.
- ◆ Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.
- ◆ Screening should not result in a label or premature diagnosis being assigned to a child. Report only that a condition was referred or that diagnostic treatment services are needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.



When the provider or the parent has concerns or questions regarding the functioning of the child in relation to expected ranges of activities after screening, make referral for developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

Developmental surveillance is different than developmental testing. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care.

Developmental surveillance is an important technique, which includes questions about the development as a part of the general developmental survey or history. It is not a “test” as such, and is not billable as a developmental screen.

Health care providers often use age-appropriate developmental checklists to record milestones during preventative care visits as part of developmental surveillance. Click [here](#) to view the surveillance tool for children, with the *Iowa Child Health and Developmental Record (CHDR)*.

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under treatment. Focus screening on such areas of special concern as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.

For further information on developmental screening, see:

- ◆ [Care for Kids Provider website](#)
- ◆ [Developmental Behavioral Online website of the American Academy of Pediatrics](#)
- ◆ [Assuring Better Child Development and Health \(ABCD\) Electronic Resource Center of the National Academy for State Health Policy](#)
- ◆ [National Center of Home Initiatives for Children with Special Needs website of the American Academy of Pediatrics](#)



c. **Health Education/Anticipatory Guidance**

Health education that includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- ◆ Assist the parents and youth in understanding what to expect in terms of the child's development.
- ◆ Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, dental, and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or click [here](#) to view the website.

These lists are guidelines only. They do not require the inclusion of topics that are inappropriate for the child nor limit topics that are appropriate for the child.

Suggested Health Education Topics: Birth - 18 Months

Oral Health

- ◆ Appropriate use of bottle and breast feeding
- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Infant oral care: cleaning teeth and gums
- ◆ Early childhood caries
- ◆ Transmission of oral bacteria
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Teething and tooth eruption
- ◆ First dental visit by age one
- ◆ Feeding and snacking habits: exposure to carbohydrates and sugars
- ◆ Use of cup and sippy cup



Injury Prevention

- ◆ Infant and child CPR
- ◆ Child care options
- ◆ Child safety seat restraint
- ◆ Child safety seats
- ◆ Importance of protective helmets
- ◆ Electric outlets
- ◆ Animals and pets
- ◆ Hot water heater temperature
- ◆ Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder, plastic bags
- ◆ Exposure to sun and heat
- ◆ Safety locks
- ◆ Lock up chemicals
- ◆ Restricted play areas on the farm
- ◆ Smoke detectors
- ◆ Stairway gates, walkers, cribs
- ◆ Syrup of ipecac, poison control
- ◆ Emergency telephone numbers
- ◆ Water precautions: buckets, tubs, small pools

Mental Health

- ◆ Adjustment to new baby
- ◆ Balancing home, work, and school
- ◆ Caretakers' expectations of infant development
- ◆ Responding to infant distress
- ◆ Baby self-regulation
- ◆ Child care
- ◆ Sibling rivalry
- ◆ Support from spouse and friends
- ◆ Recognizing unique temperament
- ◆ Creating stimulating learning environments
- ◆ Fostering baby caregiver attachment

Nutrition

- ◆ Bottle propping
- ◆ Breast or formula feeding to 1 year
- ◆ Burping
- ◆ Fluid needs
- ◆ Introduction of solid foods at 4-6 months
- ◆ Managing meal time behavior
- ◆ Self-feeding
- ◆ Snacks
- ◆ Weaning



Other Preventive Measures

- ◆ Back sleeping
- ◆ Bowel patterns
- ◆ Care of respiratory infections
- ◆ Crying or colic
- ◆ Effects of passive smoking
- ◆ Fever
- ◆ Hiccoughs
- ◆ Importance of well-child visits

Suggested Health Education Topics: 2 – 5 Years

Oral Health

- ◆ Oral care: parental tooth brushing and flossing when the teeth touch, monthly “lift the lip”
- ◆ Teething and tooth eruption
- ◆ Importance of baby teeth
- ◆ Regular dental visits
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Feeding and snacking habits: exposure to carbohydrates and sugars
- ◆ Appropriate use of bottle and breast feeding
- ◆ Use of sippy cup
- ◆ Use of sugary medications
- ◆ Early childhood carries, gingivitis
- ◆ Dental injury prevention
- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Sealants on deciduous molars and permanent six-year molars

Injury Prevention

- ◆ CPR training
- ◆ Booster car seat
- ◆ Burns and fire
- ◆ Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins
- ◆ Dangers of accessible chemicals
- ◆ Importance of protective helmets
- ◆ Machinery safety
- ◆ No extra riders on tractor
- ◆ Play equipment
- ◆ Purchase of bicycles
- ◆ Put up warning signs
- ◆ Restricted play areas
- ◆ Street danger
- ◆ Teach child how to get help
- ◆ Toys
- ◆ Tricycles
- ◆ Walking to school
- ◆ Water safety
- ◆ Gun storage



Mental Health

- ◆ Adjustment to increasing activity of child
- ◆ Balancing home, work, and school
- ◆ Helping children feel competent
- ◆ Child care
- ◆ Sibling rivalry
- ◆ Managing emotions

Nutrition

- ◆ Appropriate growth pattern
- ◆ Appropriate intake for age
- ◆ Control issues over food
- ◆ Managing meal-time behavior
- ◆ Physical activity
- ◆ Snacks

Other Preventive Measures

- ◆ Adequate sleep
- ◆ Care of illness
- ◆ Clothing
- ◆ Common habits
- ◆ Importance of preventative health visits
- ◆ Safety rules regarding strangers
- ◆ TV watching
- ◆ Age-appropriate sexuality education
- ◆ School readiness
- ◆ Toilet training
- ◆ Smoke-free environments
- ◆ Social skills

Suggested Health Education Topics: 6 – 12 Years

Oral Health

- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Oral care: supervised tooth brushing and flossing
- ◆ Gingivitis and tooth decay
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Permanent tooth eruption
- ◆ Regular dental visits
- ◆ Dental referral: orthodontist
- ◆ Diet and snacking habits: exposure to carbohydrates, sugars, and pop, diet/snack habits and sports drinks
- ◆ Dental injury prevention: mouth guards for sports
- ◆ Sealants on deciduous molars and permanent 6- and 12-year molars
- ◆ Smoking and smokeless tobacco



Injury Prevention

- ◆ Bicycle (helmet) safety
- ◆ Car safety
- ◆ CPR training
- ◆ Dangers of ponds and creeks
- ◆ Electric fences
- ◆ Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock
- ◆ Fire safety
- ◆ Gun and hunter safety
- ◆ Emergency telephone numbers
- ◆ Machinery safety
- ◆ Mowing safety
- ◆ Self-protection tips
- ◆ Sports safety
- ◆ Street safety
- ◆ Tractor safety training
- ◆ Water safety
- ◆ High noise levels

Mental Health

- ◆ Discipline
- ◆ Emotional, physical, and sexual development
- ◆ Handling conflict
- ◆ Positive family problem solving
- ◆ Developing self esteem
- ◆ Nurturing friendships
- ◆ Peer pressure and adjustment
- ◆ School-related concerns
- ◆ Sibling rivalry

Nutrition

- ◆ Appropriate intake for age
- ◆ Breakfast
- ◆ Child involvement with food decisions
- ◆ Food groups
- ◆ Inappropriate dietary behavior
- ◆ Managing meal time behavior
- ◆ Peer influence
- ◆ Physical activity
- ◆ Snacks

Other Preventive Measures

- ◆ Adequate sleep
- ◆ Clothing
- ◆ Exercise
- ◆ Hygiene
- ◆ Importance of preventative health visits
- ◆ Smoke-free environments
- ◆ Safety regarding strangers
- ◆ Age-appropriate sexuality education
- ◆ Social skills
- ◆ Preparation of girls for menarche
- ◆ Sports
- ◆ Stress
- ◆ TV viewing



Suggested Health Education Topics: 13 – 21 Years

Oral Health

- ◆ Fluoride exposure: toothpaste, water, and topical fluoride
- ◆ Daily oral care: tooth brushing and flossing
- ◆ Gingivitis, periodontal disease, and tooth decay
- ◆ Permanent tooth eruption
- ◆ Regular dental visits
- ◆ Dental referral: orthodontist and oral surgeon for third molars
- ◆ Diet and snacking habits: exposure to carbohydrates, sugars, sports drinks, and pop
- ◆ Dental injury prevention: mouth guards for sports
- ◆ Sealants on premolars and permanent 6- and 12-year molars
- ◆ Smoking and smokeless tobacco
- ◆ Drug use (methamphetamines)
- ◆ Oral piercing

Development

- ◆ Normal biopsychosocial changes of adolescence

Gender Specific Health

- ◆ Abstinence education
- ◆ Contraception, condom use
- ◆ HIV counseling or referral
- ◆ Self-breast exam
- ◆ Self-testicular exam
- ◆ Sexual abuse, date rape
- ◆ Gender-specific sexual development
- ◆ Sexual orientation
- ◆ Sexual responsibility, decision making
- ◆ Sexually transmitted diseases
- ◆ Unintended pregnancy

Health Member Issues

- ◆ Selection and purchase of health devices or items
- ◆ Selection and use of health services



Injury Prevention

- ◆ CPR and first aid training
- ◆ Dangers of farm ponds and creeks
- ◆ Falls
- ◆ Firearm safety, hunting practices
- ◆ Gun and hunter safety
- ◆ Handling agricultural chemicals
- ◆ Hearing conservation
- ◆ Machinery safety
- ◆ Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)
- ◆ Overexposure to sun
- ◆ ROPS (roll over protective structure)
- ◆ Seat belt usage
- ◆ Helmet usage
- ◆ Smoke detector
- ◆ Sports recreation, workshop laboratory, job, or home injury prevention
- ◆ Tanning practices
- ◆ Violent behavior
- ◆ Water safety
- ◆ High noise levels

Nutrition

- ◆ Body image, weight issues
- ◆ Caloric requirements by age and gender
- ◆ Balanced diet to meet needs of growth
- ◆ Exercise, sports, and fitness
- ◆ Food fads, snacks, fast foods
- ◆ Selection of fitness program by need, age, and gender
- ◆ Special diets

Personal Behavior and Relationships

- ◆ Communication skills
- ◆ Dating relationships
- ◆ Decision making
- ◆ Seeking help if feeling angry, depressed, hopeless
- ◆ Community involvement
- ◆ Relationships with adults and peers
- ◆ Self-esteem building
- ◆ Stress management and reduction
- ◆ Personal responsibility



Substance Use

- ◆ Alcohol and drug cessation
- ◆ Counseling or referral for chemical abuse
- ◆ Driving under the influence
- ◆ HIV counseling and referral
- ◆ Riding with intoxicated driver
- ◆ Sharing of drug paraphernalia
- ◆ Steroid or steroid-like use
- ◆ Tobacco cessation

Other Prevention Measures

- ◆ Adequate sleep
- ◆ Clothing
- ◆ Exercise
- ◆ Hygiene
- ◆ Importance of preventative health visits
- ◆ Smoke-free environments
- ◆ Safety regarding strangers
- ◆ Age-appropriate sexuality education
- ◆ Social skills
- ◆ Preparation of girls for menarche
- ◆ Sports
- ◆ Stress
- ◆ TV viewing

d. Mental Health Assessment

Mental health assessment should capture important and relevant information about the child as a person. It may include a psychosocial history such as:

- ◆ The child's **life-style**, home situation, and "significant others."
- ◆ A **typical day**: How the child spends the time from getting up to going to bed.
- ◆ **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the child's outlook on the future.
- ◆ **Sleep**: Amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- ◆ **Toileting**: Methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.



- ◆ **Speech:** Hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- ◆ **Habits:** Bed rocking, head banging, tics, thumb sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- ◆ **Discipline:** Parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ◆ **Schooling:** Experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- ◆ **Sexuality:** Relations with members of the opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.
- ◆ **Personality:** Degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self-image.

Source: Boyle Jr., W.E. and Hoekelman, R.A. *The Pediatric History*, In Hoekelman, R.A. ed. Primary Pediatric Care, Fourth Edition, 2001.

Clinical screening tools can increase the identification of psychosocial problems and mental disorders in primary care settings. Moreover, such tools can provide an important framework for discussing psychosocial issues with families. These screening tools can be grouped into three general categories:

- ◆ Broad psychosocial tools that assess:
 - Overall functioning, family history, and environmental factors;
 - Deal with a wide range of psychosocial problems; and
 - Identify various issues for discussion with the child or adolescent and family.

An example of this type of tool is the *Pediatric Intake Form*, which can be used to assess such issues as parental depression and substance use, gun availability, and domestic violence (Kemper and Kelleher, 1996a, 1996b).



- ◆ Tools that provide a general screen for psychosocial problems or risk in children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1998, 1999).
- ◆ Tools that screen for specific problems, symptoms, and disorders, such as the *Conner's Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).

Often a broader measure such as the *Pediatric Symptom Checklist* is used first, followed by a more specific tool focused on the predominant symptoms for those that screen positive on the broader measure.

Some of the more specific tools may not be readily available to primary care health professionals or may require specialized training.

Source: Jellinek M, Patel BP, Froehle MC, eds. 2002. *Bright Futures in Practice: Mental Health – Volume I. Practice Guide*. Arlington, VA: National Center for Education in Maternal and Child Health.

Click [here](#) to view the *Pediatric Symptom Checklist*.

2. Laboratory Tests

a. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (PAP) smears are recommended for all females who are sexually active or whose sexual history is thought to be unreliable at age 18. High-risk for cancer in situ are those who:

- ◆ Begin sexual activity in early teen years
- ◆ Have multiple partners

Sexually active females should receive family planning counseling, including PAP smears, self-breast examinations, and education on prevention of sexually-transmitted infections (STI).

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If the first smear is unsatisfactory, repeat as soon as possible.



b. Chlamydia Test

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., age less than 25, multiple sexual partners with multiple sexual contacts). For recent sexual partners of persons with positive tests for STI, also provide:

- ◆ Education on prevention of STI
- ◆ Education on the importance of contraception to prevent pregnancy

c. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

- ◆ Multiple sexual partners or a sexual partner with multiple contacts
- ◆ Sexual contacts with a person with culture-proven gonorrhea
- ◆ A history of repeated episodes of gonorrhea

Discuss how to use contraceptives and make them available. Offer education on prevention of STIs.

d. Hemoglobin and Hematocrit

One hematocrit or hemoglobin determination is suggested by the American Academy of Pediatrics during the first year, and in each of the following intervals:

- ◆ 9-12 months, if any of the following risk factors are present:
 - Qualify for EPSDT Care for Kids
 - Low socioeconomic status
 - Birth weight under 1500 grams
 - Whole milk given before 6 months of age (not recommended)
 - Low-iron formula given (not recommended)
- ◆ 11-20 years. Annual screening for females, if any of the following factors are present:
 - Qualify for EPSDT Care for Kids
 - Moderate to heavy menses
 - Chronic weight loss
 - Nutrition deficit
 - Athletic activity



A test for anemia may be performed at any age if there is:

- ◆ Medical indication noted in the physical examination
- ◆ Nutritional history of inadequate iron in the diet
- ◆ History of blood loss
- ◆ Family history of anemia

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185 percent of poverty and hemoglobin or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Fifth Percent Criteria for Children

Age/Years	Hematocrit	Hemoglobin
6 months up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.5
8 up to 12 years	35.4	11.9

Female (non-pregnant)

12 up to 15 years	35.5	11.8
15 up to 18 years	35.9	12.0
18 up to 21 years	35.7	12.0

Male

12 up to 15 years	37.3	12.5
15 up to 18 years	39.7	13.3
18 up to 21 years	39.9	13.5

Source: "Recommendations to Prevent and Control Iron Deficiency in the United States," *Morbidity and Mortality Weekly Report*, April 3, 1998; Vol. 47, No. RR-3, pages 1-29.



e. Hemoglobinopathy Screening

Screen infants not born in Iowa and children of Caribbean, Latin American, Asian, Mediterranean, and African descent who were born before February 1988 for hemoglobin disorders. Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call (319) 356-1400 for information.

f. Lead Testing

Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

For more information or assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, (515) 281-3479 or (800) 972-2026.

Click [here](#) to access the Statewide Plan for Childhood Lead Testing and Case Management of Lead-Poisoned Children which contains a Poisoning Risk Questionnaire on page 44. Use this questionnaire to decide whether to use the high risk or low risk blood lead testing schedule, or use the high risk testing schedule for all children. Do **not** assume that all children are at low risk. The lead testing and follow up protocols are also located at this link.



g. Newborn Screening

Confirm during the infant's first visit that newborn screening was done. In Iowa newborn screening is mandatory for the conditions on the screening panel.

Click [here](#) to view a current list of the screening panel.

h. Tuberculin Testing

The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin skin testing in high-risk children.

High-risk children include those in households where tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, or the Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and homes of IV drug users, alcoholics, HIV positives, and prostitutes).

3. Physical Examination

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- ◆ General appearance
- ◆ Assessment of all body systems
- ◆ Height and weight
- ◆ Head circumference through 2 years of age
- ◆ Blood pressure starting at 3 years of age
- ◆ Palpation of femoral and brachial (or radial) pulses
- ◆ Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education
- ◆ Pelvic examination, recommended for women 18 years old and older, if sexually active or having significant menstrual problems
- ◆ Testicular examination, include age-appropriate self-examination instructions and health education



a. Blood Pressure

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, conduct a blood pressure only if other physical findings suggest it may be needed.

The National Health, Lung and Blood Institute published blood pressure standards for children and adolescents. The standards are based on height as well as age and gender for children and adolescents from one through 17 years old.

This is a change from the past when height and weight were both thought to be correlates of blood pressure. Height was determined by the investigators to be a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in the Blood Pressure Tables for Children and Adolescents. See below.

To use the tables, measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age, and sex.

The National Heart, Lung, and Blood Institute recommends using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

The interpretation of children and adolescents blood pressure measurements for height, age, and gender are as follows:

- ◆ Readings below the 90th percentile are considered normotensive.
- ◆ Reading between the 90th and 95th percentile are high normal and warrant further observation and identification of risk factors.
- ◆ Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.

Click [here](#) to access Blood Pressure Tables for Children and Adolescents provided by the National Heart, Lung, and Blood Institute.



b. Growth Measurements

(1) Body Mass Index

Body Mass Index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals.

Examples: 37 pounds 4 ounces = 37.25 pounds
41½ inches = 41.5 inches

2. Insert the values into the formula:

$[\text{weight (lb.)} / \text{height (in.)} / \text{height (in.)}] \times 703 = \text{BMI}$

Example: $(37.25 \text{ lb.} / 41.5 \text{ in.} / 41.5 \text{ in.}) \times 703 = 15.2$

A reference table can also be used to calculate BMI. Click [here](#) to download the table from the Centers for Disease Control and Prevention.

For children, BMI values are plotted against age. If the BMI-for-age is less than or equal to the 5th percentile, the child is considered underweight. If the BMI-for-age is between the 85th and 94th percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

(2) Height

Measure children over 2 years of age using a standing height board or stadiometer.

If the child is two years old or older and less than 31½ inches tall, the height measurement does not fit on the 2-20 year old chart. Therefore, measure the child's recumbent length and plot the length on the Birth-36 month growth chart. Read and record the measurement to the nearest 1/8 inch.

Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.



(3) Plotting Measurements

Record measurements as soon as they are taken to reduce errors.

Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for children under 2 years of age. For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

Example:

	Year	Month	Day	
Date of visit	93 92	7 6 18	45 45	July 15, 1993
Birth date	-91	-10	-28	October 28, 1991
Age	1	8	17	= 20 months, 17 days or 21 months

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.

Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.

Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract birth date from the clinic visit date. It is allowable to borrow 30 days from the month's column or 12 months for the year column when subtracting.

Common errors result from:

- ◆ Unbalanced scales,
- ◆ Failure to remove shoes and heavy clothing,
- ◆ Use of an inappropriate chart for recording the results, and
- ◆ Uncooperative children.



(4) Recumbent Length

Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8 inch.

(5) Referral and Follow-up of Growth in Infants and Children

Nutrition. See criteria in [Nutritional Status](#).

Medical. Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:

- ◆ Growth of less than 2 inches per year for ages 3 to 10 years
- ◆ A greater than 25 percent change in weight/height percentile rank
- ◆ Sudden weight gain or loss
- ◆ More than two standard deviations below or above the mean for height

(6) Weight

Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.



c. Head Circumference

Measure the head circumference at each visit until the child is two years old. Measure with a non-stretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease and Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- ◆ Above the 95th percentile.
- ◆ Below the 5th percentile.
- ◆ Reflecting a major change in percentile levels from one measurement to the next or over time.

d. Oral Health Screening

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive oral health education is provided to the parents or guardians.

Unlike other health needs, dental problems are so prevalent that most children will need diagnostic evaluation by age 12 months. An oral screening includes a medical and dental history and an oral evaluation. Each component of the oral screening listed below must be documented in the child's record:

- ◆ Complete or update the dental history:
 - Current or recent dental problems, including pain or mouth injuries
 - Name of dentist
 - Date of child's last dental visit or length of time since last dental visit
- ◆ Medical and dental history:
 - Current or recent medical conditions
 - Current medications used
 - Allergies



- Name of child's physician and dentist
- Frequency of dental visits
- Use of fluoride by child (source of water, use of fluoridated toothpaste or fluoride products)
- Current or recent dental problems or injuries, including parental concerns
- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Exposure to sugar, carbohydrates (snacking and feeding habits, use of sugary medications)
- ◆ Oral evaluation
 - Hard tissue:
 - Suspected decay
 - Demineralized areas (white spots)
 - Visible plaque
 - Enamel defects
 - Sealants
 - Decay history (fillings, crowns)
 - Stained fissures
 - Trauma or injury
 - Soft tissue:
 - Gum redness or bleeding
 - Swelling or lumps
 - Trauma or injury
- ◆ Provide age-appropriate oral health education to the parent or guardian. Education should be based on the findings of the oral health screening.
- ◆ Refer children to a dentist for:
 - Complete dental examination annually by 12 months and periodic exams semiannually based on risk assessment
 - Obvious or suspected dental caries
 - Pain or injury to the oral tissue
 - Difficulty chewing



4. Other Services

Other services that must be included in the screening examination are:

- ◆ [Immunizations](#)
- ◆ [Hearing screening](#)
- ◆ [Assessment of nutritional status](#)
- ◆ [Vision screening](#)

a. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90 percent of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in February 2002 reflect changes and challenges in vaccine delivery.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See [ACIP Recommendations Immunization Schedule](#).) Information about immunizations may be obtained by contacting the CDC at (800) 232-4636 or the Iowa Immunization Program at (800) 831-6293.

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See [Contraindications and Precaution for Immunization](#) for a guide to contraindications to immunization.

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

Under the leadership of National Vaccine Advisory Committee (NVAC), standards were recently revised. Click [here](#) to view the revised standards which focus on:

- ◆ Making vaccines easily accessible
- ◆ Effectively communicating vaccination information
- ◆ Implementing strategies to improve vaccination rates
- ◆ Developing community partnerships to reach target patient populations



Provide the recommended childhood immunization schedule for the United States for January-December of the current year.

The recommended childhood and adolescent immunization schedule can be assessed on the following websites:

- ◆ [Centers for Disease Control and Prevention: Vaccines and Immunizations](#)
- ◆ [American Academy of Pediatrics](#)
- ◆ [American Academy of Family Physicians](#)

b. Hearing

Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. Click [here](#) to view recommendations.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have not had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.

Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before three months.

All infants with confirmed hearing loss should receive intervention services before six months of age.

For information on nearby audiologists, see the early hearing detection and intervention system (EDHI) website, click [here](#) or call (888) 425-4371.

An objective hearing screening should be performed on all infants and toddlers who do not have a documented objective newborn hearing screening or documented parental refusal. This screening should be conducted by a qualified screener during well-child health screening appointments according to the periodicity schedule.



An objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with late onset hearing loss. In order to be alert to late onset hearing loss, health providers should also monitor developmental milestones, auditory and speech skills, middle ear status, and should consider parental concerns.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following risk indicators are associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed-onset hearing loss.

- ◆ Caregiver concern^{*} regarding hearing, speech, language, or developmental delay (Roizen, 1999).
- ◆ Family history^{*} of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
- ◆ Neonatal intensive care of more than five days or any of the following regardless of length of stay:
 - Extracorporeal Membrane Oxygenation (ECMO)^{*}
 - Assisted ventilation
 - Hyperbilirubinemia requiring exchange transfusion
 - Exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix)(Fligor et al., 2005; Roizen, 2003)
- ◆ In-utero infections, such as CMV,^{*} herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006; Rivera et al., 2002).
- ◆ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
- ◆ Physical findings, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).



- ◆ Syndromes associated with hearing loss or progressive or late-onset hearing loss, * such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes including Waardenburg, Alport, Pendred and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders, * such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss, * including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy* (Bertolini et al., 2004).

c. **Nutritional Status**

To assess nutritional status, include:

- ◆ Accurate measurements of height and weight.
- ◆ A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures under [Hemoglobin and Hematocrit](#) for suggested screening ages).
- ◆ Questions about dietary practices to identify:
 - Diets that are deficient or excessive in one or more nutrients.
 - Food allergy, intolerance, or aversion.
 - Inappropriate dietary alterations.
 - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
- ◆ Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.



- ◆ If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to the following criteria:
 - Parents or grandparent, at 55 years of age or less, underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
 - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

(1) Medical Evaluation Indicated (0-12 months)

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- ◆ Measurements
 - Weight/height < 5th percentile or > 95th percentile (NCHS charts)
 - Weight/age < 5th percentile
 - Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
 - Flat growth curve (two months without an increase in weight/age of an infant below the 90th percentile weight/age)
- ◆ Laboratory tests
 - < Hct 32.9%
 - < Hgb 11 gm/dL (6-12 months)
 - ≥ 15 $\mu\text{g/dL}$ blood lead level
- ◆ Health problems
 - Metabolic disorder
 - Chronic disease requiring a special diet
 - Physical handicap or developmental delay that may alter nutritional status
- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders



(2) Medical Evaluation Indicated (1-10 years)

Use these criteria for referring a child for further medical evaluation of nutrition status:

◆ Measurements

- Weight/length < 5th percentile or > 95th percentile for 12-23 months
- BMI for age < 5th percentile or > 95th percentile for 24 months and older
- Weight/age < 5th percentile
- Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
- Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.

◆ Laboratory tests

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

◆ Health problems

- Chronic disease requiring a special diet
- Metabolic disorder
- Family history of hyperlipidemias
- Physical handicap or developmental delay that may alter nutritional status



- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders

(3) Medical Evaluation Indicated (11-21 years)

Use these criteria for referring adolescents for further medical evaluation of nutritional status:

- ◆ Laboratory tests

Age	Female		Male	
	HCT %	HGB gm/dL	HCT %	HGB gm/dL
11 up to 12	35.4	11.9	35.4	11.9
12 up to 15	35.7	11.8	37.3	12.5
15 up to 18	35.9	12.0	39.7	13.3
18 up to 21	35.7	12.0	39.9	13.6

- ◆ Health problems

- Chronic disease requiring a special diet
- Physical handicap or developmental delay that may alter nutritional status
- Metabolic disorder
- Substance use or abuse
- Family history of hyperlipidemias
- Any behaviors intended to change body weight, such as self-induced vomiting, bingeing and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise

- ◆ Physical examination. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders

Source: *Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents.* U.S. Department of Health and Human Services, October 2012.



d. Vision

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

Click [here](#) to view the full scope of pediatric vision screening as stated by the American Academy of Ophthalmology Pediatric Ophthalmology/Strabismus Panel.

F. BASIS OF PAYMENT FOR OUTPATIENT SERVICES

Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22, as amended to October 1, 2007, except as indicated in this section.

- ◆ **Teaching hospital.** A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 162, as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the IME Provider Cost Audit and Rate Setting Unit.

If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined billed with the hospital service.

Reasonable cost settlement for those costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.



- ◆ **Hospital-based ambulance service.** A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services.

EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

- ◆ **Psychiatric services.** All psychiatric services for members with a primary diagnosis of mental illness who are enrolled in the Iowa Plan program under 441 Iowa Administrative Code Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by the IME. The only exceptions to this policy are laboratory and radiology services, which will be payable by fee schedule or APC.
- ◆ **Emergency psychiatric evaluations.** Members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.
- ◆ **Substance abuse services.** Members enrolled in the Iowa Plan program under 441 Iowa Administrative Code Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by the IME. The only exceptions to this policy are laboratory and radiology services, which will be payable by fee schedule or APC.

Except for services provided by critical-access hospitals, outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

- ◆ Any specific rate or methodology established in the state plan for the particular service.
- ◆ The OPPS Ambulatory Payment Classification (APC) established rates.
- ◆ Medicaid fee schedule.

To safeguard against other inappropriate practices, the IME Medical Services Unit 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 quality improvement organization regulations.



1. **Payment Basis for Critical-Access Hospitals**

The basis of payment for critical-access hospitals is reasonable cost and is achieved through retrospective cost settlement. Critical-access hospitals are reimbursed in the interim based on the hospital's outpatient Medicaid cost-to-charge ratio, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year.

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 fee-for-service reimbursement received based on the hospital's outpatient Medicaid cost-to-charge ratio. The Department will recover any interim payments made that exceed reasonable costs.

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 and rebasing.

The cost-to-charge ratio upon which the outpatient hospital interim payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the IME Provider Cost Audit and Rate Setting Unit and Medicare cost principles.

2. **Ambulatory Payment Classification (APC) Payments**

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.



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

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> ◆ Ambulance services ◆ Clinical diagnostic laboratory services ◆ Diagnostic mammography ◆ Screening mammography ◆ Non-implantable prosthetic and orthotic devices ◆ 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 	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the IME fee schedule for outpatient hospital services.</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>



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: <ul style="list-style-type: none"> ◆ 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 the IME 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: <ul style="list-style-type: none"> ◆ 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 the IME 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.



Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetists services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the IME fee schedule for outpatient hospital services.
G	Pass-through drugs and biologicals	If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ◆ Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ◆ Paid based on the IME 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.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the IME fee schedule for outpatient hospital services.
M	Items and services not billable to the Medicare fiscal intermediary	If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment is included with payment for other services, including outliers; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.



Indicator	Item, Code, or Service	OPPS Payment Status
Q1	STVX-packaged codes	Paid under OPPS APC: <ul style="list-style-type: none"> ◆ 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.
Q2	T-packaged codes	Paid under OPPS APC: <ul style="list-style-type: none"> ◆ 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.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.
R	Blood and blood products	If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reductions.
U	Brachytherapy sources	If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.
X	Ancillary services	If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.



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 the IME 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 the IME 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 time lines 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 the IME 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.



3. Cost Outlier Payments

Additional payment is made for services provided during a single visit meeting or exceeding the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis. Facilities are paid 100 percent of outlier costs at the time of claim reimbursement.

Cases qualify as outliers when the cost of a service in a given case exceeds both the multiple threshold and the fixed-dollar threshold.

- ◆ The multiple threshold is met when the cost of furnishing an APC service or procedure exceeds 1.75 times the APC payment amount.
- ◆ The fixed-dollar threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount plus \$2,000.

If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

- ◆ The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base year cost report.
- ◆ Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all non-packaged APC services that appear on that claim.
- ◆ The amount allocated to each non-packaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all non-packaged APC services on the claim.

The quality improvement organization selects a random sample of outlier cases identified on fiscal agent claims data from all Iowa and bordering state hospitals. Staff reviews the selected cases to perform admission review, quality review, and APC validation. Questionable cases are referred to a physician reviewer for concerns about medical necessity and quality of care.

Hospitals with cases under review must submit all supporting data from the medical record to the quality improvement organization within 60 days of receipt of the outlier review notifications, or outlier payment will be recouped and forfeited. The hospital's itemized bill and remittance statement are reviewed in addition to the medical record.



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.



4. 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.

5. 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 the IME 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>