



Iowa Department of Human Services

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ACUTE HOSPITAL SERVICES MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **ACUTE HOSPITAL SERVICES MANUAL**, Chapter III, *Provider-Specific Policies*, Contents (page 1), revised; pages 7, 8, 11, 18, 20, 94, 99, 112, 123, 136, and 140, revised; and pages 8a, 8b, and 8c, new.

Summary

The **ACUTE HOSPITAL SERVICES MANUAL** is revised to:

- ◆ Align with current ICD-10 policies, procedures, and terminology.
- ◆ Update links due to the Department's new website.

Date Effective

October 1, 2015

Material Superseded

This material replaces the following pages from the **ACUTE HOSPITAL SERVICES MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 1)	June 1, 2014
7, 8, 11, 18, 20, 94, 99, 112, 123, 136, 140	June 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at:

<http://dhs.iowa.gov/sites/default/files/AHosp.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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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	0DB60ZZ	0DBB0ZZ	43842
	44.31	0DB63ZZ	0F190Z3	43843
	44.39	0DB67ZZ	0TRB07Z	43845
	44.69	0D1607A	0D190Z9	43846
	45.51	0D160JA	0D190ZA	43847
	45.91	0D160KA	0D190ZB	
		0D160ZA	0D194Z9	
		0D1687A	0D194ZA	
		0D168JA	0D194ZB	
		0D168KA	0D198Z9	
		0D168ZA	0D198ZA	
		0D160K9	0D198ZB	
		0D160Z9	0D1A0ZA	
		0D16879	0D1A0ZB	
		0D168J9	0D1A4ZA	
		0D168K9	0D1A4ZB	
		0D168Z9	0D1A8ZA	
		0DV63ZZ	0D1A8ZB	
		0DV64DZ	0D1A8ZH	
		0DV64ZZ	0D1B0ZB	
	0DV67ZZ	0D1B4ZB		
	0DV68ZZ	0D1B8ZB		
	0DB90ZZ	0D1B8ZH		
Bariatric procedures, revisions/ removals	44.5	0DQ60ZZ		43771
	44.96	0DQ63ZZ		43772
	44.97	0DQ64ZZ		43774
	44.98	0DQ67ZZ		43848
		0DQ68ZZ		43860
		0DW643Z		43865
		0DW64CZ		43886
		0DP643Z		43887
		0DP64CZ		43888
		3E0G3GC		

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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 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 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,



- ◆ 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.



- ◆ 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.



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](#)



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.



- ◆ 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.



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.



- ◆ 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>