Revised Submission 7.8.13

SUPPLEMENT 2 TO ATTACHMENT 4.19-B

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care

1. Definitions

The following definitions are provided to ensure understanding among all parties.

"Allowable costs" are those defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

"Ancillary services" means those tests and procedures ordered by a physician to assist in patient diagnosis or treatment. Ancillary procedures, such as immunizations, increase the time and resources expended during a visit, but do not dominate the visit.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report" for rates effective July 1, 2008, shall mean the hospital's cost report with fiscal year ending on or after January 1, 2006, and before January 1, 2007. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. 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 base APC rate.

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"Case-mix index" means an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean serviced provided during a single visit that have an extraordinarily high cost and therefore eligible for additional payments above and beyond the base APC payment.

"Current Procedural Terminology – (CPT)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rule is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs associated with the operation of graduate medical education programs.

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"Healthcare common procedures coding system" or "HCPCS" means the national uniform coding method maintained by the Centers for Medicare and Medicaid Services (CMS), which incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International Classification of Diseases - (ICD)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"IowaCare Waiver" means a Section 1115 Demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS) to operate from July 1, 2005 through June 30, 2010. Under this waiver, a limited benefit package, provided by a limited number of providers, will be made available to persons who don't otherwise qualify for Medicaid, and who are: ages 19 through 64, with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL); or pregnant women with income below 300 percent of the FPL. Additionally, the waiver provides for coverage of expenditures for certain Medicaid State Plan services provided to individuals in eligibility groups receiving only limited benefits.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing a single service.

"Observation services" means a set of clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or is able to be discharged from the hospital.

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"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing a single service.

"Observation services" means a set of clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or "OPPS" means the payment methodology for hospital outpatient services established herein, based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

"Outpatient visit" means those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

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"Quality improvement organization" or "QIO" shall mean the organization that performs medical peer review of the Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy of care; and appropriateness of prospective payments for outlier cases and non-emergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" means the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant-procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

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"Status indicator " or "SI" means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

2. Outpatient hospital 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 herein. Interim payments to critical access hospitals shall be based on the hospital's outpatient Medicaid cost to charge ratio.

a. 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 Iowa Medicaid enterprise 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.

b. 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.

c. All psychiatric services for members with a primary diagnosis of mental illness who are enrolled in the Iowa Plan program under Iowa Administrative Code 441--Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

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d. Emergency psychiatric evaluations for 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.

e. Substance abuse services for persons enrolled in the Iowa Plan program under Iowa Administrative Code 441--Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

3. Payment for outpatient hospital services

a. Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

(1) Any specific rate or methodology established in the state plan for the particular service.

(2) The OPPS APC rates established herein.

(3) Medicaid fee schedule. All Clinical Diagnostic Laboratory code series will be reimbursed at 100% of the Medicare rate including codes series 81000.

b. 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. Medicaid adopts the OPPS APC relative weights and discount factors using the most current calendar year update as published by the Centers for Medicare and Medicaid Services.

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c. The ambulatory payment classification payment is calculated as follows:

(1) The applicable APC relative weight is multiplied by the blended base APC rate determined according to Section 5.

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

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

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

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Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ◈ Ambulance services. ◈ Clinical diagnostic laboratory services. ◈ Diagnostic mammography. ◈ Screening mammography. ◈ Non-implantable prosthetic and orthotic devises. ◈ Physical, occupational, and speech therapy. ◈ Erythropoietin for end state renal dialysis (ESRD) patients. ◈ Routine dialysis services for ESRD patients provided in a certified dialysis unit of a hospital.	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis.	Not paid under OPPS APC. ◈ May be paid when submitted on a bill type other than outpatient hospital. ◈ An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.

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Indicator	Item, Code, or Service	OPPS Payment Status
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 Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes and services: ◆ That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ◆ That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ◆ That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ◆ For which separate payment is not provided by Medicare but maybe for Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.

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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 Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.

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Indicator	Item, Code, or Service	OPPS Payment Status
K	Non-pass-through drugs and nonimplantable biological, including therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ◆ Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ◆ Paid based on the Iowa Medicaid fee schedule for outpatient hospital services when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
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 Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services. If not covered by Iowa Medicaid, the item or service 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.

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Indicator	Item, Code, or Service	OPPS Payment Status
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX – packaged codes.	Paid under OPPS APC. Packaged APC payment if billed on the same date of service as HCPCS 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. Packaged APC payment if billed on the same date of service as HCPCS 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 code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the codes is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

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Indicator	Item, Code, or Service	OPPS Payment Status
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 reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is aid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

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Indicator	Item, Code, or Service	OPPS Payment Status
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services. For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

4. Calculation of case-mix indices

Hospital-specific and state-wide case-mix indices shall be calculated using the Medicaid claim set.

a. 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.

b. 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.

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5. Calculation of the hospital-specific base APC rates

a. The final payment rate for the current rebasing uses the hospital's base-year cost report. The rates have been trended forward using inflation indices of 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, 0,0% for SFY 2003, 0.0% for SFY 2004, 0.0% for SFY 2005, 3.0% for SFY 2006, 3.0% for SFY 2007, 0.0% for SFY 2008, and 1.0% for SFY 2009. For services beginning on December 1, 2009, rates shall be reduced by 5.0%. For services beginning on July 1, 2010, rates effective June 30, 2010, shall be increased by 13.74% except for the University of Iowa Hospital and clinics and out-of-state hospitals. For services beginning on August 1, 2011, rates effective July 31, 2011, shall be increased by 3.38% except for the University of Iowa Hospital and clinics and out-of-state hospitals. For services beginning on January 1, 2012, rates effective December 31, 2011, shall be increased by 11.14% except for the University of Iowa Hospital and clinics and out-of-state hospitals. This rate increase is effective for services rendered during January 1, 2012-June 30, 2012. For services beginning on July 1, 2012-September 30, 2012, rates effective June 30, 2012, shall be increased by 13.56% except for the University of Iowa Hospital and clinics and out-of-state hospitals. This rate increase is effective for services rendered during July 1, 2012-September 30, 2012.

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

b. 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 2552-96.

c. The cost to charge ratios are applied to each line item charge reported on claims in the Medicaid claim set, 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.

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d. The following items are subtracted from the hospital's total outpatient Medicaid costs:
   (1) 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. The requirements to receive payments from the fund, the amount allocated to the fund, and the methodology used to determine the distribution amounts from the fund are found in Section 17.
   (2) The total calculated Medicaid cost for non-inpatient program services.
   (3) The total calculated Medicaid cost for ambulance services
   (4) The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

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e. 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 in the Medicaid claim set.

f. 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.

6. Calculation of the statewide base APC rates

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

(1) The total calculated Medicaid direct medical education costs for interns and residents for all hospitals.

(2) The total calculated Medicaid cost for non-inpatient program services for all hospitals.

(3) The total calculated Medicaid cost for ambulance services for all hospitals.

(4) The total calculated Medicaid costs for services paid based on the Iowa Medicaid fee schedule for all hospitals.

b. 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 in the Medicaid claim set.

c. 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.

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7. Cost outlier payment policy

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.

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

b. The multiple threshold is met when the cost of furnishing an APC service or procedure exceeds 1.75 times the APC payment amount.

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

d. 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.

e. 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.

Facilities are paid 100 percent of outlier costs at the time of claim reimbursement. The QIO selects a random sample of outlier cases identified on fiscal agent claims data from all Iowa and bordering state hospitals.

Staff review the selected cases to perform admission review, quality review and APC validation. Questionable cases are referred to a physician reviewer for concerns related to medical necessity and quality of care.

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Outlier cases are reviewed for medical necessity of all services provided and to ensure that services were not billed in duplicate, to determine if services were actually provided, and to determine if all services were ordered by a physician. The hospital's itemized bill and remittance statement are reviewed in addition to the medical record.

On a quarterly basis, the QIO 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 $1000 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 $1000. 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 will be 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. Intensified review will be discontinued when the error rate falls below the norm for a calendar quarter. Providers will continue to be notified of all pending adverse decisions, prior to a final determination by the QIO.

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.

Hospitals with cases under review must submit all supporting data from the medical record to the QIO within 60 days of receipt of the outlier review notifications, or outlier payment will be recouped and forfeited. In addition, any hospital may request review for outlier payment by submitting documentation to the QIO 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.

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8. 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 Publications 15, subject to the exceptions and limitations provided in this rule.

a. Each hospital shall submit the following using electronic media:

(1) The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

(2) Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

(3) A copy of the revenue code crosswalk used to prepare the Medicare cost report.

b. The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, IA 50315.

c. The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

9. Rebasing

a. 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.

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b. 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.

c. 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.

10. Payment to out-of-state hospitals

Out-of-state hospitals providing care to members of Iowa's Medicaid program 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.

a. 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.

b. Out-of-state hospitals do not qualify for reimbursement for direct medical education payments from the Graduate Medical Education and Disproportionate Share Fund.

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11. Preadmission, preauthorization or inappropriate services

Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

a. The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

b. To safeguard against other inappropriate practices, the department, through the QIO, 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 QIO regulations.

12. Incentives

Payment to hospitals using the APC methodology extends the same incentives for efficiency of operations to the outpatient setting which are inherent to the DRG methodology. This system encourages 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 is allowed to 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.

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

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

13. Provider Appeals

In accordance with 42 CFR 447.253(e), Iowa Medicaid is extending the same appeal rights for rate setting in the outpatient setting as in the inpatient setting. Thus, if a provider is dissatisfied with an APC rate determination, that provider 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 (DHS) contracts with the Department of Inspections and Appeals (DIA) to conduct appeal hearings. Based upon a proposed decision by DIA, DHS makes a decision and advises the provider accordingly within 120 days.

14. Audits

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 following Medicare intermediaries in Iowa and surrounding areas:

Cahaba Government Benefits Administrator (Des Moines and Sioux City)
Mutual of Omaha (Omaha, Nebraska)
Riverbend Government Benefits Administrator (Chattanooga, Tennessee)
United Government Services (Milwaukee, Wisconsin)
Blue Cross and Blue Shield of Wisconsin (Madison, Wisconsin)

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

15. Recovery of Overpayments

When The Department determines that an outpatient hospital provider has been overpaid, a notice of overpayment and request for refund is sent to the provider. The notice states that if the provider 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 provider.

16. Rate Adjustment for Hospital Mergers

When one or more hospitals merge to form a distinctly different legal entity, the base rate is 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 that entity.

17. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

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 in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

b. 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 for September 1, 2011, through June 30, 2012, is $2,282,771.11. Thereafter, the total annual amount of funding that is allocated is $2,739,325.33.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

A reduction of this amount will be made if a hospital fails to qualify for direct medical education payments 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.

c. Distribution to Qualifying Hospitals for Direct Medical Education

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 from the GME/DSH Fund apportionment claim set, 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.

- Sum the dollar values for each hospital, then 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.

In compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and enhanced disproportionate share payments describe in Section 30 cannot exceed the amount of the federal cap under Public Law 102-234.

18. Relationship to Managed Care

Direct medical education payments are reimbursed directly to hospitals. These payments have been deducted from all managed care capitation payments as part of the rate-setting methodology. No additional payments for these components are made to any managed care organizations.

Revised 5/17/11

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

19. Reserved for future use

20. Final Settlement for Iowa State-owned Teaching Hospital

Distributions methodology for the $9,900,000

The $9,900,000 will first be applied to bring inpatient hospital reimbursement (interim payments plus GME) to 100% of inpatient hospital cost (calculated in accordance with Attachment 4.19-A). The remaining amount of the $9,900,000 will then be applied to bring outpatient hospital reimbursement to 100% of outpatient hospital cost (calculated in accordance with Attachment 4.19-B and Supplement 2 to Attachment 4.19-B).

If the total $9,900,000 is used in bringing inpatient hospital reimbursement to 100% of inpatient cost, then no further outpatient payments will be made.

In no case will total outpatient hospital payments exceed 100% of outpatient cost.

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

21. Payment for Outpatient Services Delivered in the Emergency Room

Payment for outpatient Services delivered in the emergency room will be based on the following criteria:

A. For ER visits that do not result in an inpatient admission and includes emergent diagnosis codes payment is made at 100 percent of the usual APC payment plus a triage/assessment fee schedule payment.

B. For ER visits that do not result in an inpatient admission and do not include emergent diagnosis codes, payment is made as follows:

1. For Medicaid members not participating in the MediPASS or Lock-in program referred to the ER by appropriate medical personnel payment is made at 75 percent of the usual APC payment plus a triage/assessment fee schedule payment.

2. For Medicaid members participating in the MediPASS or Lock-in program referred to the ER by their MediPASS or Lock-in primary care physician payment is made at 75 percent of the usual APC payment plus a triage/assessment fee schedule payment.

3. For Medicaid members not participating in the MediPASS or Lock-in program not referred to the ER by appropriate medical personnel payment is made at 50 percent of the usual APC payment plus a triage/assessment fee schedule payment.

4. For Medicaid members participating in the MediPASS or Lock-In program not referred to the ER by their MediPASS or Lock-in program primary care physician payment will be made for the assessment fee schedule payment only.

The copayment amount per Attachment 4.18-A will be deducted after APC payment reductions have been applied.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

22. Payment for Outpatient Services Delivered in the Emergency Room

Payment for outpatient Services delivered in the emergency room will be based on the following criteria:

A. For ER visits that do not result in an inpatient admission and includes emergent diagnosis codes payment is made at 100 percent of the usual APC payment plus a triage/assessment fee schedule payment.

B. For ER visits that do not result in an inpatient admission and do not include emergent diagnosis codes, payment is made as follows:

1. For Medicaid members not participating in the MediPASS or Lock-in program referred to the ER by appropriate medical personnel payment is made at 75 percent of the usual APC payment plus a triage/assessment fee schedule payment.

2. For Medicaid members participating in the MediPASS or Lock-in program referred to the ER by their MediPASS or Lock-in primary care physician payment is made at 75 percent of the usual APC payment plus a triage/assessment fee schedule payment.

3. For Medicaid members not participating in the MediPASS or Lock-in program not referred to the ER by appropriate medical personnel payment is made at 50 percent of the usual APC payment plus a triage/assessment fee schedule payment.

4. For Medicaid members participating in the MediPASS or Lock-In program not referred to the ER by their MediPASS or Lock-in program primary care physician payment will be made for the assessment fee schedule payment only.

The copayment amount per Attachment 4.18-A will be deducted after APC payment reductions have been applied.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Care Provided by Critical Access Hospitals

A critical access hospital is a hospital that:

- Meets Medicare guidelines established in 42 CFR Part 485, Subpart F, and state hospital licensure requirements established in 481 Iowa Administrative Code 51.52(135B) as a hospital that serves a rural or vulnerable population, and
- Is necessary to the economic health and well being of the surrounding community.

Hospitals applying for critical access status are inspected, licensed, and certified as critical access hospitals, using Medicare criteria, by the Iowa Department of Inspections and Appeals.

Critical access hospital providers are reimbursed prospectively based on the hospital's outpatient Medicaid cost-to-charge ratio. Retrospective adjustments will be made based on each critical access hospital's annual cost reports submitted to the Department at the end of the hospital's fiscal year. The retroactive adjustment equals the amount by which the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), determined in accordance with Medicare cost principals, exceeds Medicaid fee-for-service reimbursement received based on the hospital's outpatient Medicaid cost-to-charge ratio.

The Medicaid outpatient cost-to-charge ratio upon which the outpatient hospital 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 Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

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.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Prospective Interim Payment (PIP)

Hospitals qualify for a PIP if they meet one of the following:

- Being an Iowa-state-owned hospital with more than 500 beds, having eight or more separate and distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.
- Being a non-state government-owned acute care teaching hospital located in a county with a population over three hundred fifty thousand.
- Being an Iowa-state-owned acute care hospital for persons with mental illness.

The Department of Human Services' total annual PIP obligation to a qualifying hospital will be sum of IowaCare's obligation for the following: inpatient services + outpatient services + inpatient capital costs + pharmacy cost + estimated enhanced DSH and graduate medical education obligation. Third party liability payments are subtracted from the PIP obligation.

Effective for January 1, 2009, through June 30, 2009, the annual PIP, which is divided by twelve and payable monthly, to each qualifying hospital is as follows:
$27,284,584 to University of Iowa Hospitals and Clinics
$3,164,766 to Cherokee MHI
$687,779 to Clarinda MHI
$3,146,494 to Independence MHI
$2,000,961 to Mt. Pleasant MHI
$37,000,000 to Broadlawns Medical Center

For the period of January 1, 2009, through June 30, 2009, additional payments for inpatient and outpatient hospitals services, Enhanced DSH and Enhanced GME payments, not to exceed $11,000,000, in total, will be paid to Broadlawns Medical Center.

Effective for July 1, 2009, through June 30, 2010, the annual PIP, which is divided by twelve and payable monthly, to each qualifying hospital is as follows:
$27,284,584 to University of Iowa Hospitals and Clinics
$41,000,000 to Broadlawns Medical Center

For the period of July 1, 2009, through June 30, 2010, additional payments for inpatient and outpatient hospitals services, Enhanced DSH and Enhanced GME payments, not to exceed $11,000,000, in total, will be paid to Broadlawns Medical Center.

The Enhanced DSH payments will be subject to the hospital-specific DSH limit and will only be made if there remains any DSH allotment, in compliance with Public Law 102-234, as amended by Public Law 108-173 (Medicare Prescription Drug, Improvement, and Modernization Act of 2003), after determining the amount of DSH allocated to the PIP payments for each qualifying hospital, plus the DSH that is paid through the Graduate Medical Education and Disproportionate Share Fund. The Enhanced GME payments will be subject to the cost limit defined in Section 32. Final Settlement Process for Non-State Government-Owned or Government-Operated Hospitals (Inpatient).

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care

Interim Settlement

The Department of Human Services' interim settlement with a qualifying hospital will be based on the hospitals' as-filed cost report and IowaCare claims history as measured by the Department for the year for which interim settlement is being performed. The IowaCare claims will be priced according to the methodology approved for regular Medicaid claims and will consist of, otherwise payable, claims submitted for each July 1 through June 30 time period.

Final Settlement

The Department of Human Services' final settlement with a qualifying hospital is calculated using the same methodology as is used when calculating the interim payments except that the data source used will be based on the hospital's final cost report from the Medicare fiscal intermediary and IowaCare claims history, submitted for each July 1 through June 30 time period, and as measured by the Department for the same time period for which final settlement is being performed.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

22. **Payment Adjustment for Provider Preventable Conditions**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Supplement 2 to Section(s) 4.19(B)

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable conditions identifies below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

Outpatient hospital claims must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event for wrong body part, wrong patient, or wrong surgery, and at least one (1) of the diagnosis codes indicating wrong body part, wrong patient, or wrong surgery must be present as one of the first four (5) diagnoses codes on the claim.