



Medicaid Enterprise

Iowa Department of Human Services

**Acute Hospital Services
Provider Manual**



Medicaid Enterprise
Department of Human Services

Provider
Acute Hospital Services

Page
1

Date
February 1, 2011

TABLE OF CONTENTS

[Chapter I. General Program Policies](#)

[Chapter II. Member Eligibility](#)

[Chapter III. Provider-Specific Policies](#)

[Appendix](#)



Medicaid Enterprise

Iowa Department of Human Services

III. Provider-Specific Policies



TABLE OF CONTENTS

Page

CHAPTER III. PROVIDER-SPECIFIC POLICIES.....	1
A. HOSPITALS ELIGIBLE TO PARTICIPATE	1
1. Certification of Special Units.....	1
a. Criteria for Substance Abuse Units	1
b. Criteria for Neonatal Intensive Care Units.....	2
c. Criteria for Psychiatric Units	2
d. Criteria for Physical Rehabilitation Hospitals and Units.....	3
2. Cost Reporting Requirements	3
3. Incentives for Efficient Operation	4
4. Provider Appeals.....	5
5. Rate Adjustment for Hospital Mergers.....	5
6. Audits	5
7. Recovery of Overpayments	5
B. COVERAGE OF INPATIENT SERVICES	6
1. Certification of Inpatient Care.....	6
a. Preprocedure Review.....	7
b. Swing-Bed and Lower Level of Care Reviews	9
c. Retrospective Reviews.....	9
d. Outlier Review.....	10
e. Adverse Determinations.....	12
2. Abortions.....	13
a. Covered Services Associated With Noncovered Abortions.....	14
b. Noncovered Services.....	15
c. Certification Regarding Abortion, Form 470-0836	15
3. Cosmetic Surgery	16
4. Diagnosis and Treatment Tests	18
5. Fertility Services	18
6. Medicare-Covered Services	18
7. Organ Transplants	18
8. Respite Care	19
9. Sterilizations	19
a. Informed Consent.....	21
b. <i>Consent for Sterilization</i> , Forms 470-0835 and 470-0835S	22
c. Hysterectomies	22
10. Substance Abuse Rehabilitation	24
11. Vaccinations.....	24



C.	BASIS OF PAYMENT FOR INPATIENT SERVICES	25
1.	Payment for Critical-Access Hospitals.....	26
2.	Diagnosis-Related-Group Payments	27
a.	Calculation of Iowa-Specific Weights.....	28
b.	Calculation of Blended Base Amount.....	29
c.	Capital Cost Add-on	31
3.	Payment for Outliers	31
a.	Short-Stay Outliers	32
b.	Long-Stay Outliers.....	32
c.	Cost Outliers.....	33
4.	Payment for Physical Rehabilitation Units	33
5.	Payment for Inpatient Psychiatric Units.....	34
6.	Payment for Transfers and Readmissions	35
7.	Payment for Patients Eligible for Only Part of the Hospital Stay.....	36
8.	Direct Medical Education Payment	36
a.	Allocation to Fund for Direct Medical Education	36
b.	Distribution to Qualifying Hospitals.....	37
9.	Indirect Medical Education Payment.....	37
a.	Allocation to Fund for Indirect Medical Education	38
b.	Distribution to Qualifying Hospitals.....	38
10.	Disproportionate-Share Payment.....	39
a.	Allocation to Fund for Disproportionate Share	40
b.	Distribution to Qualifying Hospitals for Disproportionate Share	41
11.	Payment to Out-of-State Hospitals	42
D.	COVERAGE OF OUTPATIENT SERVICES	43
1.	Covered Outpatient Services	43
a.	Ambulance	44
b.	Dental Services	44
c.	Drugs	44
d.	Emergency Room	45
e.	Inpatient Admission After Outpatient Service.....	45
f.	Radiology Services.....	46
g.	Same-Day Surgery	46
h.	Take-Home Supplies and Medical Equipment	47
2.	Special Noninpatient Programs	47
a.	Application.....	48
b.	General Requirements.....	49
c.	Coding of Noninpatient Services.....	50



Page

- 3. Alcoholism or Substance Abuse Programs..... 53
 - a. Diagnostic and Treatment Staff..... 53
 - b. Initial Assessment 54
 - c. Admission Criteria..... 55
 - d. Plan of Treatment 55
 - e. Discharge Plan 56
 - f. Restrictions on Payment 56
- 4. Cardiac Rehabilitation Programs..... 57
 - a. Treatment Staff..... 57
 - b. Admission Criteria..... 58
 - c. Physical Environment and Equipment 58
 - d. Physician Coverage 58
 - e. Medical Records..... 59
 - f. Discharge Plan 59
 - g. Monitoring of Services 59
 - h. Restrictions..... 59
- 5. Diabetic Education Programs 60
 - a. Program Staff 60
 - b. Admission Criteria..... 60
 - c. Health Assessment 61
 - d. Restrictions on Payment 61
- 6. Eating Disorders Programs 61
 - a. Diagnostic and Treatment Staff..... 61
 - b. Admission Criteria..... 62
 - c. Initial Assessment 63
 - d. Plan of Treatment 64
 - e. Monitoring of Services 64
 - f. Discharge Plan 65
 - g. Restrictions on Payment 65
- 7. Mental Health Programs..... 66
 - a. Diagnostic and Treatment Staff..... 66
 - b. Initial Assessment 67
 - c. Covered Services..... 68
 - d. Service Requirements 69
 - e. Restrictions on Coverage 71
 - f. Frequency and Duration of Services 71
 - g. Day Treatment for Children..... 72
- 8. Nutritional Counseling Programs 83



Page

- 9. Pain Management Programs 84
 - a. Treatment Staff 84
 - b. Admission Criteria 84
 - c. Plan of Treatment 85
 - d. Discharge Plan 85
 - e. Restrictions on Payment 86
- 10. Pulmonary Rehabilitation Programs 86
 - a. Diagnostic and Treatment Staff 86
 - b. Initial Assessment 87
 - c. Admission Criteria 87
 - d. Plan of Treatment 88
 - e. Discharge Plan 88
 - f. Restrictions on Payment 88
- E. BASIS OF PAYMENT FOR OUTPATIENT SERVICES 89
 - 1. Payment Basis for Critical-Access Hospitals 90
 - 2. Ambulatory Payment Classification (APC) Payments 91
 - a. Calculation of Case-Mix Indices 96
 - b. Calculation of the Hospital-Specific Base APC Rates 96
 - c. Calculation of the Statewide Base APC Rates 98
 - d. Rebasing 98
 - 3. Cost Outlier Payments 99
 - 4. Direct Medical Education Payment 101
 - a. Allocation to Fund for Direct Medical Education 101
 - b. Distribution to Qualifying Hospitals 102
 - 5. Payment to Out-of-State Hospitals 102
- G. CLAIM FORMS 103
 - 1. Instructions for Completing the UB-04 Claim Form (CMS-1450) 103
 - 2. Claim Attachment Control, Form 470-3969 135
- H. REMITTANCE ADVICES 136
 - 1. Remittance Advice Explanation 136
 - 2. Inpatient Remittance Advice 137
 - 3. Inpatient Crossover Remittance Advice 139
 - 4. Outpatient Remittance Advice 141
 - 5. Outpatient Crossover Remittance Advice 144
 - 6. Capitation Remittance Advice 146



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 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. Certification of Special Units

Certification by the Iowa Medicaid Enterprise 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, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with 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 Iowa Medicaid enterprise 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 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 Iowa Code Chapter 125 and [641 Iowa Administrative Code Chapter 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.

b. 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 Iowa Medicaid Enterprise 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—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

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 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.

2. 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.

Each hospital shall submit the following using electronic media:

- ◆ The hospital's Medicare cost report (form CMS 2552-96, *Hospitals and Healthcare Complex Cost Report*);
- ◆ Either form 470-4514, *Hospital Supplemental Cost Report* (click [here](#) to see a sample of this form), or form 470-4515, *Critical Access Hospital Supplemental Cost Report* (click [here](#) to see a sample of this form); 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,
P.O. Box 36450
Des Moines, IA 50315.



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

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

3. Incentives for Efficient Operation

Payment to hospitals using diagnosis-related group (DRG) 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.

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

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



4. 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.

5. 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.

6. 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.

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 Iowa Medicaid 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 preprocedure 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.



a. Preprocedure Review

Surgical procedures affect health care expenditures significantly. To ensure that procedures are medically necessary, the IME Medical Services Unit conducts preprocedure review for the Medicaid program. Preprocedure review will be performed for all procedures identified on the following list:

	Hospital Use Only: <u>ICD-9-CM</u>	Physician and Ambulatory Surgical Center Use Only: <u>CPT-4</u>
Bone marrow transplant	41.00	38240
	41.01	38241
	41.02	
	41.03	
Stem cell transplant	41.04	38240
	41.05	38241
Heart transplant	37.5	33945
Liver transplant auxiliary	50.51	47135
Other transplant of liver	50.59	47135
Lung transplant	33.50	32851
Unilateral lung transplant	33.51	32852
Bilateral lung transplant	33.52	32853
	33.06	32854
High gastric bypass (Printen and Mason)	44.31	43846
		43847
Gastric stapling (gastroplasty)	44.69	43326
		43842
		43843
		43848
Small bowel bypass	45.91	43846



Requests for review of these elective procedures must be in writing and must be submitted to:

IME Medical Services Unit
P.O. Box 36478
Des Moines, Iowa 50319

Preprocedure review consists of an evaluation of the appropriateness of the procedure and the proposed setting. The Medical Services Unit needs the following information for preprocedure and preadmission review:

- ◆ Procedure
- ◆ Proposed admission date
- ◆ Hospital or location of intended procedure
- ◆ Member's name and address
- ◆ Member's age
- ◆ Member's Medicaid ID number
- ◆ Attending or surgical physician's name
- ◆ Tentative diagnosis
- ◆ Orders
- ◆ History and chief complaint (symptoms and duration of problem)
- ◆ Other medical history or problem
- ◆ Preadmission treatment
- ◆ Outpatient studies performed
- ◆ Medication

Preprocedure review is conducted using criteria that have been developed by the applicable specialties. Questionable cases are referred to a physician reviewer for determination of the medical necessity of the procedure. Denial letters are issued if the physician reviewer determines the admission or procedure is not medically necessary.

Cases reviewed on preprocedure review may also be selected for retrospective review. The information provided during the preprocedure review will be validated during the retrospective review. A denial may be issued if the information provided during precertification review is not supported by documentation in the medical record.



b. Swing-Bed and Lower Level of Care Reviews

Contact the IME Medical Services Unit for admission reviews for patients in swing beds and patients who are lowered to the skilled or nursing care level.

Submit form 470-0042, *Case Activity Report*, to the Department Centralized Facility Eligibility Unit within two business days of the date the member is admitted to swing-bed (skilled nursing care), changes level of care, dies, or is discharged. Submit the form via fax to 525-564-4040 or via email to facilities@dhs.state.ia.us.

The Medical Services Unit will provide certification information upon discharge or at interim points, if the stay exceeds 30 days. Questionable cases are referred for physician review. If the physician reviewer determines that the care is not appropriate, a denial letter is sent to all parties.

Continued-stay reviews shall be conducted at least every 14 to 90 days, according to the member's condition and care needs. For patients in the hospital at a lower level of care, continue to attempt placements in an appropriate facility.

c. 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 preprocedure reviews and a sample of Cesarean section deliveries. This review does not include Medicare beneficiaries.

d. Outlier Review

Payment for long-stay and cost outliers is prospective. (See [Payment for Outliers](#).) 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 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.



(1) 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.

(2) 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 an IFMC 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.



e. 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
- ◆ Preprocedure
- ◆ 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, preprocedure, 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.



2. 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 the physician'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 attending physician certifies in writing based on professional judgment that the pregnant woman's life would be endangered if the fetus were carried to term.

Federal funding is available if the woman suffers from a physical disorder, physical injury, or physical illness that would place the woman in danger of death unless an abortion is performed (including a life-endangering physical condition caused by or arising from the pregnancy itself).

- ◆ The pregnancy is the result of a rape that was reported to a law enforcement agency, or public or private health agency (which may include a family physician) within 45 days of the date of the incident. The report must contain the name, address, and signature of the person making the report. An official of the agency must so certify in writing.
- ◆ The pregnancy resulted from incest that was reported to a law enforcement agency or public or private health agency (which may include a family physician) within 150 days of the incident. The report must contain the name, address, and signature of the person making the report, and an official of the agency must so certify in writing.
- ◆ 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-9 diagnosis and procedure code indicating the abortion on the hospital claim and the appropriate ICD-9 diagnosis and CPT abortion procedure code on the practitioner claim.



The reason for the abortion must be identified on form 470-0836, *Certification Regarding Abortion*. 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

a. Covered Services Associated With Noncovered 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 must not be billed on the same claim with an abortion service. These services must be billed separately.



b. Noncovered 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 noncovered 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.

c. Certification Regarding Abortion, Form 470-0836

Payment cannot be made to the attending physician, to other physicians assisting in the abortion, or to the hospital if the provider does not submit a copy of form 470-0836, *Certification Regarding Abortion*, and required documentation with the claim for payment. To view a sample of this form on line, click [here](#).



Form 470-0836 shall be used for the certification from the law enforcement agency, public or private health agency, or family physician that is required for a pregnancy resulting from rape or incest. It is the responsibility of the member, someone acting in her behalf, or the attending physician to obtain the necessary certification.

The physician is responsible for making a copy of the certification available to the hospital and others billing for the service. This facilitates payment to the hospitals and others on abortion claims.

3. Cosmetic Surgery

Coverage under the Medicaid program is generally not available for cosmetic, reconstructive or plastic surgery. The Medicaid program defines cosmetic, reconstructive, or plastic surgery as surgery that can be expected primarily to improve physical appearance, or which is performed primarily for psychological purposes or which restores form, but which does not correct or materially improve the bodily functions.

When a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure is not considered cosmetic surgery. Payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive or plastic surgery done for one of the following reasons:

- ◆ 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 twelve months after the related accidental injury or surgical trauma. However, special consideration is given to cases involving children who require a growth period.



Some cosmetic, reconstructive or plastic surgery procedures are specifically **excluded**. These procedures include:

- ◆ Panniculectomy and body sculpture procedures.
- ◆ 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.
- ◆ Penile implant procedures.
- ◆ Insertion of prosthetic testicles.

When it is determined that a cosmetic, reconstructive or plastic surgery procedure does not qualify for coverage under Medicaid, all related services and supplies, including any institutional costs, are also excluded.

Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment, but only when the subsequent complications represent a separate medical condition, such as systemic infection, cardiac arrest, or acute drug reaction.

Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. Examples of complications similar to the initial period of care are repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who has undergone transsexual surgery.



4. 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.

5. Fertility Services

Iowa Medicaid does not cover fertility services.

6. Medicare-Covered Services

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

7. Organ Transplants

Payment will be made only for the following organ and tissue transplant services when medically necessary:

- ◆ Kidney, cornea, skin, and bone transplants.
- ◆ Allogeneic bone marrow transplants for the treatment of leukemia, aplastic anemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome.
- ◆ Autologous bone marrow transplants for treatment of the following conditions:
 - Acute leukemia in remission with a high probability of relapse when there is no matched donor,
 - Resistant non-Hodgkin's lymphomas,
 - Lymphomas presenting poor prognostic features,
 - Recurrent or refractory neuroblastoma, or
 - Advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.



- ◆ 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 preprocedure review by the IME Medical Services Unit and are payable only when performed in a facility that meets the requirements set forth by the Department.

- ◆ Heart transplants require preprocedure review by the IME Medical Services Unit and are payable only when performed in a facility that meets the requirements set forth by the Department.

Artificial hearts and ventricular assist devices are not covered, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant.

- ◆ Lung transplants for members having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME Medical Services Unit and are payable only when performed in a facility certified as a lung transplant facility by Medicare. Heart-lung transplants are not covered.

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.

8. Respite Care

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

9. Sterilizations

Federal regulations provide that Medicaid payment shall not be made for sterilization of a member who is under 21 or who is legally mentally incompetent or institutionalized.

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 one 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.

“Sterilization” means any medical procedure, treatment, or operation for the purpose of rendering a person permanently incapable of reproducing 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 retardation is not considered an illness or injury.

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

The following conditions must be met:

- ◆ The member to be sterilized must voluntarily request the service, and
- ◆ 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 losing benefits to which the member might otherwise be entitled, and
- ◆ A knowledgeable informant must give the member to be sterilized an explanation of the procedures to be performed upon which the member can base the consent for sterilization. An “informed consent” is required.



a. Informed Consent

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

If the member is blind or 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, is seeking to obtain or obtaining an abortion, or is under the influence of alcohol or another substance that affect the member’s state of awareness.

The elements of explanation that 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, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Acute Hospital Services	Page 22
	Chapter III. Provider-Specific Policies	Date February 1, 2011

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, *Formulario de Consentimiento Requerido*, form 470-0835S. An equivalent Medicaid form from another state is accepted.

To view a sample of Iowa’s English consent form on line, click [here](#). To view a sample of Iowa’s Spanish consent form on line, click [here](#). You may obtain a supply of the consent form from the IME Provider Services Unit upon request. See Chapter I, [Form Orders](#).

If a consent form is not attached to the claim for payment, Medicaid payment for the sterilization will be denied. It is the responsibility of the hospital and other providers associated with the services to obtain a photocopy of the completed consent form to attach to the claim submitted to the IME for payment.

A claim for sterilization submitted to pay for physician’s services may be denied due to failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided.

If a physician’s claim is denied for the service, any other claim submitted by the hospital, anesthesiologists, assistant surgeon, or associated providers for the same procedure will also be denied.

c. 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 or the claim form, or it may be 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 acknowledgment that the member received the explanation before the surgery should not be the *Consent for Sterilization*, 470-0835 or 470-0835S.

The 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 or the claim form, or may be on 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.



10. 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.

11. 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. You can obtain information about immunizations by contacting 1-800-232-4636 or 1-800-831-6293.

Vaccines available through the VFC program are found at http://www.idph.state.ia.us/adper/vaccines_for_children.asp or at 1-800-831-6293. 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 Iowa Medicaid program reimburses inpatient hospital care based on the diagnosis-related group (DRG) principle, as explained in 42 Code of Federal Regulations Part 412.

Iowa Medicaid 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 ID number on the claim. The baby's ID 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 [Payment for Critical-Access Hospitals](#).
- ◆ Physical rehabilitation performed in a certified unit are paid per diem. See [Payment for Physical Rehabilitation Units](#).
- ◆ Inpatient psychiatric services performed in a certified unit are paid per diem. See [Payment for 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 Iowa Medicaid 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, nonreimbursed or nominally reimbursed patients for inpatient services.

The following sections explain:

- ◆ [Payment for critical-access hospitals](#)
- ◆ [Diagnosis-related group payments](#)
- ◆ [Payment for outliers](#)
- ◆ [Payment for physical rehabilitation units](#)
- ◆ [Payment for inpatient psychiatric units](#)
- ◆ [Payment for transfers and readmissions](#)
- ◆ [Payment for patients eligible for only part of their hospital stay](#)
- ◆ [Payment for direct medical education costs](#)
- ◆ [Payment for indirect medical education costs](#)
- ◆ [Payment for a disproportionate share of indigent patients](#)
- ◆ [Payment to out-of state hospitals](#)

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

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

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 Iowa-Specific Weights

Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 2006, to December 31, 2007, and paid through March 31, 2008. Medicaid charge 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 Iowa-specific weights.

All normal inlier claims, the estimated inlier portion of long-stay outliers, transfers where the final payment is greater than the full DRG payment, and the estimated portion of cost outliers are used to recalibrate weights. Short-stay outliers and transfers where the final payment is less than the DRG payment are discarded. This group of claims is known as "trimmed claims."

By federal definition, 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 the DRG.
- ◆ Sum the statewide 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 aggregate 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.

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.

b. 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 Iowa Medicaid 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 Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull 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:
 - Nonfull 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 Iowa Medicaid discharges for that hospital during the applicable base year from the MMIS claims system or the cost report (whichever is greater), less the nonfull 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.

Updating of base payment amounts by the Data Resources, Inc. hospital market basket index is performed annually if funds permit. Base amounts are rebased and weights recalibrated every three years. NOTE: Hospitals receiving reimbursement as critical-access hospitals do not have base amounts rebased.



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%. Cost report data for hospitals receiving reimbursement as critical-access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

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

Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate are subject to a reduction in their capital add-on to equal the greatest amount of the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs will be calculated for any hospital that qualifies for payment only as a children's hospital based on a distinct area or areas serving children.

This cost will be calculated using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

3. **Payment for Outliers**

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

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

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



a. 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% 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.

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% 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% 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 6 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 you in processing the interim claim.



c. **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% 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% of the calculated amount and is made when the claim is paid.

Hospitals that are notified of any outlier review initiated by the Iowa Medicaid Enterprise 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.

4. **Payment for 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 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.

5. Payment for 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 2552-96 using inpatient psychiatric unit patient days and cost to charge ration.

Hospitals are required to submit with the CMS 2552-96 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.



6. Payment for 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% of the hospital's average daily rate for each day care, up to 100% of the DRG payment.	Another acute-care hospital Paid 100% of the DRG payment.
Acute-care hospital Paid 100% of the DRG payment.	Substance abuse unit, Paid 100% of the DRG payment.
Acute-care hospital Paid 100% of the DRG payment.	Physical rehabilitation unit, Paid through a per diem rate.
Acute-care hospital Paid 100% 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% 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% 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.



7. Payment for Patients Eligible for Only Part of the Hospital Stay

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

When a patient 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. Direct Medical Education Payment

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 for July 1, 2009, through June 30, 2010, is \$8,210,006, unless a hospital fails to qualify for direct medical education payments.

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.
- ◆ 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.

9. Indirect Medical Education Payment

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 Iowa Medicaid 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 for December 1, 2009, through June 30, 2010, is \$14,416,336, unless a hospital fails to qualify for indirect medical education payments. Effective July 1, 2010, the total annual amount of funding allocated is \$14,415,396.

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.
- ◆ 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.



10. 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%,
- ◆ 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% 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%, or
- ◆ The product of 2.5% 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%.

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% 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% or,
- ◆ The product of 2.5% 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 for December 1, 2009, through June 30, 2010, is \$6,890,959. Effective July 1, 2010, the annual amount allocated is \$6,890,959.



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.

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.



11. Payment to 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% 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 patients 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.



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 (noninpatient 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 preprocedure approval by the Iowa Medicaid Enterprise are updated yearly. A list of these procedures is available from the IME Provider Services Unit.

The hospital shall provide the Iowa Medicaid Enterprise 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.

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. To billing for this one-time service, use HCPCS code W0599.



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***. 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.

Reimbursement for covered outpatient prescription drugs is the lowest of the following, as of the date of dispensing:

- ◆ The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee,
- ◆ The maximum allowable cost (MAC) plus the professional dispensing fee,
- ◆ The state maximum allowable cost (SMAC) plus the professional dispensing fee, or
- ◆ The submitted charge, representing the provider's usual and customary charge for the drug.

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.

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 prior to 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. Special Noninpatient Programs

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

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

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



a. Application

A hospital that wants Medicaid payment for a special noninpatient 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, patient 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 noninpatient 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 noninpatient service; and
- ◆ Notify the provider whether certification has been approved.



b. 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 patients are receiving accurate assessments and effective treatment.
 - The service monitoring must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.
 - The service evaluation shall be based on the use of clinical indicators that reflect those components of patient care important to quality.



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

c. Coding of Noninpatient Services

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

<u>Condition Codes</u>	<u>Service</u>
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**

<u>Procedure</u>	<u>Description</u>
S9742	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**

<u>Procedure</u>	<u>Description</u>
S9455	Diabetic education program

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

◆ **Eating Disorders**

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



◆ **Mental Health**

<u>Procedure</u>	<u>Description</u>
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 nonpsychiatrist. 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 nonpsychiatrist. 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 “noninpatient” service, but is paid similarly. When billing the service, one unit equals 15 minutes.

<u>Procedure</u>	<u>Description</u>
97802	Medical nutrition therapy, per 15 minutes
99218	Initial observation care (Use this code for observation room, per hour.)
99211	Outpatient visit (Use this code for emergency room triage.)

◆ **Pain Management**

<u>Procedure</u>	<u>Description</u>
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.

◆ **Pulmonary Rehabilitation**

<u>Procedure</u>	<u>Description</u>
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.

<u>Procedure</u>	<u>Description</u>
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 patients in one of the noninpatient 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.



3. 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. 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.



b. 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.



c. 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% 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.

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 treat. Document changes in treatment.



e. 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.

f. 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.



4. 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. 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 are 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 patients 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.



b. Admission Criteria

The attending physician must refer candidates for the program. Patients 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 client or doctor preference or inoperable cardiac disease.

c. 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.

d. Physician Coverage

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



e. Medical Records

Medical records for each cardiac rehabilitation patient 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

f. 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.

g. 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.

h. 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.



5. 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 Iowa Administrative Code Chapter 9.](#))

a. 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.

b. 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.



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.

6. 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. 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.



b. Admission Criteria

The patients 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.

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; and
 - 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), and
 - 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: 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. 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 patients' participation in the development of their treatment plans.

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

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

e. 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 patient care and opportunities to improve patient care. Base the monitoring and evaluation of the services on the use of clinical indicators that reflect those components of patient care most important to quality.



f. 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 patients 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.

g. 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.



7. 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. 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.



b. 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.



c. 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 patient care or opportunities to improve patient care.

The evaluation of the services shall be based on the use of clinical indicators that reflect those components of patient 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.

d. 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 patients.

For many other patients, 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.

e. 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.

f. 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.



g. 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 postdischarge 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 patients 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 mental retardation 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, and
 - 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 previous 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 patients 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 previous 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 patients 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.

Postdischarge 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% 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 patients, 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 patients exists as much as possible.

Consider the developmental and social stage of the participants, such that no member will be significantly involved with other patients who are likely to contribute to retardation 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 your 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.



8. 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.

Patients 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.



9. 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. Treatment Staff

The number of staff should be appropriate to the patient 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.

b. 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.



c. 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.

d. 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.



e. 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.

10. 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. 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.



b. 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.

c. 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.



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

Reassess patients 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, and
- ◆ Nutritional information.

e. Discharge Plan

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

f. 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.



E. BASIS OF PAYMENT FOR OUTPATIENT SERVICES

Medicaid adopts the Medicare categories of hospitals and services subject to an 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.

- ◆ 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.

- ◆ 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.
- ◆ 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 Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.
- ◆ **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.
- ◆ **Substance abuse services** for persons 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 Iowa Medicaid. The only exceptions to this policy are reference 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 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 Iowa Medicaid Enterprise 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 OPSS 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 Section 5.
- 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	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, 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) patients. ◆ Routine dialysis services for ESRD patients 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 OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services.</p> <p>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).</p>
B	<p>Codes that are not paid by Medicare on an outpatient hospital basis</p>	<p>Not paid under OPPS APC.</p> <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	<p>Inpatient procedures</p>	<p>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.</p> <p>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.</p>



Indicator	Item, Code, or Service	OPPS Payment Status
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes and services:</p> <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. 	<p>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.</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>
F	Certified registered nurse anesthetists services Corneal tissue acquisition Hepatitis B vaccines	<p>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.</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
G	Pass-through drugs and biologicals	
H	Pass-through device categories	



Indicator	Item, Code, or Service	OPPS Payment Status
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	<p>If covered by Iowa Medicaid, the item is:</p> <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 Iowa Medicaid fee schedule for outpatient hospital services when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L M	<p>Influenza vaccine Pneumococcal pneumonia vaccine</p> <p>Items and services not billable to the Medicare fiscal intermediary</p>	<p>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.</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
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.
Q1	STVX-packaged codes	<p>Paid under OPPS APC:</p> <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.



Indicator	Item, Code, or Service	OPPS Payment Status
Q2	T-packaged codes	<p>Paid under OPPS APC:</p> <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 R S	<p>Codes that may be paid through a composite APC</p> <p>Blood and blood products</p> <p>Significant procedure, not discounted when multiple</p>	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T U	<p>Significant procedure, multiple reduction applies</p> <p>Brachytherapy sources</p>	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
V X	<p>Clinic or emergency department visit</p> <p>Ancillary services</p>	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>



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.

- ◆ 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 rates have been trended forward using the following inflation indices:

SFY 2000	2.0%	SFY 2005	0.0%
SFY 2001	3.0%	SFY 2006,	3.0%
SFY 2002	(3.0%)	SFY 2007	3.0%
SFY 2003	0.0%	SFY 2008	0.0%
SFY 2004	0.0%	SFY 2009	1.0%

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 2552-96.



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, 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 Iowa Medicaid fee schedule.

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

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 Iowa Medicaid fee schedule for all hospitals.

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

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 2552-96, *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.



If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid Enterprise 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 review 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 nonmedically 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 for July 1, 2008, through June 30, 2009, is \$2,922,459, unless a hospital fails to qualify for direct medical education payments.

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.
- ◆ 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 Iowa Medicaid program for services to Iowa Medicaid members.



G. CLAIM FORMS

1. Instructions for Completing the UB-04 Claim Form (CMS-1450)

Bill for services on claim form UB-04 *Uniform Bill* (CMS-1450). Use an original version of the UB-04 as found at an office supply store. To view a sample of this form on line, click [here](#). When more than one plan of care covers a calendar billing month, submit all pertinent care plans with the UB-04.

The table below contains information that will aid in the completion of the UB-04 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	PROVIDER NAME, ADDRESS, & TELEPHONE NUMBER	REQUIRED. Enter the complete name, address, and phone number of the billing facility or service supplier. The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org .
2.	PAY-TO NAME, ADDRESS, & SECONDARY IDENTIFICATION	SITUATIONAL. Required if the "pay to" name and address information is different from the billing provider name in Item 1.
3a.	PATIENT CONTROL NUMBER	OPTIONAL. Enter the account number assigned to the member by the provider of service. This field is limited to 10 alpha/numeric characters.
3b.	MEDICAL RECORD NUMBER	OPTIONAL. Enter the number assigned to the member's medical or health record by the provider. This field is limited to 20 alphanumeric characters. This number will be listed on the <i>Remittance Advice</i> only if field 3a is left blank.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
4.	TYPE OF BILL	<p>REQUIRED. Enter a three-digit number consisting of one digit from each of the following categories in this sequence:</p> <p>First digit Type of facility Second digit Bill classification Third digit Frequency</p> <p><u>Type of Facility</u></p> <p>1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice</p> <p><u>Bill Classification</u></p> <p>1 Inpatient hospital, inpatient SNF or hospice (nonhospital-based) 2 Hospice (hospital-based) 3 Outpatient hospital, outpatient SNF or hospice (hospital-based) 4 Hospital-referenced laboratory services, home health agency, rehabilitation agency</p> <p><u>Frequency</u></p> <p>1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim</p>
5.	FEDERAL TAX NUMBER	<p>OPTIONAL. No entry required. NOTE: Changes to the provider's tax ID number must be reported through the IME Provider Services Unit at 1-800-338-7909 or 515-256-4609 in Des Moines.</p>
6.	STATEMENT COVERS PERIOD	<p>REQUIRED. Enter the month, day, and year (in MMDDYY format) under both the 'From' and 'To' categories for the period.</p>
7.		<p>OPTIONAL. No entry required. NOTE: Covered and noncovered days are reported using value codes in fields 39A-41d.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS																																																												
8a.	PATIENT LAST NAME	REQUIRED. Enter the last name of the member.																																																												
8a.	PATIENT FIRST NAME	REQUIRED. Enter the first name and middle initial of the member.																																																												
9a-9d	PATIENT ADDRESS	OPTIONAL. Enter the full address of the patient.																																																												
9e	UNTITLED	OPTIONAL. No entry required.																																																												
10.	BIRTHDATE	OPTIONAL. Enter the member's birth date as month, day, and year.																																																												
11.	SEX	REQUIRED. Enter the member's sex.																																																												
12.	ADMISSION DATE	REQUIRED. Inpatient, PMIC, and SNF: Enter the date of admission for inpatient services. Outpatient: Enter the dates of service. Home health agency and hospice: Enter the date of admission for care. Rehabilitation agency: No entry required.																																																												
13.	ADMISSION HOUR	REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code from the following chart that corresponds to the hour when the member was admitted for inpatient care. <table border="0"> <thead> <tr> <th><u>Code</u></th> <th><u>Time - AM</u></th> <th><u>Code</u></th> <th><u>Time - PM</u></th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00 – 12:59</td> <td>12</td> <td>12:00 – 12:59</td> </tr> <tr> <td></td> <td>Midnight</td> <td></td> <td>Noon</td> </tr> <tr> <td>01</td> <td>1:00 – 1:59</td> <td>13</td> <td>1:00 – 1:59</td> </tr> <tr> <td>02</td> <td>2:00 – 2:59</td> <td>14</td> <td>2:00 – 2:59</td> </tr> <tr> <td>03</td> <td>3:00 – 3:59</td> <td>15</td> <td>3:00 – 3:59</td> </tr> <tr> <td>04</td> <td>4:00 – 4:59</td> <td>16</td> <td>4:00 – 4:59</td> </tr> <tr> <td>05</td> <td>5:00 – 5:59</td> <td>17</td> <td>5:00 – 5:59</td> </tr> <tr> <td>06</td> <td>6:00 – 6:59</td> <td>18</td> <td>6:00 – 6:59</td> </tr> <tr> <td>07</td> <td>7:00 – 7:59</td> <td>19</td> <td>7:00 – 7:59</td> </tr> <tr> <td>08</td> <td>8:00 – 8:59</td> <td>20</td> <td>8:00 – 8:59</td> </tr> <tr> <td>09</td> <td>9:00 – 9:59</td> <td>21</td> <td>9:00 – 9:59</td> </tr> <tr> <td>10</td> <td>10:00 – 10:59</td> <td>22</td> <td>10:00 – 10:59</td> </tr> <tr> <td>11</td> <td>11:00 – 11:59</td> <td>23</td> <td>11:00 – 11:59</td> </tr> <tr> <td></td> <td></td> <td>99</td> <td>Hour unknown</td> </tr> </tbody> </table>	<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>	00	12:00 – 12:59	12	12:00 – 12:59		Midnight		Noon	01	1:00 – 1:59	13	1:00 – 1:59	02	2:00 – 2:59	14	2:00 – 2:59	03	3:00 – 3:59	15	3:00 – 3:59	04	4:00 – 4:59	16	4:00 – 4:59	05	5:00 – 5:59	17	5:00 – 5:59	06	6:00 – 6:59	18	6:00 – 6:59	07	7:00 – 7:59	19	7:00 – 7:59	08	8:00 – 8:59	20	8:00 – 8:59	09	9:00 – 9:59	21	9:00 – 9:59	10	10:00 – 10:59	22	10:00 – 10:59	11	11:00 – 11:59	23	11:00 – 11:59			99	Hour unknown
<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>																																																											
00	12:00 – 12:59	12	12:00 – 12:59																																																											
	Midnight		Noon																																																											
01	1:00 – 1:59	13	1:00 – 1:59																																																											
02	2:00 – 2:59	14	2:00 – 2:59																																																											
03	3:00 – 3:59	15	3:00 – 3:59																																																											
04	4:00 – 4:59	16	4:00 – 4:59																																																											
05	5:00 – 5:59	17	5:00 – 5:59																																																											
06	6:00 – 6:59	18	6:00 – 6:59																																																											
07	7:00 – 7:59	19	7:00 – 7:59																																																											
08	8:00 – 8:59	20	8:00 – 8:59																																																											
09	9:00 – 9:59	21	9:00 – 9:59																																																											
10	10:00 – 10:59	22	10:00 – 10:59																																																											
11	11:00 – 11:59	23	11:00 – 11:59																																																											
		99	Hour unknown																																																											



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
14.	TYPE OF ADMISSION/ VISIT	<p>REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code corresponding to the priority level of this inpatient admission.</p> <ul style="list-style-type: none"> 1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable
15.	SRC (SOURCE OF ADMISSION)	<p>REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code that corresponds to the source of this admission.</p> <ul style="list-style-type: none"> 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information unavailable
16.	DHR (DISCHARGE HOUR)	<p>REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code that corresponds to the hour member was discharged from inpatient care, using the chart under Field 13, Admission Hour.</p>
17.	STAT (PATIENT STATUS)	<p>REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code that corresponds to the status of the member at the end of service.</p> <ul style="list-style-type: none"> 01 Discharged to home or self care (routine discharge) 02 Discharged or transferred to other short-term general hospital for inpatient care 03 Discharged or transferred to a skilled nursing facility (SNF) 04 Discharged or transferred to an intermediate care facility (ICF) 05 Discharged or transferred to another type of institution for inpatient care or outpatient services 06 Discharged or transferred to home with care of organized home health services



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		07 Left care against medical advice or otherwise discontinued own care 08 Discharged or transferred to home with care of home IV provider 10 Discharged or transferred to mental health care 11 Discharged or transferred to Medicaid-certified rehabilitation unit 12 Discharged or transferred to Medicaid-certified substance abuse unit 13 Discharged or transferred to Medicaid-certified psychiatric unit 20 Expired 30 Remains a patient or is expected to return for outpatient services (valid only for nonDRG claims) 40 Hospice patient died at home 41 Hospice patient died at hospice or hospital 42 Hospice patient died unknown 43 Discharged or transferred to federally qualified health center 50 Hospice home 51 Hospice medical facility 61 Transferred to swing-bed unit 62 Transferred to rehabilitation facility 64 Transferred to nursing facility 65 Discharged or transferred to psychiatric hospital 71 Transferred for another outpatient facility 72 Transferred for outpatient service
18. – 28.	CONDITION CODES	<p>SITUATIONAL. Enter corresponding codes to indicate whether treatment billed on this claim is related to any condition listed below. Up to seven codes may be used to describe the conditions surrounding a member's treatment.</p> <p><u>General</u></p> 01 Military service related 02 Condition is employment related 03 Patient covered by an insurance not reflected here 04 HMO enrollee 05 Lien has been filed



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p><u>Inpatient Only</u></p> <p>80 Neonatal level II or III unit 81 Physical rehabilitation unit 82 Substance abuse unit 83 Psychiatric unit X3 IME approved lower level of care, ICF X4 IME approved lower level of care, SNF 91 Respite care</p> <p><u>Outpatient Only</u></p> <p>84 Cardiac rehabilitation program 85 Eating disorder program 86 Mental health program 87 Substance abuse program 88 Pain management program 89 Diabetic education program 90 Pulmonary rehabilitation program 98 Pregnancy indicator – outpatient or rehabilitation agency</p> <p><u>Special Program Indicator</u></p> <p>A1 EPSDT A2 Physically handicapped children’s program A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery</p> <p><u>Home Health Agency</u> (Medicare not applicable)</p> <p>XA Condition stable XB Not homebound XC Maintenance care XD No skilled service</p>
29.	ACCIDENT STATE	OPTIONAL. No entry required.
30.	UNTITLED	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
31. – 34.	OCCURRENCE CODES AND DATES	<p>REQUIRED. If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence.</p> <p><u>Accident Related</u></p> <p>01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim</p> <p><u>Insurance Related</u></p> <p>17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted</p> <p><u>Other</u></p> <p>11 Date of onset</p>
35. - 36.	OCCURRENCE SPAN CODE AND DATES	OPTIONAL. No entry required.
37.	UNTITLED	OPTIONAL. No entry required.
38.	UNTITLED	OPTIONAL. No entry required.
39. – 41.	VALID CODES AND AMOUNTS	<p>SITUATIONAL. Required if covered or noncovered days are included in the billing period. If more than one value code is show for a billing period, codes are shown in ascending numeric sequence.</p> <p>80 Covered days 81 Noncovered days</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
42.	REVENUE CODE	<p>REQUIRED. Enter the revenue code that corresponds for each item or service billed. Replace the "X" with a subcategory code, where appropriate, to clarify the code. Note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call IME Provider Services at 1-800-338-7909 or 515-256-4609 (in Des Moines).</p> <p>11X Room & board, private (medical or general) Charges for accommodations with a single bed. Subcategories:</p> <ul style="list-style-type: none"> 0 General classifications 1 Medical/surgical/GYN 2 OB 3 Pediatric 4 Psychiatric 6 Detoxification 7 Oncology 8 Rehabilitation 9 Other <p>12X Room & Board, semiprivate, two beds (medical or general) Charges for accommodations with two beds. Subcategories:</p> <ul style="list-style-type: none"> 0 General classifications 4 Sterile environment 7 Self care 9 Other <p>13X Room & board, semiprivate three and four beds (medical or general) Charges for accommodations with three or four beds. Subcategories:</p> <ul style="list-style-type: none"> 0 General classifications 4 Sterile environment 7 Self care 9 Other



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>14X Private (deluxe) Charges for accommodations with amenities substantially in excess of those provided to other patients. Subcategories:</p> <ul style="list-style-type: none"> 0 General classifications 4 Sterile environment 7 Self care 9 Other <p>15X Room & board, ward (medical or general) Charges for accommodations with five or more beds. Subcategories:</p> <ul style="list-style-type: none"> 0 General classifications 4 Sterile environment 7 Self care 9 Other <p>16X Other room & board Charges for accommodations that cannot be included in the specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing. Subcategories:</p> <ul style="list-style-type: none"> 0 General classifications 4 Sterile environment 7 Self care 9 Other <p>17X Nursery Charges for nursing care to newborn and premature infants in nurseries. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Newborn 2 Premature 5 Neonatal ICU 9 Other <p>18X Leave of absence Charges for holding a room or bed for a patient while the patient is temporarily away from the provider. Subcategory:</p> <ul style="list-style-type: none"> 5 Nursing home (for hospitalization)



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>20X Intensive care Charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Surgical 2 Medical 3 Pediatric 4 Psychiatric 6 Post ICU 7 Burn care 8 Trauma 9 Other intensive care <p>21X Coronary care Charges for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Myocardial infarction 2 Pulmonary care 3 Heart transplant 4 Post CCU 9 Other coronary care <p>22X Special charges Charges incurred during an inpatient stay or on a daily basis for certain services. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Admission charge 2 Technical support charge 3 U.R. service charge 4 Late discharge, medically necessary 9 Other special charges



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>23X Incremental nursing charge rate Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Nursery 2 OB 3 ICU 4 CCU 9 Other <p>24X All inclusive ancillary A flat rate charge incurred on either a daily or total-stay basis for ancillary services only. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other inclusive ancillary <p>25X Pharmacy Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Generic drugs 2 Nongeneric drugs 3 Take-home drugs 4 Drugs incident to other diagnostic services 5 Drugs incident to radiology 6 Experimental drugs 7 Nonprescription 8 IV solutions 9 Other pharmacy <p>26X IV therapy Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Infusion pump 2 IV therapy/pharmacy services 3 IV therapy/drug/supply delivery 4 IV therapy/supplies 9 Other IV therapy



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>27X Medical/surgical supplies and devices (also see 62X, an extension of 27X) Charges for supply items required for patient care. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Nonsterile supply 2 Sterile supply 3 Take-home supplies 4 Prosthetic/orthotic devices 5 Pacemaker 6 Intraocular lens 7 Oxygen – take home 8 Other implants 9 Other supplies/devices <p>28X Oncology Charges for the treatment of tumors and related diseases. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other oncology <p>29X Durable medical equipment (other than renal) Charges for medical equipment that can withstand repeated use (excluding renal equipment). Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Rental 2 Purchase of new DME 3 Purchase of used DME 4 Supplies/drugs for DME effectiveness (home health agency only) 9 Other equipment



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>30X Laboratory Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, indicate the code for each laboratory charge in field 44. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Chemistry 2 Immunology 3 Renal patient (home) 4 Nonroutine dialysis 5 Hematology 6 Bacteriology and microbiology 9 Other laboratory <p>31X Laboratory, pathological Charges for diagnostic and routine laboratory tests on tissues and cultures. For outpatient services, indicate the CPT code for each laboratory charge in field 44. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Cytology 2 Histology 4 Biopsy 9 Other <p>32X Radiology, diagnostic Charges for diagnostic radiology services provided for the examination and care of members. Includes taking, processing, examining and interpreting radiographs and fluorographs. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Angiocardiology 2 Arthrography 3 Arteriography 4 Chest x-ray 9 Other



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>33X Radiology, therapeutic Charges for therapeutic radiology services and chemotherapy required for care and treatment of members. Includes therapy by injection or ingestion of radioactive substances. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Chemotherapy, injected 2 Chemotherapy, oral 3 Radiation therapy 5 Chemotherapy, IV 9 Other <p>34X Nuclear medicine Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of members. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Diagnostic 2 Therapeutic 9 Other <p>35X CT scan Charges for computed tomographic scans of the head and other parts of the body. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Head scan 2 Body scan 9 Other CT scans <p>36X Operating room services Charges for services provided to member by specifically trained nursing personnel who assisted physicians in surgical or related procedures during and immediately following surgery. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Minor surgery 2 Organ transplant – other than kidney 7 Kidney transplant 9 Other operating room services



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>37X Anesthesia Charges for anesthesia services in the hospital. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Anesthesia incident to radiology 2 Anesthesia incident to other diagnostic services 4 Acupuncture 9 Other anesthesia <p>38X Blood Charges for blood must be separately identified for private payer purposes. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Packed red cells 2 Whole blood 3 Plasma 4 Platelets 5 Leukocytes 6 Other components 7 Other derivatives (cryoprecipitates) 9 Other blood <p>39X Blood storage and processing Charges for the storage and processing of whole blood. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Blood administration 9 Other blood storage and processing <p>40X Other imaging services Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Diagnostic mammography 2 Ultrasound 3 Screening mammography 4 Positron emission tomography 9 Other imaging services



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>41X Respiratory services Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the member's ability to exchange oxygen and other gases. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Inhalation services 3 Hyperbaric oxygen therapy 9 Other respiratory services <p>42X Physical therapy Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of members who have neuromuscular, orthopedic, and other disabilities. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy or trial occupational therapy by rehab agency <p>43X Occupational therapy Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy or trial occupational therapy by rehab agency



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>44X Speech language pathology Charges for services provided to those with impaired functional communication skills. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other speech-language pathology or trial speech therapy by rehab agency <p>45X Emergency room Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other emergency room <p>46X Pulmonary function Charges for tests measuring inhaled and exhaled gases, the analysis of blood, and tests evaluating the member's ability to exchange oxygen and other gases. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other pulmonary function <p>47X Audiology Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Diagnosis 2 Treatment 9 Other audiology



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>48X Cardiology Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Cardiac catheter lab 2 Stress test 9 Other cardiology <p>49X Ambulatory surgical care Charges for ambulatory surgery not covered by other categories. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other ambulatory surgical care <p>50X Outpatient services Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other outpatient services <p>51X Clinic Charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a nonemergency, scheduled outpatient basis to ambulatory patients. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Chronic pain center 2 Dental clinic 3 Psychiatric clinic 4 OB-GYN clinic 5 Pediatric clinic 9 Other clinic <p>52X Free-standing clinic Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Rural health, at clinic 2 Rural health, at home 3 Family practice 9 Other free-standing clinic



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>53X Osteopathic services Charges for a structural evaluation of the cranium, entire cervical, dorsal, and lumbar spine by a doctor of osteopathy. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Osteopathic therapy 9 Other osteopathic services <p>54X Ambulance Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Supplies 2 Medical transport 3 Heart mobile 4 Oxygen 5 Air ambulance 6 Neonatal ambulance services 7 Pharmacy 8 Telephone transmission EKG 9 Other ambulance <p>Documentation of medical necessity must be provided for ambulance transport. The diagnosis and documentation must reflect that the member was nonambulatory and the trip was to the nearest adequate facility.</p> <p>NOTE: Ambulance is payable on the UB-04 only in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form.</p> <p>55X Skilled nursing (home health agency only) Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the member and achieving the medically desired result. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Visit charge 2 Hourly charge 9 Other skilled nursing



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>56X Medical social services (home health agency only) Charges for services provided to patients on any basis, such as counseling, interviewing, and interpreting social situation problems. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Visit charge 2 Hourly charge 9 Other medical social services <p>57X Home health aide (home health agency only) Charges made by a home health agency for personnel primarily responsible for the personal care of the member. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Visit charge 2 Hourly charge 9 Other home health aide services <p>61X MRI Charges for Magnetic Resonance Imaging of the brain and other body parts. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Brain (including brainstem) 2 Spinal cord (including spine) 9 Other MRI <p>62X Medical/surgical supplies (extension of 27X) Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcategories:</p> <ul style="list-style-type: none"> 1 Supplies incident to radiology (for providers that cannot bill supplies used for radiology procedures under radiology) 2 Supplies incident to other diagnostic services (for providers that cannot bill supplies used for other diagnostic procedures)



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>63X Drugs requiring specific identification Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in field 44. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Single source drug 2 Multiple source drug 3 Restrictive prescription 4 Erythropoietin (EPO), less than 10,000 units 5 Erythropoietin (EPO), 10,000 or more units 6 Drugs requiring detailed coding <p>64X Home IV therapy services Charges for intravenous drug therapy services performed in the member's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Nonroutine nursing, central line 2 IV site care, central line 3 IV site/change, peripheral line 4 Nonroutine nursing, peripheral line 5 Training member/caregiver, central line 6 Training, disabled member, central line 7 Training, member/caregiver, peripheral line 8 Training, disabled member, peripheral line 9 Other IV therapy services <p>65X Hospice services (hospice only) Charges for hospice care services for a terminally ill member if he or she elects these services in lieu of other services for the terminal condition. Subcategories:</p> <ul style="list-style-type: none"> 1 Routine home care 2 Continuous home care (hourly) 5 Inpatient respite care 6 General inpatient care 8 Care in an ICF or SNF



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>70X Cast room Charges for services related to the application, maintenance, and removal of casts. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other cast room <p>71X Recovery room Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other recovery room <p>72X Labor room/delivery Charges for labor and delivery room services provided to patients by specially trained nursing personnel. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Labor 2 Delivery 3 Circumcision 4 Birthing center 9 Other labor room/delivery <p>73X EKG/ECG (electrocardiogram) Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments. Subcategories:</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none"> 0 General classification 1 Holter monitor 2 Telemetry 9 Other EKG/ECG



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>74X EEG (electroencephalogram) Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other EEG <p>75X Gastrointestinal services Procedure room charges for endoscopic procedures not performed in the operating room. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other gastro-intestinal <p>76X Treatment or observation room Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes on outpatient claims (one unit per hour). Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Treatment room 2 Observation room 9 Other treatment/observation room <p>79X Lithotripsy Charges for the use of lithotripsy in the treatment of kidney stones. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 9 Other lithotripsy



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>80X Inpatient renal dialysis A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Inpatient hemodialysis 2 Inpatient peritoneal (nonCAPD) 3 Inpatient continuous ambulatory peritoneal dialysis 4 Inpatient continuous cycling peritoneal dialysis (CCPD) 9 Other inpatient dialysis <p>81X Organ acquisition (see 89X) The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.) Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Living donor, kidney 2 Cadaver donor kidney 3 Unknown donor, kidney 4 Other kidney acquisition 5 Cadaver donor, heart 6 Other heart acquisition 7 Donor, liver 9 Other organ acquisition <p>82X Hemodialysis, outpatient or home A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Hemodialysis/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient hemodialysis



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>83X Peritoneal dialysis, outpatient or home A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Peritoneal/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient peritoneal dialysis <p>84X Continuous ambulatory peritoneal dialysis (CCPD), outpatient or home A continuous dialysis process performed in an outpatient or home setting using the member peritoneal membrane as a dialyzer. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 CAPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CAPD <p>85X Continuous cycling peritoneal dialysis (CCPD), outpatient or home A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 CCPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CCPD



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>88X Miscellaneous dialysis Charges for dialysis services not identified elsewhere. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Ultrafiltration 2 Home dialysis aid visit 9 Miscellaneous dialysis other <p>89X Other donor bank (extension of 81X) Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts; see 81X). Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Bone 2 Organ (other than kidney) 3 Skin 9 Other donor bank <p>92X Other diagnostic services Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Peripheral vascular lab 2 Electromyogram 3 Pap smear 4 Allergy test 5 Pregnancy test 9 Other diagnostic services <p>94X Other therapeutic services Charges for other therapeutic services not otherwise categorized. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Recreational therapy 2 Education/training 3 Cardiac rehabilitation 4 Drug rehabilitation 5 Alcohol rehabilitation 6 Complex medical equipment, routine 7 Complex medical equipment, ancillary 9 Other therapeutic services



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		<p>99X Patient convenience items Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered. Subcategories:</p> <ul style="list-style-type: none"> 0 General classification 1 Cafeteria or guest tray 2 Private linen service 3 Telephone or telegraph 4 TV or radio 5 Nonpatient room rentals 6 Late discharge charge 7 Admission kits 8 Beauty shop or barber 9 Other patient convenience items
43.	DESCRIPTION	<p>SITUATIONAL. Required if you enter a HCPCS "J" code for a drug that has been administered. Enter the National Drug Code (NDC) that corresponds to the J-code entered in Field 44 in NNNNN-NNNN-NN format, preceded by an "N4" qualifier. No other entries should be made in this field.</p>
43.	PAGE ___ OF ___	<p>REQUIRED if claim is more than one page. Enter the page number and the total number of pages for the claim.</p>
44.	HCPCS/RATE/ HIPPS CODE	<p>REQUIRED for outpatient hospital, inpatient SNF, and home health agencies. When applicable, add a procedure code modifier after the procedure code. Do not enter rates in this field.</p> <p>Outpatient hospital: Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APC.</p> <p>Inpatient SNF: Enter the HCPCS code W0511 for ventilator-dependent patients; otherwise leave blank.</p> <p>Home health agencies: Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT-related services.</p> <p>All others: Leave blank.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
45.	SERVICE DATES	SITUATIONAL. Required for outpatient claims. Enter the service date for outpatient service referenced in field 42 of field 44. Note that one entry is required for each date in which the service was performed.
46.	SERVICE UNITS	SITUATIONAL. Required for inpatient, outpatient, and home health agencies. Enter all units using whole numbers only (e.g., 1). Do not indicate partial units or anything after the decimal (e.g., 1.5 or 1.0). Inpatient: Enter the number of units of service for accommodation days. Outpatient: Enter the number of units of service provided per CPT or revenue code. (Batch-bill APCs require one unit for every 15 minutes of service time.) Home health agencies: Enter the number of units for each service billed. A unit of service equals a visit. For prior authorization private duty nursing or personal care, one unit equals an hour.
47.	TOTAL CHARGES	REQUIRED. Enter the total charges for each code billed. The total must include both dollars and cents.
47. LINE 23	TOTALS	REQUIRED. On the last page of the claim only, enter the sum of the total charges for all codes billed (all of field 47). The total must include both dollars and cents.
48.	NONCOVERED CHARGES	REQUIRED. Enter the noncovered charges for each applicable code.
48. LINE 23	TOTALS	REQUIRED. On the last page of the claim only, enter the sum of the total noncovered charges for all codes billed (all of field 48). The total must include both dollars and cents.
49.	UNTITLED	OPTIONAL. No entry required.
50. A-C	PAYER IDENTIFICATION	REQUIRED. Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
51. A-C	HEALTH PLAN ID	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
52. A-C	RELEASE OF INFORMATION CERTIFICATION INDICATOR	OPTIONAL. No entry required. By submitting the claim, you have agreed to all the information of the back of the claim form, including release of information.
53. A-C	ASSIGNMENT OF BENEFITS...	OPTIONAL. No entry required.
54. A-C	PRIOR PAYMENTS	REQUIRED if a payer other than Medicaid has made prior payments. If applicable, enter the amount paid by a payer other than Medicaid. Do not enter previous Medicaid payments. The total must include both dollars and cents.
55. A-C	ESTIMATED AMOUNT DUE	OPTIONAL. No entry required.
56.	NPI	REQUIRED. Enter the national provider ID of the billing entity.
57. A-C	OTHER PROVIDER ID	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
58. A-C	INSURED'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member on the line (A, B, or C) that corresponds to Medicaid from Field 50.
59.	P REL	OPTIONAL. No entry required.
60. A-C	INSURED'S UNIQUE ID	REQUIRED. Enter the member's Medicaid identification number found on the line (A, B, or C) that corresponds to Medicaid from Field 50. Get the number from the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, e.g., 1234567A.
61. A-C	GROUP NAME	OPTIONAL. No entry required.
62. A-C	INSURANCE GROUP NUMBER	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
63.	TREATMENT AUTHORIZATION CODE	SITUATIONAL. Enter the prior authorization number, if applicable. NOTE: This field is no longer used to report a MediPASS referral. Refer to field 79 to enter the MediPASS referral. Lock-in is moved to field 78.
64.	DOCUMENT CONTROL NUMBER	OPTIONAL. No entry required.
65.	EMPLOYER NAME	OPTIONAL. No entry required.
66.	DX	OPTIONAL. No entry required.
67.	PRINCIPAL DIAGNOSIS CODE	REQUIRED. Enter the ICD-9-CM code for the principal diagnosis.
67. A-Q	OTHER DIAGNOSIS CODES	SITUATIONAL. Required if a diagnosis other than the principal is made. Enter the ICD-9-CM codes for additional diagnoses.
68.	UNTITLED	OPTIONAL. No entry required.
69.	ADMITTING DIAGNOSIS	SITUATIONAL. Required for inpatient hospital claims. For inpatient hospital, enter the admitting diagnosis
70. A-C	PATIENT REASON DX	SITUATIONAL. Required if visit is unscheduled. Enter the diagnosis code representing the member's reason for the visit on all unscheduled outpatient visits.
71.	PPS CODE	OPTIONAL. No entry required.
72.	ECI	OPTIONAL. No entry required.
73.	UNTITLED	OPTIONAL. No entry required.
74.	PRINCIPAL PROCEDURE CODE, DATE	SITUATIONAL. Required for the principal surgical procedure. Enter the ICD-9-CM procedure code and surgery date, when applicable.
74. A-E	OTHER PROCEDURE CODES, DATES	SITUATIONAL. Required for additional surgical procedures. Enter the ICD-9-CM procedure codes and surgery dates.
75.	UNTITLED	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
76.	ATTENDING	Provider name and identifiers.
	NPI	REQUIRED. Enter the NPI of the attending physician. EXCEPTION: For outpatient care, enter the NPI of the referring physician. Leave blank if the primary physician did not make the referral. Do not show treating physician information in this area.
	QUAL	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
	LAST	REQUIRED. Enter the last name of the attending physician.
	FIRST	REQUIRED. Enter the first name of the attending physician.
77.	OPERATING	Provider name and identifiers.
	NPI	SITUATIONAL. Required if the physician performing the principal procedure is different than the attending physician. Enter the NPI of the operating physician.
	QUAL	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
	LAST	SITUATIONAL. Enter the last name of the operating physician.
	FIRST	SITUATIONAL. Enter the first name of the operating physician.
78.	OTHER	Provider name and identifiers.
	NPI	SITUATIONAL. Required if the member is in the lock-in program. Enter the NPI of the member's lock-in provider.
	QUAL	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
	LAST	SITUATIONAL. Enter the last name of the member's lock-in provider.
	FIRST	SITUATIONAL. Enter the first name of the member's lock-in provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
79.	OTHER NPI QUAL LAST FIRST	<p>Provider name and identifiers.</p> <p>SITUATIONAL. Required if the member is in the MediPASS program. Enter the NPI of the referring MediPASS physician.</p> <p>LEAVE BLANK. Entering information in this field will cause the claim to be returned.</p> <p>SITUATIONAL. Enter the last name of the referring MediPASS physician.</p> <p>SITUATIONAL. Enter the first name of the referring MediPASS physician.</p>
80.	REMARKS	<p>REQUIRED if a diagnosis other than the principal diagnosis is made. When applicable, enter one of the following:</p> <ul style="list-style-type: none"> • Not a Medicare benefit. • Resubmit (list the original filing date). • Member is retro eligible and NOD is attached. (Attach the Notice of Decision setting the member's eligibility date.)
81.	CC	<p>REQUIRED. Enter "B3" followed by the taxonomy code associated with the NPI of the billing entity (field 56).</p> <p>NOTE: The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the verified taxonomy code, go to imeservices.org</p>



2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click [here](#).)
- ◆ Complete the "attachment control number" with the same number submitted on the electronic claim. The IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ Do **not** attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise
P.O. Box 150001
Des Moines, IA 50315

Once the IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.



H. REMITTANCE ADVICES

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the *Medicaid Provider Application* at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*.

- ◆ The first appears as a credit to negate the claim;
- ◆ The second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.



An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Inpatient Remittance Advice

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code



	Field Name	Field Description
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Billed Amt.	Total billed amount of all claims within same claim type or status
S	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Non Cov Charges	Total non-covered charges within same claim type or status

1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card
2	Recipient ID Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Covered Period (From To)	First to last date of service on claim
5	DRG Code	Diagnosis-related group code (inpatient hospital claims only)
6	Cover Days	Number of covered days billed on claim
7	Billed Amt.	Total billed amount on claim
8	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
9	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
10	Non Cov Charges	Amount of non-covered charges on claim
11	Medical Record Num	Medical record number or patient account number
12	Subm/Reimb Diff	Difference between the amount billed and amount paid



3. Inpatient Crossover Remittance Advice

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Medicare Paid Amt.	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status



Field Name		Field Description
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
U	TIN	Total dollar amount allowed by Medicaid within same claim type or status
X	Mcaid Paid Amt.	Total amount Medicaid paid within same claim type or status

1	Patient Nme	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt.	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt.	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or patient account number
10	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



4. Outpatient Remittance Advice

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total "other sources" on claim (for example: TPL, spenddown)



	Field Name	Field Description
T	Total Non Cov Charges	Total non-covered charges within same claim type or status
U	TIN	Total dollar amount allowed by Medicaid within same claim type or status
V	Total Allowed Charge	Total allowed charge for claim
X	Total Paid by Mcaid	Total dollar amount paid within same claim type or status

1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Non Cov Charges	Total non-covered charges on claim
7	Allowed Charge	Allowed charge for claim
8	Paid by Mcaid	Dollar amount paid by Medicaid for claim
9	Medical Rec. No.	Medical record number assigned by provider
10	EOB	Explanation of benefits denial code for claim
11	Line	Line number on claim
12	Svc-Date	Date of service as billed on claim
13	Proc	CPT or HCPCS code billed on claim
14	APG/APC	APC code that line item is grouping to
15	Units	Number of units billed for each line item on claim
16	Billed Amt.	Billed amount for each line item on claim
17	Other Sources	Other sources for each line item on claim (for example: TPL)
18	Non Cov Charges	Non-covered charges for each line item on claim
19	Allowed Charge	Allowed charges for each line item billed on claim
20	APC-ST/DIS/PK/Weight	APC status indicator, discount formula, packaging flag, and weight. For more information, go to http://www.ime.state.ia.us/Providers/OutpatientHospital.html



Field Name		Field Description
21	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
22	EOB	Explanation of benefits denial reason code for each line



5. Outpatient Crossover Remittance Advice

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Medicare Paid Amt	Total dollar amount of Medicare payment



Field Name		Field Description
S	Deductible	Total deductible paid amount within same claim type or status
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
X	Mcaid Paid Amt	Total amount Medicaid paid within same claim type or status

1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or patient account number
10	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



6. Capitation Remittance Advice

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status



Field Name		Field Description
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total copayment on claim
8	Med Rcd Num	Account number assigned by the provider
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on line
15	Paid by Mcaid	Amount paid by Medicaid on line
16	Copay Amt.	Copayment amount on line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number



Field Name		Field Description
18	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
19	EOB	Explanation of benefits denial reason code