79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Ambulatory patient group (APG)" shall mean a group of similar outpatient procedures, encounters or ancillary services which are combined based on patient clinical characteristics and expected resource use. Data used to define APGs include ICD-9-CM diagnoses codes and CPT-4 procedure codes.

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

"APG relative weight" shall mean a number that reflects the expected resource consumption for cases associated with each APG, relative to the average APG. That is, the Iowa-specific weight for a certain APG reflects the relative charge for treating all singleton cases classified in that particular APG, compared to the average charge for treating all Medicaid APGs in Iowa hospitals.

"Assessment payment" shall mean an additional payment made to a hospital for only the initial assessment and determination of medical necessity of a patient for the purpose of determining if the ER is the most appropriate treatment site. This payment shall be equal to 50 percent of the customary reimbursement rate for CPT-4 code 99281 (Evaluation and Management of a Patient in the Emergency Room) as of December 31, 1994.

"Base year cost report" shall mean the hospital's cost report with fiscal-year-end on or after January 1, 1995, and prior to January 1, 1996, except as noted in paragraph *"s."* Cost reports shall be reviewed using Medicare's cost reporting and cost principles regulations for those cost reporting periods.

"Blended base amount" shall mean the case-mix adjusted, hospital-specific operating cost per visit associated with treating Medicaid outpatients, plus the statewide average case-mix adjusted operating cost per Medicaid visit, divided by two. This basic amount is the value to which add-on payments and inflation are added to form a final payment rate.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index.

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

"Consolidation" shall mean the process by which the APG classification system determines whether separate payment is appropriate when a patient is assigned multiple significant procedure APGs. All significant procedures within a single APG are suppressed (or grouped) for payment purposes, into one APG. Multiple, related significant procedures in different APGs are consolidated into the highest weighted APG for reimbursement purposes. Multiple, unrelated significant procedures in different APGs are not consolidated; thus, each receives separate payment.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in paragraph *"g"* and, thus, are eligible for additional payments above and beyond the base APG payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Direct medical education costs" shall mean a per visit add-on to the APG payment amount which shall compensate for costs associated with outpatient direct medical education of interns and residents. Costs associated with direct medical education are determined from the hospital base year cost reports and are inflated.

"Discounting" shall mean a reduction in standard payment when related procedures or ancillary services are performed during a single visit. Discount rates are defined in paragraph *"h."*

"Final payment rate" shall mean the blended base amount that forms the final dollar value used to calculate each provider's reimbursement amount, when multiplied by the APG weight. These dollar values are displayed on the rate table listing.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Grouper" shall mean the Version 2 Grouper software developed by Minnesota Mining and Manufacturing (3M) for the Health Care Financing Administration, with modifications for payable APGs made to support Medicaid program policy in Iowa. (See paragraph *"i."*)

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

"Inlier" shall mean those cases where the cost of treatment falls within the established cost boundaries of APG payment.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single UB-92 claim form, and which occur within 72 hours of initiation of service, with exceptions as noted in paragraph *"m."*

"Packaging" shall mean the inclusion of routinely performed ancillary services in the reimbursement of an APG. In the APG classification system, there are many routine, low-cost ancillary procedures or tests, such as routine urinalysis which are customarily ordered and performed during a visit. When this ancillary service is packaged, this indicates that the relative APG weight has been set to reflect the inclusion of the costs of the related ancillary procedures. The packaged APGs are 310 (plain film), 332 (simple pathology), 343 (simple immunology), 345 (simple microbiology), 347 (simple endocrinology), 350 (basic chemistry), 349 (simple chemistry), 351 (multichannel chemistry), 359 (urinalysis), 356 (simple clotting), 358 (simple hematology), 360 (blood and urine dipstick), 371 (simple pulmonary function tests), 373 (cardiogram), 383 (introduction of needles and catheter), 384 (dressings and other minor procedures), 385 (other ancillary procedures), and 321 (anesthesia).

"Peer review organization (PRO)" shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room.

"Rate table listing" shall mean a schedule of rate payments maintained by the department for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate APG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" shall mean the adjustment of all APG weights to reflect changes in relative resource consumption.

"Risk corridor" shall mean payment limits to prevent immediate large financial gains or losses for Iowa hospitals due to APG implementation.

"Significant procedure APG" shall mean a procedure which constitutes the reason for the visit and which dominates the time and resources expended during the visit.

"Singleton APG" shall mean those APGs on a patient claim which, following consolidation of significant procedures and packaging of ancillaries, are part of a visit with no remaining multiple significant procedures. These singletons, as well as medical and ancillary visits, are used to calculate relative weights in the procedure described in paragraph *"d."*

"Statewide visit expected payment (SVEP)" shall mean the expected payment for an outpatient visit, for use in defining cost outliers. This payment equals the sum of the statewide average case-mix adjusted operating cost per Medicaid visit multiplied by the relative weight for each valid APG within a visit (following packaging and discounting), which includes the applicable fee schedule amounts.

b. Determination of final payment rate amount. Each hospital's APG-based payment equals the hospital's case-mix index multiplied by the number of valid visits multiplied by the blended base amount. The blended base rate is then adjusted, so that statewide reimbursement equals statewide valid costs from cost reports. Payment is then recomputed using the adjusted blended base amount. The hospital's final APG payment amount reflects the sum of inflation adjustments to the blended base amount.

c. Trimming of outpatient charge data. Trimming of outliers from charge data is necessary to minimize the impact of coding errors and to ensure that charges for one unusual case do not bias the resulting weights. Trimmed data is not excluded from analysis; instead, values outside the trim points are reset, as described below. Standard deviation methodology is used to set trim points. For each APG, the mean charge and standard deviation are computed geometrically, based on all singleton occurrences of that APG. In a first pass, the trim points equal the mean charge, plus or minus two times the standard deviation for that APG. The mean charge and standard deviation are then geometrically computed again, with charges trimmed at the first pass trim points. The final low trim point equals the new mean charge minus 1.5 times the new standard deviation and, correspondingly, the final high trim point equals the new mean charge plus 1.5 times the new standard deviation.

d. Calculation of Iowa-specific relative weights and case-mix index. Using all applicable claims with dates of service occurring in the period July 1, 1994, through March 22, 1996, and paid through March 22, 1996, relative weights were calculated using all valid singleton claims, which had been trimmed at high and low trim points, as discussed in paragraph *"c."* Using all applicable claims with dates of service occurring within the individual hospital's 1995 fiscal year and paid through March 22, 1996, the hospital-specific case-mix indices were calculated using all valid singleton claims, which had been trimmed at the high and low trim points, as discussed in paragraph *"c."*

(1) A relative weight is determined for each APG through the following calculations:

1. The statewide geometric mean charge is determined for all singleton occurrences of each APG.

2. The statewide aggregate geometric mean charge is computed by summing the statewide geometric charge for all APGs and dividing by the total number of *APG* occurrences.

3. The statewide geometric mean charges for each APG are divided by the statewide aggregate geometric mean charge for all APGs to derive the Iowa-specific relative weight for each APG.

4. Relative weights for APGs which had low or no volume in the claims data, and those weights which were deemed too high or low by a committee of clinicians from the Iowa Foundation for Medical Care, shall be administratively adjusted.

5. The relative weights are then normalized, so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by summing the relative weights for each valid occurrence of an APG at that hospital and dividing by the number of valid Medicaid visits for that hospital.

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

(1) Calculation of statewide average case-mix adjusted cost per visit. The statewide average cost per visit is calculated by subtracting from the statewide total Iowa Medicaid outpatient expenditures: the total calculated dollar expenditures based on hospitals' base year cost reports for medical education costs, and, using valid claims, calculation of actual payments that will be made for outliers, fee scheduled laboratory services, and services known as noninpatient programs as set forth at 441—subrule 78.31(1), paragraphs *"g"* to *"n."* The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation) is divided by the statewide total number of Iowa Medicaid visits reported in the Medicaid management information system (MMIS).

(2) Calculation of hospital-specific case-mix adjusted average cost per visit. The hospital-specific case-mix adjusted average cost per visit is calculated by subtracting from the lesser of total Iowa 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 direct medical education costs for interns and residents and, using valid claims, calculation of actual payments that will be made for outliers, fee scheduled laboratory services and services known as noninpatient programs as set forth at 441—subrule 78.31(1), paragraphs *"g"* to *"n."* The remaining amount is case-mix adjusted, adjusted to reflect inflation and divided by the total number of Iowa Medicaid visits from the MMIS claims system or cost report, whichever is greater, for that hospital during the applicable base year.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per visit is added to the case-mix adjusted statewide average cost per visit and divided by two to arrive at a 50/50 blended base amount.

f. Payment add-ons. If applicable to the provider, direct outpatient costs associated with education of interns and residents will be added to the base APG amount prior to setting the final APG payment rate and shall be reimbursed to qualifying hospitals on a per claim basis if the claim has a first date of service prior to July 1, 1997. The amount added on reflects Iowa Medicaid's average cost per visit for hospital-specific direct medical education adjusted to case-mix. This add-on is determined from the base year cost reports and is adjusted to reflect inflation. For claims with a first date of service on or after July 1, 1997, all applicable reimbursement for graduate medical education shall be calculated and distributed according to policy at paragraph *"v."*

g. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding the following Medicaid criteria of cost outliers for each APG.

Cases qualify as cost outliers when costs of service in a given case exceed the cost threshold. For visits with a "statewide visit expected payment (SVEP)" equal to or between $150 and $700, this cost threshold is determined to be two times the statewide average APG-based payment or SVEP for that visit. For SVEPs greater than $700, the outlier cost threshold for a hospital outpatient visit equals the statewide average payment plus $500. There is no outlier threshold (or additional payment) for hospital visits with an SVEP less than $150. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base year cost reports. Additional payment for cost outliers is 60 percent of the excess between the hospital's cost for the visit and the cost threshold established to define cost outliers.

h. Discounting policy. The purpose of reducing standard payment for multiple procedures or ancillaries in a single visit is to encourage efficient provision of these services. The discount factor reflects the fact that fixed costs are reduced for multiple procedures. Examples of fixed costs are: operating room charges, anesthesia, and specimen collection. Claims for multiple medical visits within a 72-hour period and claims for services billed in "batches" (see paragraph *"m"*) are not subject to discounted payment. Multiple, nonconsolidated significant procedures will be paid at 100 percent of the expected APG payment for the procedure with the highest relative weight for that APG occurrence, 60 percent of next highest weighted APG payment for the second occurrence and 40 percent for the third or more occurrence. Multiple nonpackaged laboratory tests within the same APG will be paid at 100 percent of the expected APG payment for the first APG occurrence, and 80 percent of expected APG payment for each subsequent occurrence. Multiple, nonpackaged nonlaboratory ancillaries in the same APG will be paid at 100 percent of the expected APG payment for the first APG occurrence, 60 percent of expected APG payment for the second occurrence and 40 percent for the third or more occurrence.

Clinical laboratory testing performed by a hospital shall be paid using the Medicare fee schedule as set forth at rule 441—78.20(249A) in instances when the only procedure performed by the hospital is the collection or testing of the specimen.

i. Services covered by APG payments. Medicaid adopts the Medicare definition of outpatient hospital services at 42 CFR 414.32, as amended to September 15, 1992, which will be covered by the APG-based prospective payment system, except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from the Health Care Financing Administration (HCFA) to combine bills. Teaching hospitals having HCFA's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have filed the approval notice with the department's fiscal agent. Reasonable cost settlement for teaching physicians for those costs not included in the APG cost-finding process will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

Ambulance transportation will not be reimbursed by APG payment. A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and follow policy as specified at rule 441—78.11(249A) unless the recipient's condition results in an inpatient admission to the hospital. In the case of an inpatient admission, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate. Enrollment information and claim submission for ambulance services should be directed to the Medicaid fiscal agent.

Claims for all noninpatient services (NIP), including outpatient mental health, substance abuse, eating disorders, cardiac rehabilitation, pulmonary rehabilitation, diabetic education, pain management, and nutritional counseling, should be billed to Iowa Medicaid and will be paid under the respective NIP program on a fixed fee schedule.

Upon implementation of the managed mental health care program (MHAP), all psychiatric services for recipients with a primary diagnosis of mental illness, except for reference lab services and radiology services, in those eligibility groups targeted under the MHAP program will be the responsibility of the MHAP contractor and will not be otherwise payable by Iowa Medicaid. Emergency psychiatric evaluations for recipients who are covered by the MHAP program will be the responsibility of the contractor. For those recipients who are not covered by the MHAP program, services will be payable under either the APG for emergency psychiatric evaluation or under the respective NIP program. Additionally, laboratory services to monitor Clozaril are payable under the APG system only if the recipient is not MHAP eligible. Eligibility groups served under the managed substance abuse care plan (MSACP) program, will be the responsibility of the MSACP contractor and not payable through the APG system. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APG.

Claims for the following APGs, as defined in Version 2 of the Grouper software, will not be accepted by Iowa Medicaid for payment: APG 005—Nail Procedures, APG 171—Artificial Fertilization, APG 212—Fitting of Contact Lenses, APG 386—Biofeedback and hypnotherapy, and APG 382—Provision of vision aids.

Claims grouping into APG 702 (Well Child Exam) shall meet all early and periodic screening, diagnosis and treatment requirements as set forth at rule 441—84.3(249A).

j. System implementation, rebasing, and recalibration. For state fiscal years 1995 and 1996, a risk corridor has been established to ensure that APG payments to each hospital will not be less than 95 percent or greater than 105 percent of Medicaid allowable costs. For the state fiscal year 1997, a risk corridor has been established to ensure that hospital payments will not be less than 90 percent or greater than 110 percent of Medicaid allowable costs.

Periodic interim payments, made quarterly to ensure adequate cash flow to hospitals during the transition, will begin 30 days after the quarter ending March 31, 1995. No periodic interim payment will be made to any hospital within the corridor limits. Money may also be requested to be refunded if an overpayment exists.

The APG system will be rebased and recalibrated every three years beginning October 1, 1996. Cost reports used will be hospital fiscal year-end reports within the calendar year ending no later than December 31, 1995. Case-mix indices shall be calculated using valid claims most nearly matching each hospital's fiscal year end.

k. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average case-mix adjusted base amount or the Iowa statewide average case-mix adjusted base amount blended with the hospital-specific base amount. Hospitals that submit a cost report with data for Iowa Medicaid patients only, no less than 120 days prior to rebasing, will receive a case-mix adjusted blended base rate using hospital-specific Iowa only Medicaid data and the Iowa statewide average cost per visit amount. If a hospital qualifies for reimbursement for the direct medical education component under Medicare guidelines, it shall qualify for this add-on component for reimbursement purposes in Iowa. Hospitals wishing to submit the HCFA 2552 (or HCFA accepted substitute) cost report must do so within 60 days from the date of patient visit to the state of Iowa's fiscal agent. Hospitals which elect to submit cost reports for the determination of blended rates shall submit new reports to the department's fiscal agent on an annual basis within 90 days of the close of the hospital's fiscal year end. When audited, finalized reports become available from the Medicare intermediary, the facility may submit them to the Iowa Medicaid fiscal agent.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services which require preadmission or preprocedure approval by the PRO are updated yearly and are available from the PRO. The hospital shall provide the PRO authorization number on the UB-92 claim form to receive payment. Claims submitted for payment without this authorization number will be denied. To safeguard against other inappropriate practices, the department, through the PRO, 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 PRO regulations.

m. Hospital billing. Hospitals shall normally submit a UB-92 claim, with all services occurring within a 72-hour period, for APG reimbursement to the fiscal intermediary after a patient's outpatient "visit" is complete. Payment for outlier costs is determined when the claim is filed with the fiscal agent, as described in paragraph *"g."* However, the following exceptions are allowed:

(1) Bills for multiple visits may be submitted on a single claim for the following services: noninpatient units (substance abuse, pain management, nutritional counseling, diabetic education, pulmonary rehabilitation, cardiac rehabilitation, eating disorders and mental health), physical, occupational and speech therapies, chemotherapy, radiation therapy, and renal dialysis. For these services, each unit of service on the UB-92 claim form will be considered a separate visit.

(2) Bills for multiple medical encounters (for unrelated diagnoses), such as clinic visits, occurring within a 72-hour period shall be submitted on separate UB-92 claim forms in order to generate full APG payment for these encounters. In the case of hospital-based clinics where multiple, unrelated medical visits occur on the same day, an individual claim form will need to be filed for each separate visit.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the PRO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

p. Cost report adjustments. Hospitals with 1995 cost reports adjusted by Medicare through the cost settlement process for cost reports applicable to the APG base year, may appeal to the department the hospital-specific base and add-on costs used in calculating the Medicaid APG rates if the Medicare adjustment results in a material change to the rate. Any appeal of the APG rate due to Medicare's adjustment process must be made in writing to the department within 30 days of Medicare's finalization and notification to the provider. If the provider does not notify the department of the adjusted amounts within the 30-day period, no costs shall be reconsidered for adjustment by Iowa Medicaid. Claims adjustment reflecting the changed rates shall only be made to claims that have been processed within one year prior to the notification from the provider or the beginning of the rebasing period, whichever is less.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Upon implementation of a managed mental health care program, mental health NIP services will become the responsibility of the managed mental health contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Payment for outpatient services delivered in the emergency room shall be based on the following criteria. All visits to hospital emergency rooms by Medicaid beneficiaries which do not result in inpatient admission shall result in the hospital receiving payment, at a level to be determined by the department, for patient assessment. All treatment conducted in the emergency room for either a regular Medicaid recipient or a Medipass participant, for conditions defined as emergent in accord with diagnoses codes found in the provider manual, shall receive the full APG payment plus the assessment payment. If a regular Medicaid patient is referred by a non-emergency room based physician, as documented in the record and on the claim, and is treated in the emergency room but does not have an emergency diagnosis, the hospital shall receive the assessment payment plus 75 percent of the APG payment. If the patient is assessed in the emergency room, found to be nonemergent and referred for further treatment to a hospital-based clinic, regular clinic, physician's office, or other similar site, only the assessment payment shall be made to the hospital for the emergency room. The responsible clinic or physician's office shall subsequently bill for any additional services provided. If the patient is not referred by a physician and does not have an emergent condition, but was treated in the emergency room setting, the hospital will receive 50 percent of the APG payment plus an assessment payment.

For Medicaid beneficiaries participating in the Medipass program, an assessment payment plus 75 percent of the full APG payment shall be paid for treatment of nonemergent conditions contingent upon documentation in the claim and medical record of permission or referral from the recipient's primary care physician. Should treatment for nonemergent conditions be provided to Medipass participants without this documentation, payment shall consist only of the assessment payment. When a Medipass patient is treated in a hospital-based clinic and that clinic is the Medipass patient manager, the full APG payment will be made. When the patient is treated in a hospital-based clinic, the clinic is not the patient manager and has not obtained the permission of the recipient's patient manager to perform the treatment, no payment shall be made to the clinic.

s. Rescinded IAB 7/31/96, effective 10/1/96.

t. Limitations on payments. Ambulatory patient groups, as well as other outpatient services, are subject to upper limits rules set forth in Sections 42 CFR 447.321 and 447.325 as amended to July 28, 1987. Requirements under these sections state that in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare. In aggregate, the total Medicaid payments may not exceed the total payments received by all providers from recipients, carriers or intermediaries for providing comparable services under comparable circumstances under Medicare.

u. PRO review. For outpatient claims with dates of service ending July 1, 1994, and after, the PRO will review a yearly random sample of at least 500 hospital outpatient service cases performed for Medicaid recipients and identified on fiscal agent claims data from all Iowa and bordering state hospitals. The PRO will perform review activities on all APG categories for concerns relating to admission review, quality review, and APG validation. Questionable cases will be referred to a physician reviewer for concerns relating to medical necessity and quality of care. The PRO will also conduct a retrospective review of hospital claims assessing observation bed status lasting more than 24 hours. The review will consist of an evaluation for the appropriateness of the admission and continued stay in the observation bed status. Questionable cases will be referred to a physician reviewer for determination of the medical necessity.

When a review identifies a potential adverse determination by the PRO, an initial letter informing the provider about the adverse action will be sent and the provider will be given an opportunity to submit additional information about the case. This information will be taken into account prior to the final review determination. If the final review decision is upheld, a final letter will be sent to all parties. A reconsideration process will be available to all parties when there are payment consequences associated with the decision. The fiscal agent will be notified of all decisions resulting in payment consequences and appropriate adjustments will be made to claims.

Hospitals with cases under review must submit all requested supporting data from the medical record to the PRO within 60 days of receipt of the request or payment for those services may be recouped and forfeited. The hospital may request a review by submitting documentation to the PRO within 365 calendar days of the claim adjudication date. If a request is not filed by the hospital within that time, the hospital loses the right to appeal or contest that payment.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The amount in the fund and distributions from the fund shall be calculated as follows:

(1) Allocation for direct medical education. To determine the total amount of funding that will be allocated to the graduate medical education and disproportionate share fund, the department shall:

1. Sum all direct medical education add-on payments for outpatient services using claims reimbursed to qualifying providers with the first date of service on or after October 1, 1996, prior to March 31, 1997, and paid through June 30, 1997. These amounts shall then be multiplied by two to annualize the amount of money to be placed in the fund for distribution and the total amount of computed reimbursement shall be allocated to the fund.

2. Sum all direct medical education add-on payments for outpatient services, using claims reimbursed to qualifying providers, when those claims have been used as a basis for the calculation of capitation rates and reimbursement with any health maintenance organization (HMO) or other prepaid health plan with which the department has entered into a contract effective on or after July 1, 1997.

For each prepaid health plan, divide the total dollar reimbursement from claims by the number of member months applicable to the rate-setting methodology for the per member per month (PMPM) allocation to calculate the amount of reimbursement to be allocated to the fund that represents capitation rate reimbursement allocation for direct medical education. The direct medical education PMPM allocation shall then be multiplied by the total number of members enrolled in the plan for state fiscal year 1997, allocating that amount of money to the fund.

3. Trend the total allocation for direct medical education (which includes money for both the fee for service population and the capitated risk-based population, calculated under numbers "1" and "2" above) forward using annually appropriated legislative update factors and determine the total amount of money that shall be allocated to the graduate medical education and disproportionate share fund for direct medical education Medicaid reimbursement. No adjustments shall be made to this fund beyond appropriated amounts.

(2) Distribution of direct medical education. Distribution of the fund for direct medical education shall be on a quarterly basis beginning October 1, 1997, and shall be calculated by taking the previous fiscal year's percentage allocation of direct medical education reimbursement (based upon paid outpatient claims to qualifying hospitals) and multiplying that percentage by the amount in the fund for direct medical education.

If a hospital fails to qualify for the provision of medical education under Medicare regulations, the amount of money that would have been allocated that hospital shall be removed from the total fund.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Money shall be added to or subtracted from the graduate medical education and disproportionate share fund, when the average monthly Medicaid population deviates from the previous year's averages by greater than 5 percent. The average annual population (expressed in a monthly total) shall be determined on June 30 for both the previous and current years by adding the total enrolled population for all respective months from both years' B-1 MARS report and dividing each year's totals by 12. If the average monthly number of enrolled persons for the current year is found to vary more than 5 percent from the previous year, a PMPM amount shall be calculated for each component (using the average number of eligibles for the previous year calculated above) and an annualized PMPM adjustment shall be made for each eligible person that is beyond the 5 percent variance.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) Grounds for sanctioning providers. Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

u. Failure to repay or reach written agreement for the repayment of overpayments or other erroneous payments within 60 days of receipt of the overpayment.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Health Care Financing Administration, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Health Care Financing Administration and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claim prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Medicaid fiscal agent. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

(1) Seriousness of the offense.
(2) Extent of violations.
(3) History of prior violations.
(4) Prior imposition of sanctions.
(5) Prior provision of provider education.
(6) Provider willingness to obey program rules.
(7) Whether a lesser sanction will be sufficient to remedy the problem.
(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment whether personally or through claims submitted by any clinic, group, corporation, or other association to the department or its fiscal agent for any services or supplies provided under the medical assistance program except for those services provided prior to the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided prior to the suspension or termination.

d. When the provisions of paragraph 79.2(5)"*c*" are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,
b. The known dollar value of the discrepancies or violations,
c. The method of computing the dollar value,
d. Notification of further actions to be taken or sanctions to be imposed by the department, and

e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

This rule is intended to implement Iowa Code section 249A.4.

441—79.3(249A) Maintenance of fiscal and clinical records by providers of service. The fiscal and clinical records shall be maintained for a minimum of five years from when a charge was made to the program. After five years the fiscal and clinical records may be destroyed.

79.3(1) Fiscal records. Providers of service shall maintain fiscal records in support of services for which a charge is made to the program and shall make the records available to the department or its duly authorized representative on request. The fiscal records shall support each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

79.3(2) Clinical records. Providers of service shall maintain complete and legible clinical records for which a charge is made to the program documenting that the services are medically necessary, the services are consistent with the diagnosis of the patient's condition, and the services are consistent with professionally recognized standards of care. Providers shall make the records available to the department or its duly authorized representative on request. The documentation for each patient encounter shall include the following when appropriate:

a. Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.

b. Specific procedures or treatments performed.

c. Medications or other supplies.

d. Patient's progress, response to and changes in treatment, and revision of diagnosis.

e. Information necessary to support each item of service reported on the Medicaid claim form.

79.3(3) Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment.

79.3(4) Medicaid providers contracted under 441—Chapter 152 are not subject to subrules 79.3(1), 79.3(2), and 79.3(3).

This rule is intended to implement Iowa Code section 249A.4.

441—79.4(249A) Appeal by provider of care. Providers may appeal decisions of the department according to rules in 441—Chapter 7, Iowa Administrative Code.

This rule is intended to implement Iowa Code section 249A.4.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form XIX (PA-1), Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services re Participation in the Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program. Rehabilitative treatment service providers wishing to participate in the program shall execute an agreement with the department on Form 470-3052, Rehabilitative Treatment and Supportive Services Contract.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson, and a vice-chairperson.

a. Elections will be held the first meeting after the beginning of the calendar year.

b. The term of office shall be two years. Officers shall serve no more than two terms for each office.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a nominating committee of not less than three members and shall appoint other committees approved by the council.

79.7(2) *Alternates.* Each organization represented may select one alternate as representative when the primary appointee is unable to be present. Alternates may attend any and all meetings of the council, but only one representative of each organization shall be allowed to vote.

79.7(3) *Expenses.* The travel expenses of the public representatives and other expenses, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations.

79.7(4) *Meetings.* The council shall meet at least four times each year. At least two of these meetings shall be with the department of human services. Additional meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the commissioner of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of such meetings. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and alternate and to the executive office of each organization or body represented.

d. Notice shall be made to the representing organization when the member, or alternate, has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties. The medical assistance advisory council shall:

a. Make recommendations on the reimbursement for medical services rendered by providers of services.

b. Assist in identifying unmet medical needs and maintenance needs which affect health.

c. Make recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

d. Reserved.

e. Reserved.

f. Recommend ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

g. Advise on such administrative and fiscal matters as the commissioner of the department of human services may request.

h. Advise professional groups and act as liaison between them and the department.

i. Report at least annually to the appointing authority.

j. Perform other functions as may be provided by state or federal law or regulation.

k. Communicate information considered by the council to the member organizations and bodies.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the member organizations and bodies. The department will consider all advice and counsel of the council.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, regulations, laws, and guidelines, for its information, review, and comment.

e. The department shall present the biennial budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members and alternates on the council.

441—79.8(249A) Requests for prior authorization. When the fiscal agent has not reached a decision on a request for prior authorization after 60 days from the date of receipt by the fiscal agent, the request will be approved.

79.8(1) Requests for prior approval for any items or procedures other than prescription drugs shall be made using Form XIX P Auth, Request for Prior Authorization. For prior authorization of prescription drugs, requests may be made by telephone, facsimile (fax) or mail. Requests for prior authorization made by fax or by mail shall be made using Form XIX Drug P Auth, Request For Drug Prior Authorization.

Requests for prior approval shall be sent to Consultec, Inc., P.O. Box 14422, Des Moines, Iowa 50306-3422. The request should include the relevant criteria applicable to the particular service, medication or equipment, for which prior approval is sought, according to the criteria outlined in rule 441—78.28(249A). Copies of history and examination results may be attached rather than incorporated in the letter.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests. In the case of prescription drugs, the requesting provider shall be notified of approval or denial using the same manner of transmission as the request, if possible, or by mail. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limitation will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) Unless the prior authorization request is made for prescription drugs, recipients shall receive a notice of decision upon a denial of request for prior approval pursuant to 441—Chapter 7. The notice of decision to the recipient, Form MA-3028, shall be mailed within five working days of the date the prior approval form is returned to the provider. In the case of prior authorization for drugs, no notice of denial will be issued to recipients.

79.8(10) If a request for prior approval is denied by the fiscal agent, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

This rule is intended to implement Iowa Code section 249A.4.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Foundation for Medical Care (IFMC) as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee or the hospital will contact the IFMC to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IFMC and instructions in the Medicaid provider's manual.

79.10(2) Medicaid payment will not be made to the hospital if the IFMC denies the procedure requested in the preadmission review.

79.10(3) A letter of denial will be issued by the IFMC to the patient, physician and hospital when a request is denied. The patient, physician or hospital can request a reconsideration of the decision by filing a written request with the IFMC within 60 days of the date of the denial letter.

79.10(4) A denial by the IFMC of a request for reconsideration can be appealed by the aggrieved party to the department according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Foundation for Medical Care (IFMC) conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) Approval must be requested by the physician from the IFMC when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid providers' manual.

All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid providers' manual and instructions issued to providers by the IFMC.

79.11(2) The physician shall be issued a validation number for each request by the IFMC and advised if payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IFMC does not give approval.

79.11(4) A denial letter will be issued by the IFMC to the patient, physician and facility when the requested procedure is not approved. The patient, physician or facility can request a reconsideration of the decision by filing a written request with the IFMC within 60 days of the date of the denial letter.

79.11(5) A denial letter of a request for reconsideration by the IFMC can be appealed by the aggrieved party to the department in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to February 28, 1992. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application forms. All providers of medical services interested in enrolling as Medicaid providers shall begin the enrollment process by contacting the fiscal agent at Provider Enrollment, CONSULTEC, Inc., P.O. Box 14422, Des Moines, Iowa 50306-3422, to request an application, with the following exceptions: nursing facility providers shall complete the process set forth in rule 441—81.13(249A) and intermediate care facilities for the mentally retarded shall complete the process set forth in rule 441—82.3(249A). CONSULTEC shall send the provider the appropriate application forms for completion as set forth below.

a. The following institutional providers shall complete the Institutional Medicaid Provider Enrollment, Form 470-2967:

(1) Ambulatory surgical centers.
(2) Home health agencies.
(3) Hospital and swing beds.
(4) Medicare-certified skilled facilities.
(5) Nursing facilities for the mentally ill.
(6) Psychiatric hospitals.
(7) Psychiatric medical institutions for children.
(8) Rehabilitation agencies. Rehabilitation agencies shall also complete Form 470-2971, Rehabilitation Agency Information Sheet.
(9) Inpatient and outpatient general hospitals. Inpatient and outpatient general hospitals shall also complete Form 2977, Supplemental Hospital Information.

b. The following noninstitutional Medicaid providers shall complete the Noninstitutional Medicaid Provider Application, Form 470-2966:

(1) Ambulances.
(2) Area education agencies.
(3) Audiologists.
(4) Birth centers.
(5) Chiropractors.
(6) Clinics.
(7) Community mental health centers. Community mental health centers shall also complete Form 470-2970, Group Practice Information.
(8) Dentists.
(9) Durable medical equipment and supply dealers.

(10) Early and periodic screening centers.

(11) Family or pediatric nurse practitioners.

(12) Family planning clinics.

(13) Federally qualified health centers. Federally qualified health centers shall also complete Form 470-2969, Federally Qualified Health Professionals Listing, and submit a copy of their federal grant.

(14) Genetic consultation clinics.

(15) Hearing aid dealers.

(16) Independent laboratories.

(17) Maternal health centers. Maternal health centers shall also complete Form 470-2970, Group Practice Information.

(18) Nurse midwives.

(19) Orthopedic shoe dealers.

(20) Opticians.

(21) Optometrists.

(22) Physical therapists.

(23) Physicians.

(24) Podiatrists.

(25) Providers of prescribed drugs.

(26) Psychologists. Psychologists not on the National Register of Health Service Providers shall also complete Form 470-2968, Equivalency Form.

(27) Rural health clinics.

c. Hospices, health maintenance providers (HMOs), case management providers, and enhanced service providers shall submit Form 470-2976, Medicaid Provider Application for Hospices, HMOs, and Enhanced Service Providers.

d. Certified registered nurse anesthetists shall submit Form 470-2972, Medicaid Provider Application for Certified Registered Nurse Anesthetists.

e. All HCBS waiver providers shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date. Consultec shall forward the application to the department for processing.

f. and *g.* Rescinded IAB 12/3/97, effective 2/1/98.

h. Rehabilitative treatment service providers shall complete Form 470-3052, Rehabilitative Treatment and Support Services Contract.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the fiscal agent.

79.14(3) Notification. Providers shall be notified of the decision on their application by the fiscal agent within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the fiscal agent.

79.14(6) Providers approved for certification as a Medicaid provider shall complete Form 470-2965, Medicaid Provider Agreement.

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the department's fiscal agent and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the fiscal agent. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

This rule is intended to implement Iowa Code section 249A.4.

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