"Base year cost report" shall mean the hospital's cost report with fiscal-year-end on or after January 1, 1998, and prior to January 1, 1999, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which add-on payments for inflation, capital costs, direct medical education costs, and costs associated with treating a disproportionate share of poor patients and indirect medical education are added to form a final payment rate.

"Blended capital costs" shall mean hospital-specific capital costs, plus statewide average capital costs, divided by two.

"Capital costs" shall mean an add-on to the blended base amount which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital 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 cases treated in a hospital compared to the statewide average.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports, and is inflated and case-mix adjusted in determining the direct medical education rate. On or after July 1, 1997, payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (HCFA 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is further divided by the hospital's case-mix index, then is divided by net discharges. This formula is limited by funding availability that is legislatively appropriated.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"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 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.

"Indirect medical education costs" shall mean costs that are not directly associated with running a medical education program, but that are incurred by the facility because of that program. Types of these costs would be costs of maintaining a more extensive library to serve educational needs.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

"Medicaid-certified unit" shall mean a hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified for operation by the Iowa department of inspections and appeals on or after October 1, 1987, and is certified for reimbursement according to procedures contained in 79.1(5)*"r"* by the Iowa Medicaid fiscal agent.

These units may be certified for operation by the Iowa department of inspections and appeals, acting on behalf of the state of Iowa, or Medicare. Neonatal units may be certified using standards adopted by the Iowa department of public health and set forth by the American Academy of Pediatricians in "Recommendations Based on Standards for Hospital Care of the Newborn Infant."

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"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; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

"Rate table listing" shall mean a schedule of rate payments 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 DRG 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 DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

"Transfer" shall mean the movement of a patient from a bed in a non-Medicaid-certified unit of a hospital to a bed in a Medicaid-certified unit of the same hospital or to another hospital.

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Medicaid-certified substance abuse units. Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in Medicaid-certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age Medicaid-certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only Medicaid-certified substance abuse units. Hospitals with these units are reimbursed using the weight that reflects the age of each patient.

(2) Neonatal intensive care units. Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Medicaid-certified psychiatric units. Four sets of DRG weights are developed for DRGs concerning psychiatric treatment. The first set of weights reflects charges associated with the treatment of adult psychiatric patients in Medicaid-certified psychiatric units. The second set of weights reflects charges associated with the treatment of adolescent patients in mixed-age Medicaid-certified psychiatric units. The third set of weights reflects charges associated with the treatment of adolescent patients in designated adolescent-only Medicaid-certified psychiatric units. The fourth set of weights reflects charges associated with the treatment of psychiatric patients in hospitals without Medicaid-certified psychiatric units. Hospitals are reimbursed using the weight that reflects the patient's age and the setting for psychiatric treatment.

c. Calculation of Iowa-specific weights and case-mix index. Using all applicable claims for the period January 1, 1997, through December 31, 1998, and paid through March 31, 1999, the recalibration will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment and including transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 1997, to December 31, 1998, and paid through March 31, 1999. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's 1998 fiscal year and paid through March 31, 1999, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period.

d. Calculation of blended base amount. The DRG 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 discharge. The statewide average 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, medical education costs, and calculation of actual payments that will be made for additional transfers, outliers, physical rehabilitation services, and indirect medical education. 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.

(2) Calculation of hospital-specific case-mix adjusted average cost per discharge. The hospital-specific case-mix adjusted average cost per discharge 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 capital costs, direct medical education costs, the payments that will be made for nonfull DRG transfers, outliers, and physical rehabilitation services if included. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

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

e. Add-on to the base amount. One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount prior to setting the final payment rate schedule. 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 Iowa Medicaid patients. Allowable capital costs are determined by multiplying the capital amount from the base year cost report by 80 percent. 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 will be subject to a reduction in their capital add-on to equal the first standard deviation.

(2) Direct medical education costs. Rescinded IAB 5/30/01, effective 8/1/01.

(3) Disproportionate share adjustment. Rescinded IAB 5/30/01, effective 8/1/01.

(4) Indirect medical education costs. Rescinded IAB 5/30/01, effective 8/1/01.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The PRO will select a 10 percent random sample of outlier cases identified on fiscal agent claims data from all Iowa and bordering state hospitals. At least one case every six months per facility will be selected for review if available.

Staff will review the cases to perform admission review, quality review, discharge review, and DRG validation. Questionable cases will be referred to a physician reviewer for medical necessity and quality of care concerns. Day outlier cases will be reviewed to identify any medically unnecessary days which will be "carved out" in determining the qualifying outlier days. Cost outlier cases will be reviewed for medical necessity of all services provided and to ensure that services were not duplicately billed, to determine if services were actually provided, and to determine if all services were ordered by a physician. The hospital's itemized bill and remittance statement will be reviewed in addition to the medical record.

On a quarterly basis, the PRO will calculate denial rates for each facility based on completed reviews during the quarter. All outlier cases reviewed will be included in the computation or error rates. Cases with denied charges which exceed $1000 for inappropriate or nonmedically necessary services or days will be counted as errors.

Intensified review may be initiated for hospitals whose error rate reaches or exceeds the norm for similar cases in other hospitals. The error rate is determined based on the completed outlier reviews in a quarter per hospital and the number of those cases with denied charges exceeding $1000. The number of cases sampled for hospitals under intensified review may change based on further professional review and the specific hospital's outlier denial history.

Specific areas for review will be identified based on prior outlier experience. When it is determined that a significant number of the errors identified for a hospital is attributable to one source, review efforts will be focused on the specific cause of the error. Intensified review will be discontinued when the error rate falls below the norm for a calendar quarter. Providers will continue to be notified of all pending adverse decisions prior to a final determination by the PRO. 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 be notified in writing. Hospitals with cases under review must then submit all supporting data from the medical record to the PRO within 60 days of receipt of the outlier review notifications, or outlier payment will be recouped and forfeited.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the greater of 23 days of care or two standard deviations above the average statewide length of stay for a given DRG. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean 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 will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to PRO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, 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 determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost to charge ratios determined in the base year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid. Those hospitals that are notified of any outlier review initiated by the PRO must submit all requested supporting data to the PRO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the PRO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Medicaid-certified substance abuse and psychiatric units. When a patient is discharged to or from an acute care hospital and is admitted to or from a Medicaid-certified substance abuse or psychiatric unit, both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Medicaid-certified physical rehabilitation units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a Medicaid-certified rehabilitation unit and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a physical rehabilitation unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in Medicaid-certified physical rehabilitation units which are paid per diem.

i. Payment for Medicaid-certified 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.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's cost report for the hospital's 1998 fiscal year. No recognition will be given to the professional component of the hospital-based physicians except as noted under 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. 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. Teaching hospitals having Medicare'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 the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient 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. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration. Inflation of base payment amounts by the Data Resources, Inc. hospital market basket index shall be performed annually, subject to legislative appropriations. Base amounts shall be rebased and weights recalibrated every three years. The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were 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.

m. 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 blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. For those hospitals that wish to submit a cost report no less than 120 days prior to rebasing using data for Iowa Medicaid patients only, that provider 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. Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."* If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph *"y."* Hospitals that wish to submit the HCFA 2552 (or HCFA accepted substitute) cost report must do so within 60 days from the date of patient discharge to the state of Iowa's fiscal agent. Hospitals that elect to submit cost reports for the determination of blended rates must submit new reports on an annual basis within 150 days of the close of the hospital's fiscal year end. When audited, finalized reports become available from the Medicare intermediary, these should be submitted to the Iowa Medicaid fiscal agent.

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare PRO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the PRO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the PRO. Inpatient or outpatient services which require preadmission or preprocedure approval by the PRO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the PRO to the fiscal agent and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and 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.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the fiscal agent after a patient's discharge. Payment for outlier days or costs is determined when the claim is paid by the fiscal agent, as described in paragraph *"f."* When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Administrator, Division of Medical Services, Iowa Department of Human Services, 1305 East Walnut, Des Moines, Iowa 50309-0114, and shall include the patient's name, state identification number, date of admission, brief summary of the case, current listing of charges, and physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days. A departmental employee will then contact the facility to assist the facility in filing the interim claim.

p. 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, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa foundation for medical care (IFMC) to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IFMC and cannot be found to be medically necessary on other grounds, 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.

q. 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 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.

r. Certification of special units. Medicaid certification of substance abuse, psychiatric and rehabilitation units is based on the Medicare reimbursement criteria for these units. Neonatal units are certified using standards adopted by the department of public health in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. In Iowa, the department of inspections and appeals is responsible for Medicaid certification of these units for in-state hospitals.

Additional certification for reimbursement by the Iowa Medicaid fiscal agent is required for reimbursement of physical rehabilitation services on a per diem basis, for reimbursement of psychiatric or substance abuse services in adolescent-only or adult-only units, and for reimbursement of neonatal units as a level II or level III unit. To receive additional certification, the Medicare PPS exemption notice must be forwarded to the Iowa Medicaid fiscal agent every fiscal year when it becomes available. Supplemental Form 2977, indicating all the various certified programs for which the hospital may become certified, must also accompany the PPS exemption notice. This form will be available from the fiscal agent as part of the enrollment process or on request. Hospitals that elect to receive additional certification for substance abuse units must submit approved documentation of the Iowa substance abuse inspection to the Medicaid fiscal agent, plus additional documentation of the specific substance abuse programs available at the facility, staffing, facility information, treatment standards, and description of the population served by the facility. The Medicaid fiscal agent will notify the facility of the additional reimbursement certification for the provider after review of those documentation submissions. The additional reimbursement certification will be retroactive to the first day of the month during which the application is received by the Medicaid fiscal agent. Hospitals that have had additional reimbursement certification prior to July 1, 1993, do not have to reapply for certification by Medicaid but must submit the appropriate PPS exemption notices as they become due and available.

An out-of-state hospital may receive Medicaid-certified unit status as a qualifying psychiatric unit when the unit is eligible for reimbursement under the Medicare prospective payment system. Out-of-state hospitals must submit a copy of the Medicare PPS exemption notice to the Iowa Medicaid fiscal agent in order to receive Medicaid certification as a substance abuse unit or certification for reimbursement as an adolescent-only or adult-only psychiatric unit. Neonatal units are accepted as being certified when the hospital is inspected by the home state agency responsible for licensing, using standards set forth by the American Academy of Pediatrics for newborn care and that notice is forwarded to the Medicaid fiscal agent for reimbursement certification as a level II or level III neonatal unit. Out-of-state hospitals are not recognized as having special units for substance abuse or physical rehabilitation treatment. Reimbursement for physical rehabilitation is through the DRG payment. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment. There will be no retroactive payment adjustment made (to a certified higher level payment) when the hospital fails to make timely application for reimbursement certification.

s. Cost report adjustments. Hospitals with cost reports adjusted by Medicare through the cost settlement process on or after October 1, 1996, may appeal to the department the hospital-specific base amount and add-ons used in calculating the Medicaid DRG payment, if the Medicare adjustment results in material changes to the rates. Any appeal of the DRG 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.

t. Limitations and application of limitations on payment. Diagnosis related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 26, 1991.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(1) Except as provided in subparagraph (2) below, the department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(2) The department may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

(3) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. Rescinded IAB 5/30/01, effective 8/1/01.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(5)"*y*"(3), 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, 2000, through June 30, 2001, is $8,314,810. Adjustments may be made to this amount for inflation, subject to legislative appropriations, and for utilization increases as established in paragraph 79.1(5)"*z.*"

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall 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, 1999, through June 30, 2000, 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. The dollar values for each hospital are summed, then each hospital's dollar value is divided by the total dollar value, resulting in a percentage. Each hospital's percentage is multiplied by the amount allocated for direct medical education to determine the payment to each hospital. Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. If a hospital fails to qualify for direct medical education payments from the fund because it 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 shall be removed from the fund.

(4) Qualifying for indirect medical education. 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.

(5) Allocation to fund for indirect medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(6), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education for July 1, 2000, through June 30, 2001, is $14,599,413. Adjustments may be made to this amount for inflation, subject to legislative appropriations, and for utilization increases as established in paragraph 79.1(5)*"z."*

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall 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, 1999, through June 30, 2000, 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. The dollar values for each hospital are summed, then each hospital's dollar value is divided by the total dollar value, resulting in a percentage. Each hospital's percentage is multiplied by the amount allocated for indirect medical education to determine the payment to each hospital. Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. If a hospital fails to qualify for indirect medical education payments from the fund because it 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 shall be removed from the fund.

(7) Qualifying for disproportionate share. Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent or when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate. For those 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 shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. For those 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 shall be 2½ percent. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals. Information contained in the hospital's available 1998 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

Additionally, a qualifying 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-eligible persons who are in need of obstetric services. In the case of 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.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the 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.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

(8) Allocation to fund for disproportionate share. The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments for July 1, 2000, through June 30, 2001, is $6,978,925. Adjustments may be made to this amount for inflation, subject to legislative appropriations, and for utilization increases as established in paragraph 79.1(5)*"z."*

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall 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, 1999, through June 30, 2000, for each qualifying hospital by each hospital's disproportionate share rate to obtain a dollar value. The dollar values for each hospital are summed, then each hospital's dollar value is divided by the total dollar value, resulting in a percentage. Each hospital's percentage is multiplied by the amount allocated for disproportionate share to determine the payment to each hospital. Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments pursuant to paragraph 79.1(5)*"ab"* cannot exceed the amount of the federal cap under Public Law 102-234.

z. 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 en-rolled 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 per member per month (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.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid prior to adjustment that exceed reasonable costs shall be recovered by the department. The base rate upon which the DRG and APG 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 recipients for the coming year using the most recent utilization as submitted to the fiscal agent and Medicare cost principles.

ab. Supplemental indirect medical education and supplemental disproportionate share. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all hospitals qualifying for supplemental indirect medical education and supplemental disproportionate share payments. The requirements to receive supplemental payments, the amounts available, and the methodology used for determining payments are as follows:

(1) Qualifying for supplemental indirect medical education. Hospitals qualify for supplemental indirect medical education payments by receiving a direct medical education payment from Iowa Medicaid, qualifying for an indirect medical education payment from Medicare, being an Iowa state-owned hospital with more than 500 beds, and having eight or more separate and distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Available amount for supplemental indirect medical education. The total amount of funding that is available for supplemental indirect medical education for July 1, 2000, through June 30, 2001, is $24,834,207. Adjustments made to this amount are determined pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248).

(3) Payments to qualifying hospitals for supplemental indirect medical education. Subject to the amount available, the amount to be distributed to each qualifying hospital for supplemental indirect medical education is determined by the following formula: The statewide average case-mix adjusted operating cost per Medicaid discharge is multiplied by five and divided by two, then added to the statewide average capital costs multiplied by five and divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159. The number of interns, residents and beds is based on information contained in the hospital's base period Medicare cost report which will be updated when rebasing and recalibration are performed. Payments for supplemental indirect medical education shall be on a monthly basis.

(4) Qualifying for supplemental disproportionate share. In-state hospitals that are state-owned acute-care hospitals, that have more than 500 beds, and that qualify for payments from the graduate medical education and disproportionate share fund for disproportionate share pursuant to paragraph 79.1(5)*"y"* also qualify for supplemental disproportionate share payments.

(5) Available amount for supplemental disproportionate share. In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y"* and supplemental disproportionate share payments cannot exceed the amount of the federal cap under Public Law 102-234. The amount available for supplemental disproportionate share payments shall be the lesser of (1) the applicable state appropriation or (2) the federal cap minus disproportionate share payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y."*

(6) Payments to qualifying hospitals for supplemental disproportionate share. Payments for supplemental disproportionate share are made after the end of each federal fiscal year. Subject to the amount available, qualifying hospitals receive a payment of up to 166 percent of the hospital's total calculated reimbursement for all cases paid by the Medicaid fiscal agent within the previous federal fiscal year.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Health Care Financing Administration (HCFA). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by HCFA to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

79.1(8) *Prescribed drugs.* The amount of payment shall be based on several factors in accordance with 42 CFR 447.331—333 as amended to October 28, 1987:

a. *"Estimated acquisition cost (EAC)"* is defined as the average wholesale price as published by First Data Bank less 10 percent.

"Maximum allowable cost (MAC)" is defined as the upper limit for multiple source drugs established in accordance with the methodology of the Health Care Financing Administration (HCFA) as described in 42 CFR 447.332(a)(i) and (ii).

The basis of payment for prescribed drugs for which the MAC has been established shall be the lesser of the MAC plus a professional dispensing fee of $5.17 or the pharmacist's usual and customary charge to the general public.

The basis of payment for drugs for which the MAC has not been established shall be the lesser of the EAC plus a professional dispensing fee of $5.17 or the pharmacist's usual and customary charge to the general public.

If a physician certifies in the physician's handwriting that, in the physician's medical judgment, a specific brand is medically necessary for a particular recipient, the MAC does not apply and the payment equals the average wholesale price of the brand name product less 10 percent. If a physician does not so certify, and a lower cost equivalent product is not substituted by the pharmacist, the payment for the product equals the established MAC.

Equivalent products shall be defined as those products which meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

b. The determination of the unit cost component of the drug shall be based on the package size of drugs most frequently purchased by providers.

c. No payment shall be made for sales tax.

d. All hospitals which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Hospitals receive reimbursement for the administration of vaccines to Medicaid recipients through the DRG reimbursement for inpatients and APG reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that a maximum allowable reimbursable cost for these drugs shall be established by the department at the median of the average wholesale prices of the chemically equivalent products available. No exceptions for reimbursement for higher cost products will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

79.1(9) *Nursing facility reimbursement for skilled nursing care.* Rescinded IAB 7/11/01, effective 7/1/01.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by recipient.* A copayment in the amount specified shall be charged to recipients for the following covered services:

a. Nullified by 1992 Iowa Acts, H.J.R. 2015.

b. The recipient shall pay $1.00 copayment on each covered drug prescription, including each refill, and for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The recipient shall pay $2.00 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and sickroom supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, optometrists, opticians, rehabilitation agencies, psychologists, and ambulance services.

d. The recipient shall pay $3.00 copayment for total covered service rendered on a given date for dental services and hearing aids.

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a recipient receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The recipient shall pay $1.00 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid recipients.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the recipient is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a recipient is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *Reimbursement for HCBS MR and BI supported community living and supported employment and HCBS AIDS/HIV, BI, elderly, ill and handicapped, and MR respite when basis of reimbursement is retrospectively limited prospective rate.* This includes home health agencies providing group respite; nonfacility providers of specialized, basic individual, and group respite; camps; home care agencies providing specialized, basic individual, and group respite; and providers of residential-based supported community living.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to Ryun, Givens, Wenthe, and Company, 1601 48th Street, Suite 150, West Des Moines, Iowa 50266-6722, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the division of medical services by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved individual comprehensive plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer travel and transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The annual adjustment shall be equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the division of medical services. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

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, 1998, and prior to January 1, 1999, except as noted in paragraph *"s."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles 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 costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (HCFA 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits. This formula is limited by funding availability that is legislatively appropriated.

"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.

"Invalid claims or visits" shall mean claims or visits that are not priced and paid using the ambulatory patient group (APG) system.

"Net number of Iowa Medicaid valid visits" shall mean total visits plus the incremental portion of visits that resulted in outliers less invalid visits.

"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.

"Valid claims or visits" shall mean those claims or visits that are priced and paid using the ambulatory patient group (APG) system.

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 January 1, 1997, through December 31, 1998, and paid through March 31, 1999, relative weights are calculated using all valid singleton claims, which are 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 1998 fiscal year and paid through March 31, 1999, the hospital-specific case-mix indices are calculated using all valid singleton claims, which are 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 have low or no volume in the claims data, and those weights which are 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 total Iowa Medicaid costs the actual dollar expenditures for direct medical education costs for interns and residents, observation bed 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 is case-mix adjusted, adjusted to reflect inflation and divided by the total net number of Iowa Medicaid valid visits from the MMIS claims system 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. Rescinded IAB 5/30/01, effective 8/1/01.

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 Medicaid 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 and substance abuse program (Iowa Plan), 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 Iowa Plan program will be the responsibility of the Iowa Plan contractor and will not be otherwise payable by Iowa Medicaid. Emergency psychiatric evaluations for recipients who are covered by the Iowa Plan program will be the responsibility of the contractor. For those recipients who are not covered by the Iowa Plan 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 eligible under the Iowa Plan program. Substance abuse services for persons eligible under managed care will be the responsibility of the Iowa Plan 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, inflation factors, 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.

Inflation of base payment amounts by the Data Resources, Inc. hospital market basket index shall be performed annually, subject to legislative appropriations. Base amounts shall be rebased and APG weights recalibrated every three years. Cost reports used will be hospital fiscal year-end reports within the calendar year ending no later than December 31, 1998. Case-mix indices shall be calculated using valid claims most nearly matching each hospital's fiscal year end. The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

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 direct medical education under Medicare guidelines, it shall qualify 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 Medicaid fiscal agent. Hospitals that 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 150 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 agent after a patient's outpatient "visit" is complete. Payment for outlier costs is determined when the claim is paid by 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 1998 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 cost 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. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) 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 requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(16)"*v*"(3), 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, 2000, through June 30, 2001, is $2,811,778. Adjustments may be made to this amount for inflation, subject to legislative appropriations, and for utilization increases as established in paragraph 79.1(16)"*w.*"

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall 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, 1999, through June 30, 2000, 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. The dollar values for each hospital are summed, then each hospital's dollar value is divided by the total dollar value, resulting in a percentage. Each hospital's percentage is multiplied by the amount allocated for direct medical education to determine the payment to each hospital. Effective for payments from the fund for July 2003, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year. If a hospital fails to qualify for direct medical education payments from the fund because it 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 shall be removed from the 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.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for rehabilitation services for adults with chronic mental illness.*

a. Reimbursement methodology. Providers are reimbursed on the basis of a unit-of-service rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of Form 470-0664, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, by the provider. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (as specified in OMB Circular A-87) to be the actual cost of service rendered to medical assistance recipients.

b. County payment. Pursuant to 2000 Iowa Acts, chapter 1228, section 8, subsection 11, county funding shall be used to provide the nonfederal share of funding for rehabilitation services to adults with chronic mental illness for whom a county is financially responsible. State funding shall be used to provide the nonfederal share of funding for persons with state case status.

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

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) Rescinded IAB 6/28/00, effective 8/2/00.

(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.

i. Rehabilitation services providers for adults with chronic mental illness shall submit Form 470-3819, Rehabilitation Services for Adults with Chronic Mental Illness Provider Application.

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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