AMOUNT, DURATION AND SCOPE OF MEDlCAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services(77O), Ch 78] [Prior to 2/11/87, Human Services(498)[

441-78.1(249A) Physicians services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no profes sional fee shall be paid.

b. Routine physical examinations. A routine physical examination is an examination performed without relationship to treatment or diagnosis for a specific illness, symptom, com plaint, or injury. No payment will be made for these examinations unless:

(1) The examination is required as a condition of employment or training and is approved by the department.

(2) The examination is required for an initial certification or period of recertification of the need for nursing care.

(3) The examination is in connection with early and periodic screening, diagnosis, and treatment or persons under age 21 in aid to dependent children cases, as specified in rule 78. 18(249A).

(4) The examination is required of a child or disabled adult for attendance at school or camp.

(5)The examination is in connection with the prescription of birth control medications and devices.

(6)The examination is for a pap smear which is allowed as preventative medicine services.

(7)The examination is for well baby care or a routine physical examination for a child under six (6) years of age.

(8)The examination is an annual routine physical examination for a child in foster care for whom the department assumes financial responsibility.

c. Treatment of certain foot conditions as specified in 78.S(2)"a", "b", and "c".

d. Acupuncture treatments.

e. Rescinded 9/6/78.

i; Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced b~ the Iowa foundation for medical care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa foundation for medical care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa foundation for medical care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List".

78.1(2) Payment will be made for drugs and supplies when prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physi cian assistant, or advanced registered nurse practitioner) as provided in this rule.

a. Prescription drugs.

(1)Subject to subparagraphs (2) and (3), payment will be made for prescription drugs marketed by manufacturers that have

signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508.

(2)Notwithstanding subparagraph (1), payment is not made for: drugs if the prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act, drugs used to cause anorexia or weight gain, drugs used for cosmetic purposes or hair growth, drugs used to promote smoking cessation, covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee, drugs described in Section 107(c)(3) of the Drug Amendments of 1962, and identical, similar or related drugs (within the meaning of Section 310.6(b)(l) of Title 21 of the Code of Federal Regula tions (DESI drugs).

(3)Payment will be made for certain drugs only when prior approval is obtained from the fiscal agent and when prescribed for treatment of specified conditions as follows. Prior authori zation will be granted for 12-month periods per recipient as needed unless otherwise specified.

Payment for amphetamines and combinations of amphetamines with other therapeutic agents and amphetamine-like sympathomimetic compounds used for obesity control, including any combination of these compounds with other therapeutic agents, will be provided when there is a diagnosis of narcolepsy, hyperkinesis in children, or senile depression but not for obesity control. (Cross-reference 78.28(1)' 'a")

Payment for multiple vitamins, tonic preparations and combinations thereof with minerals, hormones, stimulants, or other compounds which are available as separate entities for treatment of specific conditions will be approved when there is a specifically diagnosed vitamin deficiency disease. (Prior approval is not required for products principally marketed as prenatal vitamin-mineral supplements.) (Cross-reference 78.28(l)"b")

Payment for clozapine will be approved to a Medicaid-certified provider when the following criteria have been met:

1. The condition being treated meets the Diagnostic and Statistical Manual (DSM) lll-R criteria for a schizophrenic disorder.

2. The patient has had an unsuccessful trial on at least three or more different antipsychotic medications or is unable to tolerate other neuroleptics due to tardive dyskinesia or other side effects.

3. The patient must be treatment-resistant as evidenced by a documented duration of illness longer than five years with multiple hospitalizations, or continuous hospitalization for more than one year.

4. The patient must have a score of 50 or higher on the Brief Psychiatric Rating Scale (BPRS).

5. Payment will be approved for 12 weeks of therapy for patients meeting criteria 1 to 4 above if there are no contraindications for use of the drug and the patient has undergone a medical evaluation prior to the beginning of drug therapy.

6. After 12 weeks, patients showing improvement (a 20 percent reduction in the total BPRS score from baseline and documented progress) will continue to be covered.

7. Patients showing some documented clinical improvement after 12 weeks but not meeting continuation criteria must be reviewed for consideration of an additional 12 weeks of therapy. If an additional 12 weeks is granted, continuation criteria must be met to continue coverage after a total of 24 weeks of therapy.

8. Patients showing no improvement after 12 weeks of therapy are not eligible for continued therapy with clozapine. (Crossreference 78.28(1)"g")

When the above criteria have not been met, payment for clozapine will be approved if recommended as appropriate treatment for chronic, treatment-resistant schizophrenia by a physician review panel established by the department. The review panel shall base its recommendation on clinical documentation provided by the prescribing physician.

Full therapeutic dose levels and maintenance dose levels for the following drugs are those listed in the American Hospital Formulary Service Drug Information, United States PharmacopeiaDrug Information, American Medical Association Drug Evaluations, and the peer-reviewed medical literature.

Prior authorization is required for prescriptions for all histamine H2-receptor antagonists, and sucralfate, at full therapeutic dose levels that exceed a 90-day supply for

therapy at that dose level. Prior authorization is not required for prescriptions for maintenance doses of these drugs or for a 90day supply at full therapeutic dose levels per 12-month period per recipient.

Sucralfate prescribed concurrently with histamine H2-receptor antagonists for a period exceeding 30 days will be considered duplicative and inappropriate.

The following conditions will be considered justification for continued use of full therapeutic doses of histamine H2-receptor antagonists beyond the 90-day limitation:

1. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).

2. Symptomatic gastroesophageal reflux (not responding or failure by maintenance therapy).

3. Symptomatic relapses (duodenum or gastric ulcer) on maintenance therapy.

4. Barretts Esophagus.

Other conditions will be considered on an individual patient basis.

Prior authorization is required for prescriptions for omeprazole at full therapeutic dose levels that exceed a 60-day supply for therapy at that dose level. Prior authorization is not required for a 60-day supply at full therapeutic dose levels per 12-month period per recipient. Justification for additional therapy will be considered on an individual patient basis.

Omeprazole prescribed concurrently with histamine H2-receptor antagonists will be considered duplicative and inappropriate.

Prior authorization is not required for misoprostol when prescribed concurrently with a nonsteroidal anti-inflammatory drug. Prior authorization is required for any other therapy with misoprostol beyond 90 days. Justification for other therapy will be considered on an individual patient basis. Misoprostol prescribed concurrently with histamine H2-receptor antagonists will be considered duplicative and inappropriate. (Crossreference 78.28(l)"d"(l))

Prior authorization is required for single-source nonsteroidal anti-inflammatory drugs. Requests must document

previous trials and therapy failure with at least two multiple-source nonsteroidal anti-inflammatory drugs. Prior authorization for chronic conditions will be issued for a 12-month period. Once a prior authorization has been issued, the single-source nonsteroidal anti-inflammatory drug being prescribed may be changed to another single-source product without a new request within the approved time period of 12 months. Patients who have been established on proven therapy with a single-source product prior to October 1, 1992, will not require a prior authorization.

Prior authorization is not required for prescriptions for multiple-source nonsteroidal antiintlammatory drugs. (Cross-reference 78.28(l)"d"(2))

Prior authorization is required for single-source benzodiazepines. Requests must document a previous trial and therapy failure with one multiple-source product. Prior authoriza tion will be approved for 12 months for documented:

1. Generalized anxiety disorder.
2. Panic attack with or without agoraphobia.
3. Seizure.
4. Nonprogressive motor disorder.
5. Bipolar depression.
6. Dystonia.

Prior authorization requests will be approved for a three-month period for all other diagnoses related to the use of benzodiazepines. Justification will be considered on an individual patient basis. Patients who have been established on proven therapy with a single-source product prior to October 1, 1992, will not require a prior authorization. (Cross-reference 78.28(l)"d"(3))

Prior authorization is required for therapy with growth hormones. All of the following criteria must be met for approval for prescribing of growth hormones:

I. Standard deviation of 2.0 or more below mean height for chronological age.

2. No intracranial lesion or tumor diagnosed by MRI.

3. Growth rate below five centimeters per year.

4. Failure of any two stimuli tests to raise the serum growth hormone level above seven nanograms per milliliter.

5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males.

6. Epiphyses open.

Prior authorization will be granted for [2-month periods per recipient as needed. (Cross-reference 78.28(l)"d"(4))

Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vuigaris. An initial treatment failure of an over-the-counter ben zoyl peroxide product, which is covered by the program, is required prior to the initiation of a prescription product, or evidence must be provided that use of these agents would be medically contraindicated. If the patient presents with a preponderance of comedonal acne, tretinoin products may be utilized as first line agents without prior authorization. (Crossreference 78.28(l)"d"(5))

Prior authorization is required for all tretinoin prescription products for those patients over the age of 25 years. Alternatives such as topical benzoyl peroxide (OTC), and topical erythromycin, clindamycin, or oral tetracycline must first be tried (unless evidence is provided that use of these agents would be medically contraindicated) for the following conditions: endocrinopathy, mild to moderate acne (noninflammatory and inflammatory), and drug-induced acne. Prior authorization will not be required for those patients presenting with a preponderance of comedonal acne. Upon treatment failure with the above-mentioned products or if medically contraindicated, tretinoin products will be approved for three months.

If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period. Skin cancer, lamellar ichthyosis, and Darier's Disease diagnoses will receive automatic approval for lifetime use of tretinoin products. (Crossreference 78.28(1 (6))

Prior authorization is required for all nonsedating antihistamines. Patients must have received two unsucces ul trials with other covered antihistamines (chlorpheniramine or diphenhydramine or evidence must be provided that use of these agents would be medically contraindicated, prior to the utilization of the nonsedating antihistamines. (Cross-reference 78.28(l)"d"(7))

Prior authorization is required for all dipyridamole prescriptions outside the hospital setting. Dipyridamole will only be approved if aspirin is medically contraindicated in a patient. (Cross-reference 78.28(l)"d"(8))

Prior authorization is required for all cephalexin hydrochloride monohydrate prescriptions. Treatment failure with cephalexin monohydrate will be required prior to the initiation of a cephalexin hydrochloride monohydrate prescription. (Crossreference 78.28(l)"d"(9))

Prior authorization is required for epoetin prescribed for outpatients for the treatment of anemia. Patients who meet the following criteria may receive prior authorization for the use of epoetin:

1. Hematocrit less than 30 percent.

2. Transferrin saturation greater than 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), or ferritin levels greater than 100 mg/ml.

3. Laboratory values must be current to within three months of the prior authorization request.

4. For AZT treated patients endogenous serum erythropoetin level needs to be greater than 500 mU/ml.

5. Patient should not have a demonstrated gastrointestinal bleed.

6. Exceptions may be made if the patient does not meet criteria "2," but is on aggressive oral iron therapy (i.e., twice or three times per day dosing). The prior authorization for this exception would be for a limited time. (Cross-reference 78.28(l)"d"(l0))

Prior authorization is required for filgrastim prescribed for outpatients whose conditions meet the following indications for use:

I. Decrease the incidence of infection due to severe neutropenia caused b~ myclosuppressive anticancer therapy. For this indication the following criteria apply: Filgrastim therapy can continue until the postnadir, absolute neutrophil count is greater than 10.000 cells per cubic millimeter and routine CBC and platelet counts are required twice per ~~eek.

2. Decrease the incidence of infection due to severe neutropenia in AIDS patients on zidovudine. For this indication, the following criteria apply: Evidence of neutropenic infection exists or absolute neutrophil count is below 750 cells per cubic millimeter, filgrastim is adjusted to maintain absolute neutrophil count of approximately [000 cells per cubic millimeter, and routine CBC and platelet counts are required once per week. (Cross-reference 7~.28(l)"d"(l I))

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

b. Medical and sickroom supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use. No payment will be approved for medical and sickroom supplies for a recipient receiving care in a Medicarecertified skilled nursing facility. When a recipient is

receiving care in a nursing facility or residential care facility which is not a Medicare-certified skilled nursing facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings. liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including disposable or reusable needles and syringes. testape, clinitest tablets, and clinistix.

c. Prescription records are required for all drugs as specified in Iowa Code sections 155.33, 155.34 and 204.308. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of medication sufficient for a 30-day supply. Maintenance drugs in the following therapeutic classifications for use in prolonged therapy may be prescribed in 90-day quantities:

(1) Oral contraceptives

(2) Cardiac drugs

(3) Hypotensive agents

I(4) Vasodilating agents

(5) Anticonvulsants

(6) Diuretics

(7) Anticoagulants

(8) Thyroid and antithyroid agents

(9) Antidiabeiic agents

e. In lieu of payment, replacement vaccine will be supplied by the department of public health to physicians enrolled in Medicaid who administer immunizations to Medicaid recipients for the following: diphtheria, tetanus toxoids vaccine (DT); diphtheria, tetanus toxoids, pertussis (DTP); oral poliovirus vaccine (OPV); measles, mumps, and rubella vaccine (MMR); tetanus and diphtheria toxoids (TD); hemophilus influenza 0 (HI 0); and hepatitis B vaccine (HEP). Vaccine will be replaced based on adjudicated claims. Physicians shall receive reimbursement for the administration of the aforementioned vaccines to Medicaid recipients. Exceptions

to this policy are: Medicaid recipients who are enrolled in an HMO which has contracted with the department of human services to provide specific Medicaid services and Medicaid recipients who are also eligible for Medicare when the vaccine is co'ered by Medicare.

f. The following nonprescription drugs arc payable:

Aspirin Tablets 325 mg., 650 mg., 81 mg. (chewable)
Aspirin Tablets, Enteric Coated 325 mg., 650 mg. Aspirin
Tablets, Buffered 325 mg. Acetaminophen Tablets 325 mg., 500
mg. Acetaminophen Elixir [20 mg./5 ml. Acetaminophen Elixir
[60
mg./5 ml. Acetaminophen Solution 100 mg./ml. Acetaminophen
Suppositories [20 mg. Bacitracin Ointment 500 units/Gm.
Benzoyl
Peroxide 5~~6, Cleanser, Lotion, Cream, Gel Benzoyl Peroxide
l0~~, Cleanser, Lotion, Cream, Gel Chlorpheniramine Maleate
Tablets 4 mg. Ferrous Sulfate Tablets 300 mg., 325 mg.
Ferrous
Sulfate Elixir 220 mg./5 ml. Ferrous Sulfate Drops 75 mg./0.6
ml. Ferrous Gluconate Tablets 300 mg., 325 mg. Ferrous
Gluconate Elixir 300 mg./5 ml. Ferrous Fumarate Tablets 300
mg., 325 mg.
Nicotinic Acid (Niacin) Tablets 25 mg., 50 mg., 100 mg., 250
mg., 500 mg. Pediatric Oral Electrolyte Solutions Permethrin

Liquid 1 87o Pseudoephedrine Hydrochloride Tablets 30 mg., 60 mg. Pseudoephedrine Hydrochloride Liquid 30 mg./5 ml. Sodium Chloride Solution 0.9~ for inhalation with metered dispensing valve 90 ml., 240 ml.

Tolnaftate l~ Cream, Solution, Powder

Nonprescription multiple vitamin and mineral products specifically formulated and recommended for use as a dietary supplement during pregnancy and lactation.

With prior authorization, nonprescription multiple vitamins and minerals under the conditions specified in subrule 78.l(2)"a"(3).

Insulin.

Oral solid forms of the above covered items shall be prescribed and dispensed in a mini-mum quantity of 100 units per prescription except when dispensed via a uni dose system. When used for maintenance therapy, all of the above listed items may be prescribed and dispensed in 90-day quantities.

78.37(6) Respite care services. Respite care services are temporary care to a client to provide relief to the usual informal caregiver and provide all the care the usual caregiver would provide.

a. If the respite care is provided in the client's home, only the cost of care is reimbursed.

b. If the respite care is provided outside of the client's home, charges may include room and board.

c. A unit of service is either one 24-hour day for out-of-home respite care provided by a facility or one 4- to 8-hour day for in-home respite care provided by a home health agency.

d. The maximum is 30 units of care in each 12-month period beginning with the first use of the service.

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

78.37(7) Chore services. Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) llotiie delivered meals. Home delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the

required daily allowance needed in a day. A maximum of seven meals is allowed per week. A unit of service is a meal.

78.37(9) Hoiize and vehide modification. Covered home and vehicle modifications are those set forth in subrule 78.41(4), paragraphs "a" to "d."

78.37(10) Alental health outreach. Mental health outreach services are services provi ·e'1 in a recipient's home to identify, evaluate, and provide treatment and psychosocial supp The services can only be provided on the basis of a referral from the Case Management ~,ogram for the Frail Elderly (CMPFE) interdisciplinary team. A unit of service is 15 minutes.

7it~3"(1 1) Trnn~pQrt,tit~~~. Transportution scrvice9 mny bc pro~idcd for r~cipi~nts to coil-duct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is either per mile or per trip.

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

441-78.38(249A) AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the A1DS/HIV waiver services as established in 441-Chapter 83. Services must be billed in whole units.

78.38(1) Counseling services. Counseling services are face-toface mental health services provided to the client and caregiver by a mental health professional as defined in rule 441-33.1(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services neccessary for the management of depres sion, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a terminal illness. Counseling services may be provided to the recipient's caregiver only when included as part of a counseling session for the recipient.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver recipient or the waiver recipient and the recipient's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the actual number of persons who comprise the group, but not less than six.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule

-78.9(249A). A unit of service is one hour. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service are:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. Meal preparation: planning and preparing balanced meals. 441-79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and intermediate care facilities are reimbursed on a cost-related basis and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's met hodology without making any additional charge to the recipient.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is invoIv~d in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Copies of fee schedules in effect for the providers covered by fee schedules can be obtained by contacting the department's fiscal agent at the following address: PARAMAX, 1601 48th Street, Suite 110, West Des Moines, Iowa 50265, (515) 226-2200.

d. * Monthly fee for service. Providers are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in a case management program for any

portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in services provision.

79.1(2) Basis of reimbursement of specific provider categories.

Provider category	Basis of reimbursement	Upper limit
AIDS/HIV waiver service		

providers, including:		
1.	Counseling	
Individual:	Fee schedule	$9.80 per unit
Group:	Fee schedule	$39.20 per hour

2.	Home health aide	Retrospective cost-	Maximum
	related	Medicare rate	
3.	Homemaker	Fee schedule	$15.60 per hour
4.	Nursing care	Fee schedule	$9 per unit
5.	Respite care		
In-home:	Fee schedule	$104 per day	
Out-of-home:	Prospective reimbursement	Limit for level of care	

Ambulance	Fee schedule	Fee schedule in effect 6/30/90 plus 2~~
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Rate determined by Medicare
Area education agencies	Fee schedule	Fee schedule in effect 6/30/90 plus 2~
Audiologists	Fee schedule	Fee schedule in effect 6/30/90 plus 2Wo
Birth centers	Fee schedule	Fee schedule in effect 6/30/90 plus 7.4407o for obstetrical service
Case management providers	Retrospective cost-related	Retrospective rate
Certified registered nurse anesthetists	Fee schedule	Fee schedule in effect 6/30/90 plus 1.6~~
Chiropractors	Fee schedule	Fee schedule in effect 6/30/90 plus 2~7b

441-80.1(249A) The fiscal agent function in medical assistance.

80.1(1) General administrative responsibilities offiscal agent. The fiscal agent designated by the department will perform the following primary functions:

a. Receive, process and pay claims submifted by providers of medical and remedial care participating in the program.

b. Make available instructional materials and billing forms to providers participating in the program.

c. Provide reports, statistical and accounting information as required by the department.

d. Participate with staff of the department in analysis and evaluation of policies and procedures.

e. In cooperation with the department develop and carry out a continuous program of cost and utilization review which is applicable to all groups of providers participating in the program. The purpose of~cost and utilization review is to assure that only required medical and health services are being provided to recipients of medical assistance in accordance with department policy and that the cost of the services is not in excess of that charged the general public.

80.1(2) Method of selection of fiscal agent. The department shall publish a request for proposal announcing the forthcoming selection of a fiscal agent for the medical assistance program and outline the elements of the fiscal agent contract. The department will receive sealed bids from prospective fiscal agents for the medical assistance program. Basis of competitive bidding will be a per claim rate which would be applicable to all claims processed by the fiscal agent under the program in combination with an evaluation of technical, business and financial aspects of the bidders. A certified check payable to the Iowa department of human services in the amount of $50,000 shall be filed with each proposal. This check may be cashed and the proceeds retained by the department as liquidated damages if the bidder fails to execute a contract and file security as required by the specifications issued by the department.

Proposals containing any reservations not provided for in the specifications may be rejected and the department reserves the right to waive technicalities and to reject any or all bids.

80.1(3) Reimbursement of fiscal agent for performance of contract. All allowable costs other than amount paid providers of medical and remedial care and services shall be referred to as administrative costs.

a. Rate per claim. Administrative costs other than those not associated with the processing of claims as set forth below shall be based on a fixed rate per claim handled. The fiscal agent will bill the department once each month the sum of the bid price multiplied by the number of original adjudicated claims.

b. Costs not associated with processing of claims. Costs not associated with processing claims will be established by contract with the fiscal agent. The fiscal agent will bill the department under separate voucher for these services according to the dates agreed upon by contract.

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

441-80.2(U9A) Submission of claims. Providers of medical and remedial care participating in the program will submit claims for services rendered to the fiscal agent on at least a monthly basis. Following audit of the claim the fiscal agent will make payment to the provider of care.

80.2(1) Claims for payment for services provided recipients who are Medicare beneficiaries shall be submitted on forms specified for that program.

80.2(2) Claims for payment for services provided recipients who are not Medicare beneficiaries shall be submitted on the following forms:

a. Ambulance services shall submit claims on Form XIX AMB-I, Ambulance Claim.

b. Audiologists and hearing aid dealers shall submit claims on HCFA-1500, Health Insurance Claim Form.

c. Chiropractors shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

d. Community Mental Health Centers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

e. Dentists shall submit claims on Form XIX DENT-1, Dental Claim.

f Practitioners and institutions providing screening services shall submit claims on Form HCFA 1500, Health Insurance Claim Form.

g. Practitioners and institutions providing family planning services shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

h. Home health agencies shall submit claims on Form UB-82-HCFA-1450.

i. Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals, shall submit claims on Form UB-82-HCFA-l450.

j. Laboratories shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

k. Medical equipment, appliance and sickroom supply dealers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

I. Opticians shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

m. Optometrists shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

n. Orthopedic shoe dealers shall submit claims on Form HCFA-I500, Health Insurance Claim Form.

0. Pharmacies shall submit claims on the Universal Pharmacy Claim Form.

p. Independently practicing physical therapists shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

q. Physicians shall submit claims on Form HCFA-1S00, Health Insurance Claim Form.

r. Podiatrists shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

5. Rehabilitation agencies shall submit claims on Form UB-82-HCFA-1450.

t. Rural health clinics shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

u. Medicare-certified nursing facilities wishing to receive Medicaid skilled payment shall submit claims on Form UB-82-HCFAl450.

v. Maternal health centers shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

w. Ambulatory surgical centers shall submit claims on Form HCFA-
1500, Health Insurance Claim Form.

x. Independently practicing psychologists shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

y. Genetic consultation clinics shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

z. Nurse-midwives shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

aa. Birth centers shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

ab. Area education agencies shall submit claims on Form HCFA-1500, Health Insurance Claim Form.

ac. Psychiatric medical institutions for children shall submit claims on Form UB-82-HCFA- 1450.

ad. Case management providers shall submit claims on Form 470-

2486, Claim for Targeted Medical Care.

ae. Model waiver service providers shall submit claims for a calendar month or less of service on Form 470-2486, Claim for Targeted Medical Care, except for hospitals and skilled nursing facilities providing respite care, which shall submit their claims on Form UB-82-HCFA-l450.

af Certified registered nurse anesthetist providers shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

ag. Hospice providers shall submit claims on Form UB-82-HCFA-l450.

ah. Elderly waiver service providers shall submit claims for a calendar month or less of service on Form 470-2486, Claim for Targeted Medical Care, except for hospitals and skilled nursing facilities providing respite care, which shall submit their claims on Form UB-82-HCFA- 1450.

ai. AIDS/HlV waiver service providers, including nursing facilities providing out-of-home respite at the lCF level of care, shall submit claims for a calendar month or less of service on the Claim for Targeted Medical Care, Form 470-2486. Nursing facilities providing out-of-home respite at the SNF level of care and hospitals shall submit their claims on Form UB-82-HCFA- 1450.

aj. Federally qualified health centers shall submit claims on Form HCFA-l500, Health Insurance Claim Form.

ak. Independently practicing family or pediatric nurse practitioners shall submit claims on Form HCFA 1500, Health Insurance Claim Form.

at. HCBS/MR and HCBS/MR/OBRA waiver service providers shall submit claims for a calendar month or less of service on the Claim for Targeted Medical Care, Form 4~O-2486.

ajit. Nursing facilities for persons 'vii Ii menial illness shall submit claims on Form UB-82-HCFA- 1450.

an. Rehabilitative treatment providers shall submit claims on Form AA-224l-0, Purchase of Service Provider Invoice.

80.2(3) Providers shall purchase or copy their supplies of forms HCFA-l450 and HCFA-l500 for use in billing.

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

441-80.3(249A) Amounts paid provider from other sources. The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted

from the established cost standard for the service provided to establish the amount of payment to be made by the carrier.

441-80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) Submission of claims. Payment will not be made on any claim where the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the fiscal agent exceeds 365 days except that payment for claims submitted beyond the 365-day limit shall be considered if retroactive eligibility on newly approved cases is made which exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. EXCEPTI0N: Rehabilitative treatment service providers shall submit claims pursuant to rule 441-185.121(234).

80.4(2) Claim adjustments. A provider's request for an adjustment to a paid claim must be received by the fiscal agent within one year from the date the claim was paid in order to have the adjustment considered. ExcEpTioN: Rehabilitative treatment service providers shall have claim adjustments processed pursuant to rule 441-185.121(234).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.l2.