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6d9. CERTAIN PHARMACISTS SERVICES
Fee Schedule.

6d10. SERVICES OF ADVANCED NURSE PRACTITIONERS CERTIFIED IN PSYCHIATRIC OR MENTAL HEALTH SPECIALTIES
Fee Schedule. 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). The fee schedule is established as 85% of the physician fee schedule.

7. HOME HEALTH SERVICES
The payment for each home health service is determined retrospectively based on the disciplines (skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT), speech therapy and medical social services) in aggregate. Interim payments for home health agencies are made based on the home health agency's cost-to-charge ratios. A tentative cost settlement is performed based on the as-submitted Medicare cost report and a final cost settlement is performed based on the finalized Medicare cost report.

7a. HOME HEALTH SERVICES – SKILLED NURSING SERVICES (INTERMITTENT)
The basis of payment for intermittent skilled nursing services provided by a home health agency is reasonable cost subject, reconciled on a retrospective basis by the State Medicaid Agency, subject to the following:

Payment for intermittent skilled nursing services is made at the lower of: the home health agency's average cost per visit per the submitted Medicare cost report; the agency's Medicaid per visit limit in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation effective November 30, 2009.

The average cost per visit is derived from the Medicare cost report where cost for Medicaid is calculated by multiplying the average cost per visit times the covered Medicaid intermittent skilled nursing visits which are subject to a desk review. The agency's Medicaid per visit limit is based on agency cost at 06/30/2001 subject to periodic adjustment. The base year for the Medicare per visit limit was calendar year 2000 subject to annual home health market basket updates.

7b. HOME HEALTH SERVICES– HOME HEALTH AIDE SERVICES
Same as 7a.

7c. HOME HEALTH SERVICES - MEDICAL SUPPLIES AND EQUIPMENT
Fee schedule.

7d. HOME HEALTH SERVICES - PHYSICAL THERAPY, OCCUPATIONAL THERAPY & SPEECH PATHOLOGY SERVICES
Same as 7a.

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8. RESERVED

9. CLINIC SERVICES

Physician and dental fee schedules, except as follows:

(a). Clinics that are renal dialysis clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(b). Clinics that are ambulatory surgical centers are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(c). Clinics that are maternal health centers are paid for clinic services on a prospective cost-based fee schedule with no retroactive cost settlement, as determined by the Department based on a cost center report submitted by clinics on an annual basis. Services payable to the clinics include: 1) Maternal Health 2) Maternal Oral Health 3) Immunization 4) Laboratory. Cost of services to calculate the cost-based fee schedule rates includes direct cost (personnel and supplies) and overhead indirect cost incurred to support the services. Agency rates were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(d). Clinics that are family planning clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(e). Clinics that are Indian Health Service Facilities are paid for clinic services provided to Native American Indians and Alaska Natives by Indian Health Service 638 facilities at the most current encounter rate established by the Indian Health Service, which is published periodically in the Federal Register. Only one encounter will be payable daily for services provided to any covered recipient.

(f). When a facility provides services, which are otherwise covered under the state plan, in addition to clinic services, payment is based on the methodology as defined for the service that is provided.

(g). Reimbursement methodology for Community Mental Health Centers:

Community Mental Health Centers are reimbursed using a cost based methodology. This methodology will consist of a cost report and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

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Interim Payment

The Department makes interim payments to the Community Mental Health Center based upon 105% of the greater of the statewide fee schedule for Community Mental Health Centers effective July 1, 2006 or the average Medicaid managed care contracted fee amounts for Community Mental Health Centers effective July 1, 2006.

After cost reports are received, the Department will examine the cost data for Community Mental Health Center services to determine if an interim rate change is justified.

Determination of Medicaid-allowable direct and indirect costs

To determine the Medicaid-allowable direct and indirect costs of providing Community Mental Health Center services, the following steps are performed:

1. Direct costs for Community Mental Health Center services include unallocated payroll costs and other unallocated costs than can be directly assigned to Community Mental Health Center services. Direct payroll costs include total compensation of direct services personnel.

   Other direct costs include costs directly related to the approved Community Mental Health Center personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment.

   These direct costs are accumulated on the annual cost report, resulting in total direct costs.

2. General and Administrative indirect costs are determined based on the percentage of directly assigned Community Mental Health Center direct cost to Total cost before general and administrative overhead.

3. Net direct cost and general and administrative indirect costs are combined.

4. The combined costs from Item 3 are divided by total Community Mental Health Center units of service provided for all patients to calculate a cost per unit.

5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the total Medicaid units of service that were paid from the claims data.

Annual Cost Report Process

Community Mental Health Centers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after their fiscal year for free-standing clinics and 120 days for hospital-based clinics. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Community Mental Health Center.

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The primary purposes of the Medicaid cost report are to:

1. Document the provider's total Medicaid-allowable costs of delivering Medicaid coverable services.
2. Reconcile annual interim payments to its total Medicaid allowable-costs.

All filed annual Medicaid cost reports are subject to a desk review by the Department or its designee. Community Mental Health Centers must eliminate unallowable expenses from the cost report. If they are not removed the Department or its designee will make the appropriate adjustments to the Community Mental Health Center's Medicaid cost report.

Cost Reconciliation Process

The cost reconciliation must be completed by the Department or its designee within twenty-four (24) months of the end of the cost reporting period covered by the annual Medicaid cost report. The total Medicaid-allowable costs are compared to interim payments received by the Community Mental Health Center for services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

Cost Settlement Process

EXAMPLE: For services delivered for the period January 1, 2010, through December 31, 2010, the annual Medicaid cost report is due on or before March 31, 2011, for free-standing clinics or May 31, 2011, for hospital-based clinics, with the cost reconciliation process completed no later than December 31, 2012.

If a Community Mental Health Center's payments for Medicaid-covered services exceed the actual Medicaid costs for services, the Department will recoup the overpayment using one of these two methods:

1. Offset all future claims payments from the Community Mental Health Center until the amount of the overpayment is recovered;
2. The Community Mental Health Center will return an amount equal to the overpayment to the Department of Human Services.

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If a Community Mental Health Center's actual Medicaid costs exceed the payments for Medicaid-covered services the Department will pay the difference to the Community Mental Health Center.

The Department shall issue a notice of settlement that denotes the amount due to or from the Community Mental Health Center.

10. DENTAL SERVICES
Fee Schedule. The definitions of dental and surgical procedures are based on the definitions of dental and surgical procedures given in the Current Dental Terminology (CDT).

11a. PHYSICAL THERAPY SERVICES
Fee Schedule. 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).

11b. OCCUPATIONAL THERAPY SERVICES
Fee Schedule. 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).

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(4) Use of isokinetic or isotonic equipment in physical therapy is covered when normal ambulation or range of motion of a joint is affected due to bone, joint, ligament or tendon injury or due to post-surgical trauma. Only the time actually spent by the therapist in instructing the patient and assessing the patient's progress is covered.

(5) Payment will be made for individual diagnostic or trial therapy pursuant to a plan, once per year per condition. Such service shall not exceed 12 hours per month for two months.

8. RESERVED

9. CLINIC SERVICES

Clinic services, as defined in 42 CFR 440.90, which are provided by a clinic which is otherwise required as a matter of state or federal law to be licensed, certified or approved to provide health care services, are covered services under Iowa Medicaid only if the clinic is so licensed, certified or approved.

Services provided by facilities which are not clinic services (as defined in 42 CFR 440.90) may be provided through the facility if provided by licensed practitioner of the healing arts whose services are otherwise covered under the Iowa Medicaid plan, where the practitioner has an employment or contractual relationship with the facility under which the facility submits the claim (Reference: 42 CFR 447.10(g)).

10. DENTAL SERVICES

A. *Preventive services.* Iowa Medicaid covers the following preventive services, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions:

a. Oral prophylaxis, including necessary scaling and polishing. *Limitation:* Once in a six month period except for persons who, because of physical or mental disability, need more frequent care.

b. Topical application of fluoride. *Limitation:* Once in a six-month period except for people who need more frequent applications because of physical or mental disability. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants. *Limitation.* Covered on deciduous and permanent posterior teeth for children less than 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.