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The following services will be reduced:

Various services applicable to fees schedule language on page 1 (Physician Services; Podiatrist Services; Optometrist Services; Chiropractor Services; Audiology Services; Hearing Aide Dispenser Services; Psychologist Services; Services of Advanced Registered Nurse Practitioners; Services of Certified Nurse Anesthetists; Certain Pharmacists Services; Services of Advanced Nurse Practitioners Certified in Psychiatric or Mental Health Specialties; Renal Dialysis Clinics; Ambulatory Surgical Centers; Maternal Health Centers; Physical Therapy Services; Occupational Therapy Services; Services for Individuals with Speech, Hearing and Language Disorders; Prosthetic Devices; Eyeglasses; Nurse Midwife Services; Extended Services for Pregnant Women; Ambulatory Prenatal Care for Pregnant Women during a Presumptive Eligibility Period; Nurse Practitioner Services; Transportation Services) – Effective for services rendered on or after December 1, 2009, reimbursement will be 95% of the agency's rates set as of July 1, 2008, excluding IowaCare network providers. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered between December 1, 2009 and December 31, 2009, reimbursement will be made at 95% of Medicare's January 1, 2009 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered on or after January 1, 2010, reimbursement will be 95% of Medicare's January 1, 2010 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Various services applicable to fees schedule language on page 1 (Dental Services; Dentures; Medical and Surgical Services Furnished by a Dentist) – Effective for services rendered on or after December 1, 2009, reimbursement will be 97.5% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

Preventative Exam Codes rendered in connection to services provided by IowaCare network providers – Effective for services rendered on or after December 1, 2009, reimbursement will be 95% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

EPSDT: Rehabilitation – Effective for services rendered on or after December 1, 2009 through June 30, 2011, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 5 of Attachment 4.19-B)

Family Planning Services – Agency's rates were set as of July 1, 2008, and are effective for services rendered on or after that date. (Page 1 of Attachment 4.19-B)

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Home Health-Intermittent Nursing Services – Effective for services rendered on or after December 1, 2009, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation. (Page 8 of Attachment 4.19-B)

Community Mental Health Centers – Effective for services rendered December 1, 2009 through June 30, 2010, reimbursement will be reduced to 97.5% of reconciled cost. (Page 9, of Attachment 4.19-B)

Rehabilitation – Effective for services rendered on or after December 1, 2009 through June 30, 2011, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 12 of Attachment 4.19-B)

Hospital-Specific Base APC Rates – Effective for services rendered on or after December 1, 2009, all reimbursement rates will be reduced by 5%, excluding IowaCare network providers. (Page 14 of Supplement 2 of Attachment 4.19-B)

Graduate Medical Education and Disproportionate Share Pool – Effective on or after December 1, 2009, the total annual pool amount that is allocated to the Graduate Medical education and disproportionate share pool for direct medical education related to outpatient services is $2,776,336. (Page 22 of Supplement 2 of Attachment 4.19-B)

year base rate. The geographic area will be considered the current MCE rate setting region as determined by the Department.

3. OTHER INDEPENDENT LABORATORIES SERVICES
Fee Schedule. The fee schedule is based on the Medicare Clinical Laboratory Fee Schedule.

4a. NURSING FACILITY SERVICES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES)
See Attachment 4.19-D of the State Plan.

4b. EARLY PERIODIC DIAGNOSTIC AND SCREENING SERVICES

(1) Outpatient Hospital Services: Fee schedule.

(2) Services of licensed practitioners of the healing arts: Fee schedule.

(3) Home health services – nursing services: Same as home health services under Item 7a.

(4) Home health services –medical supplies and equipment: Fee Schedule

(5) Private duty nursing services: Same basis as home health service payments – nursing services described in Item 7a.

(6) Dental services: Fee Schedule.

(7) Diagnostic services: Fee Schedule

(8) Rehabilitative Services: For services provided on July 1, 2011 and after, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using finalized cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Except as otherwise noted in the plan, payment for rehabilitation services is based on state-developed provider-specific fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of 7/1/2011 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

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(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

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For services provided prior to July 1, 2011, rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary cost shall not exceed 110 percent of the statewide average allowable cost for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

The retroactive adjustment is performed each year at the end of the agency's fiscal year based on submission of the agency's cost report. Based on this report the department adjusts the interim rate for the following months until submission of the next cost report.

(9) Transportation services: Fee schedule.

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Pharmacies and providers will submit information to the department or its designee within 30 days following a request for such information unless the department or its designee grants an extension upon written request of the pharmacy or provider. Pharmacies and providers are required to produce and submit information in the manner and format requested by the department or its designee, as requested, at no cost to the department or its designee.

12b. DENTURES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

12c. PROSTHETIC DEVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

12d. EYEGLASSES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

13a. RESERVED

13b. RESERVED

13c. RESERVED

13d. REHABILITATIVE SERVICES

For services provided on July 1, 2011 and after, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

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Except as otherwise noted in the plan, payment for rehabilitation services is based on state-developed provider-specific fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of 7/1/2011 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.
(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:
1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.

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11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

For services provided prior to July 1, 2011, Rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary costs shall not exceed 110 percent of the statewide average allowable costs for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

14a. SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INPATIENT HOSPITAL SERVICES

See Attachment 4.19-A of the State Plan.

14b. SERVICES FOR INDIVIDUAL AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – NURSING FACILITY SERVICES

See Attachment 4.19-D of the State Plan.

15a. ICF/MR SERVICES – NOT PUBLIC

See Attachment 4.19-D of the State Plan.

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15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

16. INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 21 YEAR OF AGE

See Attachment 4.19-A of the State Plan.

17. NURSE-MIDWIFE SERVICES

When nurse midwife services are provided in a birthing center by a nurse-midwife employed by the center, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse mid-wives in birth centers, provided the nurse mid-wife is required to turn over his or her fees to the center as a condition of employment.

When nurse midwife services are provided in a birthing center by a nurse mid-wife with whom the nurse-midwife has a contract under which the facility submits the claim, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse midwives in birthing centers.