

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT HOSPITAL SERVICES

Revised: September 1, 2006

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1. Inpatient Hospital Services (Continued)
    - A. In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals (Continued)
      3. Other Covered Transplants (Continued)

Reimbursement for the actual organ to be transplanted (organ acquisition) will be at (a) 100% of the submitted organ invoice amount from an outside organ provider organization or (b) reasonable cost with interim reimbursement and year-end cost settlement. The hospital has the choice of using either method. If (a) is used, the provider will submit a copy of the invoice for the organ acquired and Medicaid will reimburse 100% of the invoice amount and no additional amounts will be reimbursed to the hospital. If (b) is used, an interim amount will be reimbursed to the hospital and a year-end cost settlement will be calculated. The interim amount reimbursed and the year-end cost settlement will be calculated in a manner consistent with the method used by the Medicare Program for organ acquisition costs.
    - B. In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals
      1. Corneal, Renal and Pancreas/Kidney Transplants

Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.
      2. Bone Marrow Transplants

Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Reimbursement will not exceed \$150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the \$150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.
      3. Other Covered Transplants

Hospital services provided by In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

**Effective for discharge dates occurring on or after September 1, 2006, the TEFRA rate of increase limit will no longer be applied to in-state Pediatric Hospitals for other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow).**

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service. All excess length of stay approval requirements also apply.
    - C. Recipient Financial Services

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.



# Arkansas Department of Health and Human Services



## Division of Medical Services

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**TO:** Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)

**DATE:** October 1, 2006

**SUBJECT:** Provider Manual Update Transmittal #104

### REMOVE

Section	Date
250.212	10-13-03
250.714	3-15-05
250.715	3-15-05

### INSERT

Section	Date
250.212	10-1-06
250.714	10-1-06
250.715	10-1-06

### Explanation of Updates

Section 250.212: Part D has been added to this section to reflect an additional exception to the TEFRA rate of increase limit.

Section 250.714: Part D has been added to this section to indicate that certain transplant procedures performed in in-state pediatric hospitals are not subject to the TEFRA rate of increase limit.

Section 250.715: This section is included only to correct a punctuation error in its heading.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us).

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

*TOC not required***250.212 TEFRA Exceptions**

10-1-06

Waiver of the TEFRA limit and adjustment of the limit are permitted in particular circumstances.

- A. A state may waive the TEFRA limit for a cost-reporting period in which extraordinary circumstances cause an unusual, temporary and substantial increase in costs.
  - 1. If the hospital can demonstrate to the state that it incurred increased costs due to extraordinary circumstances over which it had no control, the state may waive the TEFRA limit for the cost-reporting period in which the extraordinary circumstance occurred.
  - 2. The TEFRA rate that, absent the waiver, would have applied is applied after the next cost reporting period in addition to the TEFRA rate due to be applied at that time. Waiving the TEFRA limit for one cost reporting period only suspends the application of that period's inflation factor until the next year, at which time the inflation factors for both years are applied.
- B. Changes in the hospital's case mix or adding or discontinuing services or units may result in a distortion of the rate of costs increase, possibly justifying an adjustment in the TEFRA limit.
  - 1. The hospital must demonstrate that such an event has occurred and the extent to which costs have been affected.
  - 2. If the state finds cause for action, it may adjust the TEFRA limit for the year in which the cost distortion occurred.
- C. New pediatric hospitals may request an exemption from the TEFRA rate-of-increase limit. See Section 250.610, part C.2.
- D. Effective for discharge dates on and after September 1, 2006, the TEFRA rate of increase limit is not applied to in-state pediatric hospitals for covered transplant procedures other than corneal, renal, pancreas/kidney and bone marrow transplants.

**250.714 Other Covered Transplants in In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals**

10-1-06

- A. Hospital services provided by in-state pediatric hospitals and Arkansas state-operated teaching hospitals related to other covered transplant procedures (does not include bone marrow, corneal, kidney or pancreas/kidney) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement.
- B. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.
- C. Medically necessary (as determined by AFMC) readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same reimbursement methodology as the initial transplant service.
- D. Effective for discharge dates on and after September 1, 2006, the TEFRA rate of increase limit is not applied to in-state pediatric hospitals for covered transplant procedures other than corneal, renal, pancreas/kidney and bone marrow transplants.

**250.715 Organ Acquisition Related to “Other Covered Transplants”**

10-1-06

Organ transplants other than bone marrow, corneal, kidney and pancreas/kidney are considered “other covered transplants” for the purposes of this rule.

- A. Reimbursement for the acquisition of the organ to be transplanted is at:
  - 1. 100% of the submitted organ invoice amount from a third-party organ provider organization or
  - 2. The hospital’s reasonable cost with interim reimbursement and year-end cost settlement.
- B. The hospital may choose either of the two methods.
  - 1. Under the invoice method, Medicaid will reimburse the hospital 100% of the invoice amount, with no additional reimbursement.
  - 2. Under the interim reimbursement method, Medicaid will remit an interim payment and calculate a year-end cost settlement in a manner consistent with the method used by the Medicare Program for organ acquisition costs.