with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: (3-17-22)

i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary hospital charges; or (3-17-22)

ii. The blended payment amount that is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or (3-17-22)

iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or (3-17-22)

iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. (3-17-22)

e. Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: (3-17-22)

i. The hospital's reasonable costs; or (3-17-22)

ii. The hospital's customary charges; or (3-17-22)

iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (3-17-22)

02. Reduction to Outpatient Hospital Costs. For services dates through June 30, 2021, outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. This reduction will only apply to the following provider classes: (3-17-22)

a. In-state hospitals specified in Section 56-1408(2), Idaho Code, that are not a Medicare-designated sole community hospital or rural primary care hospital. (3-17-22)

b. Out-of-state hospitals that are not a Medicare-designated sole community hospital or rural primary care hospital. (3-17-22)

416. -- 421. (RESERVED)

422. RECONSTRUCTIVE SURGERY: COVERAGE AND LIMITATIONS.
Reconstruction or restorative procedures that may be rendered with prior approval by the Department include procedures that restore function of the affected or related body part(s). Approvable procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. (3-17-22)

423. -- 430. (RESERVED)

431. SURGICAL PROCEDURES FOR WEIGHT LOSS: PARTICIPANT ELIGIBILITY.
Surgery for the correction of obesity is covered when all of the following conditions are met: (3-17-22)

01. Participant Medical Condition. The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition