

- g. One hundred percent review of the provider's claims prior to payment.
- h. Referral to the state licensing board for investigation.
- i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.
- j. Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- (1) Seriousness of the offense.
- (2) Extent of violations.
- (3) History of prior violations.
- (4) Prior imposition of sanctions.
- (5) Prior provision of provider education.
- (6) Provider willingness to obey program rules.
- (7) Whether a lesser sanction will be sufficient to remedy the problem.
- (8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5) "c" are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

- a. The nature of the discrepancies or violations,
- b. The known dollar value of the discrepancies or violations,

- c. The method of computing the dollar value,
- d. Notification of further actions to be taken or sanctions to be imposed by the department, and
- e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) Suspension or withholding of payments pending a final determination. Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program, except as provided in paragraph 79.3(2) "d."

a. *Definition.* "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) *Identification.* The medical record shall contain demographic information about the member receiving services. Each page of the medical record shall contain:

- 1. The member's full name.
- 2. The member's date of birth.
- 3. The member's medical assistance identification number.

(2) *Basis for service.* The medical record shall reflect the reason for performing the service or activity. Documentation may include one or more of the following, as applicable to the service being provided:

- 1. The member's complaint or symptoms.
- 2. The member's history.
- 3. Examination findings.
- 4. Diagnostic test results.
- 5. Goals or needs identified in the member's plan of care.
- 6. The observer's assessment, clinical impression, or diagnosis, including the date of the observation and the identity of the observer.

(3) Service documentation. The record for each service encounter shall include information necessary to support each item of service reported on the medical assistance claim form. The documentation shall identify the following:

1. The specific procedures or treatments performed.
2. The date and the beginning and ending time when the service was provided.
3. The location where the service was provided.
4. The name, dosage, and route of administration of any medication administered.
5. Medications or other supplies dispensed.
6. The first and last name and title of the person providing the service.
7. The signature of the person providing the service.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Exceptions. A provider of products, goods, or ancillary services is required to maintain limited medical records that include a prescription or service plan notice of decision for the provision of goods and services.

(1) "Ancillary services" means the following home- and community-based waiver services:

1. Chore service.
2. Financial management.
3. Transportation.
4. Home and vehicle modifications.
5. Personal emergency response systems.
6. Home-delivered meals.

(2) Providers of products, goods, or ancillary services shall maintain a financial record for each service encounter that includes the information necessary to support that each item reported on the medical assistance claim form was properly authorized and delivered. At a minimum, the record shall include the date and time of service and the specific product, good or service provided.

e. Forms. A provider of home- and community-based consumer-directed attendant care service may meet these requirements by completing the following forms:

- (1) Form 470-4388, Skilled Consumer-Directed Care Services, for skilled services;
- (2) Form 470-4389, Unskilled Consumer-Directed Attendant Care Services, for unskilled services; and
- (3) Form 470-4390, Consumer-Directed Attendant Care Addendum, as necessary.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. The provider shall make supporting fiscal and clinical records available to the department or its authorized representative upon request.

a. Submission of records for review or audit. Upon formal written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 days of the mailing date of the request, except as provided in paragraph "b."

b. Extension of time limit for submission.

- (1) The department may grant an extension to the required submission date of up to 15 days upon written request from the provider or the provider's designee. The request must:
 1. Establish good cause for the delay in submitting the records; and
 2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. Records that are not received within the initial 30-day period or within an extension granted pursuant to 79.3(4)“b” shall not be accepted or considered in any decision by the department regarding claim denial or recoupment.

d. Access to records during on-site review or audit. The department may elect to conduct announced or unannounced on-site reviews and audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) No notice is required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered as the end of the period within which to produce records.

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

441—79.4(249A) Appeal by provider of care. Providers may appeal decisions of the department according to rules in 441—Chapter 7, Iowa Administrative Code.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program. Rehabilitative treatment service providers wishing to participate in the program shall execute an agreement with the department on Form 470-3052, Rehabilitative Treatment and Supportive Services Contract.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson, and a vice-chairperson.

- a. Elections will be held the first meeting after the beginning of the calendar year.
- b. The term of office shall be two years. Officers shall serve no more than two terms for each office.
- c. The vice-chairperson shall serve in the absence of the chairperson.
- d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.
- e. The chairperson shall appoint a nominating committee of not less than three members and shall appoint other committees approved by the council.

79.7(2) Alternates. Each organization represented may select one alternate as representative when the primary appointee is unable to be present. Alternates may attend any and all meetings of the council, but only one representative of each organization shall be allowed to vote.

79.7(3) Expenses. The travel expenses of the public representatives and other expenses, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations.

79.7(4) Meetings. The council shall meet at least four times each year. At least two of these meetings shall be with the department of human services. Additional meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

- a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.
- b. Written notice of council meetings shall be mailed at least two weeks in advance of such meetings. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

- a. A quorum shall consist of 50 percent of the voting members.
- b. Where a quorum is present, a position is carried by two-thirds of the council members present.
- c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and alternate and to the executive office of each organization or body represented.
- d. Notice shall be made to the representing organization when the member, or alternate, has been absent from three consecutive meetings.
- e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties. The medical assistance advisory council shall:

- a. Make recommendations on the reimbursement for medical services rendered by providers of services.

- b. Assist in identifying unmet medical needs and maintenance needs which affect health.
- c. Make recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
- d. Reserved.
- e. Reserved.
- f. Recommend ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.
- g. Advise on such administrative and fiscal matters as the commissioner of the department of human services may request.
- h. Advise professional groups and act as liaison between them and the department.
- i. Report at least annually to the appointing authority.
- j. Perform other functions as may be provided by state or federal law or regulation.
- k. Communicate information considered by the council to the member organizations and bodies.

79.7(7) Responsibilities.

- a. Recommendations of the council shall be advisory and not binding upon the department of human services or the member organizations and bodies. The department will consider all advice and counsel of the council.
- b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.
- c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.
- d. The department shall provide the council with reports, data, and proposed and final amendments to rules, regulations, laws, and guidelines, for its information, review, and comment.
- e. The department shall present the annual budget for the medical assistance program for review and comment.
- f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.
- g. The department shall maintain a current list of members and alternates on the council.

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

- a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.
- b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.
- c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:
 - (1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and
 - (2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

- a.* A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).
- b.* An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

[Filed March 11, 1970]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 3/25/77, Notice 12/1/76—published 4/20/77, effective 5/25/77]

[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]

[Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]

[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]

[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]

[Filed 10/10/78, Notice 7/26/78—published 11/1/78, effective 12/6/78]

[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]

[Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]

[Filed 12/5/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]

[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]

[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]

[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]

[Filed emergency 4/23/81—published 5/13/81, effective 4/23/81]

[Filed 8/24/81, Notice 3/4/81—published 9/16/81, effective 11/1/81]

[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]

[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]

[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]

[Filed 7/30/82, Notice 6/9/82—published 8/18/82, effective 10/1/82]

[Filed emergency 8/20/82 after Notice of 6/23/82—published 9/15/82, effective 10/1/82]

- [Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
- [Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
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- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
- [Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
- [Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88*]
- [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]∅
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
- [Filed emergency 11/23/88 after Notices of 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
- [Filed 12/22/88, Notices 11/16/88∅—published 1/11/89, effective 3/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]

*Effective date of 79.1(2) and 79.1(5)“r” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

∅Two ARCs

- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90**]
- [Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
- [Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
- [Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]
- [Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
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- [Filed 8/16/90, Notices 7/11/90—published 9/5/90, effective 11/1/90]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91***]
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92****]
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]
- [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
- [Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]
- [Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
- [Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]
- [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
- [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]

**Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

***Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

****Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed 6/11/93, Notice 4/28/93—published 7/7/93, effective 9/1/93]
- [Filed emergency 6/25/93—published 7/21/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
- [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
- [Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed 3/10/94, Notices 1/19/94, 2/2/94^o—published 3/30/94, effective 6/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
- [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]
- [Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]
- [Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95^o—published 12/6/95, effective 2/1/96]
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
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- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]
- [Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
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- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]
- [Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
- [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
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- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 6/10/99, Notice 5/5/99—published 6/30/99, effective 9/1/99]
- [Filed 7/15/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]

^oTwo ARCs

- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
- [Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
- [Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
- [Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]à
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
- [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]à
- [Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
- [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02*]
- [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
- [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
- [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
- [Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]
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- [Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]
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- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
- [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
- [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]ð
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]ð
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]ð
- [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
- [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]ð
- [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
- [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]ð
- [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]

àTwo ARCs

*At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

- [Filed emergency 6/17/05—published 7/6/05, effective 6/25/05]
- [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]∅
- [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05∅—published 11/9/05, effective 12/14/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
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- [Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]

∅Two or more ARCs