ARC 2341C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

These amendments implement the provider qualifications, scope of services and reimbursement methodology for community-based neurobehavioral rehabilitation residential and intermittent services.

The Department entered into an agreement with Community NeuroRehab in 2010 to provide community-based neurobehavioral rehabilitation services for adults who have experienced a brain injury co-occurring with a mental health diagnosis, as an alternative to costly out-of-state facility-based neurobehavioral rehabilitation, hospitalization, institutionalization, incarceration or homelessness. The Department has been funding these services through exceptions to policy while administrative rules were being developed with a stakeholder group representing brain injury professionals. These services yield a cost savings to the state for members who would otherwise have been admitted to out-of-state facility-based services for neurobehavioral rehabilitation.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2113C** on August 19, 2015. The Department received comments from two respondents during the public comment period. A summary of the comments and the Department's responses are as follows:

Comment 1: Both respondents stated that the Department should add "formal fire prevention and reaction training on a regular basis" to paragraph 77.52(3)"c."

Department response 1: The Department agreed with the comment and has changed new paragraph 77.52(3)"c" as follows:

c. Within 30 days of commencement of direct service provision, employees shall complete cardiopulmonary resuscitation (CPR) training, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually.

Comment 2: One respondent stated that the Department should revise subparagraph 77.52(3)"k"(3) to add that the member should participate in the evaluation of the member's progress towards treatment goals. The respondent stated that reference to the evaluation of progress towards treatment goals is implied in the subparagraph regarding development of the individualized service plan (ISP) but appears to have been omitted in subparagraph (3) of paragraph "k" and that the reference to the evaluation of progress towards treatment goals must be there to ensure person-centered focus.

Department response 2: The Department agreed with the comment and has changed new subparagraph 77.52(3)"k"(3) as follows:

(3) The member and the member's treatment team evaluate the member's progress towards treatment goals ~~is evaluated~~ regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

Comment 3: In regard to subparagraph 77.52(3)"k"(5), a respondent stated that any restraint, particularly one of a chemical nature, must be in accordance with a prescription, regular oversight, and support of a licensed medical professional and that, overall, the language about the use of retreating is outdated and not in accordance with best practice of positive behavioral supports. The respondent stated that the language should be brought into accordance with best practice in this area.

Department response 3: The homes where the residential community-based neurobehavioral rehabilitation services are provided are licensed as residential care facilities with a specialized license for three to five beds under rule 481—63.47(135C) of the Department of Inspections and Appeals (DIA). DIA subrule 63.23(4) and rules 481—63.33(135C) and 481—63.37(135C) address residents' rights and the use of least restrictive interventions. The Department agreed with the comment and has changed new subparagraph 77.52(3)"k"(5), introductory paragraph, as follows:

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with 481—subrule 63.23(4), rule 481—63.33(135C), and rule 481—63.37(135C). When a member has a guardian or legal representative, that person will provide informed consent to treat and provide informed consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

Comment 4: Both respondents noted an error in subparagraph 78.56(2)"b"(2), namely, that "other than" instead should read "inclusive of."

Department response 4: The Department agreed with the comment from the respondents. New subparagraph 78.56(2)"b"(2) has been changed as follows:

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care ~~other than hospitalization, institutionalization, incarceration or homelessness~~ more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).

Comment 5: A respondent stated that subparagraph 77.52(3)"a"(6) does not specify how competency in performing assigned duties and interacting with members will be assessed.

Department response 5: Providers have expressed that it is they who are best qualified to determine which methodologies are most useful in assessing the competency of the direct care personnel. The Department does not prescribe specific methodologies of personnel competency assessment for other Medicaid services and will continue to expect that the providers will determine the best methods of assessing the competency of their direct care personnel and that are most appropriate for their individual organizations. The Department did not make any changes in response to comment 5.

Comment 6: A respondent commented that in subparagraph 77.52(3)"k"(5), the mention of chemical restraint as a restrictive intervention which may be required does not specify how or by whom such a restraint may be prescribed and implies that it is something imposed by the program. The respondent stated that in addition, no parameters are noted for the use of any restraints and no staff training is required relative to the implementation of manual or mechanical restraints. The respondent further stated that no mention is made of what type of professional must approve such a plan and how it is to be monitored. The respondent noted that rules governing more institutional levels of care (SNF, ICF, RCF) require that measures used must be the "least restrictive" and asserted that surely any restraint measures used in a community-based setting should include this language and include strict controls as to their use, if allowed at all.

Department response 6: The Department agreed with the respondent and believes that the changes to subparagraph 77.52(3)"k"(5) as shown in Department response 3 above address this comment.

Comment 7: A respondent stated that subparagraphs 78.56(2)"b"(1) and (2) note that "the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless; or is at risk of hospitalization, institutionalization, incarceration or homelessness" or has a history of such. The respondent stated that the language does not specify that such treatment has occurred after the individual has sustained a brain injury, so individuals may qualify for this level of service by virtue of their behavior/symptomology unrelated to a brain injury and that, consequently, many individuals will qualify for this level of service by their premorbid history, which was not the intent of the legislature, the Iowa Medicaid Enterprise (IME), or the provider work group focused on the development of these rules.

Department response 7: The Department stated that in order to be eligible for community-based neurobehavioral rehabilitation services (CNRS), the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A). For the purposes of clarity, the introductory paragraph of new paragraph 78.56(2)"b" has been changed as follows:

b. Risk factors. The member has the following post-brain injury risk factors:

The Council on Human Services adopted these amendments on October 14, 2015.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective February 10, 2016.

The following amendments are adopted.

ITEM 1. Adopt the following **new** rule 441—77.52(249A):

441—77.52(249A) Community-based neurobehavioral rehabilitation services.

77.52(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

77.52(2) *Eligible providers.* The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.52(3) *Provider standards.* All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;

2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a certified brain injury specialist or have other brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members, including but not limited to:

1. Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access.

2. Compensatory strategies to assist in managing ADLS (activities of daily living).

3. Quality of life issues.

4. Behavioral supports and identification of antecedent triggers.

5. Health and medication management.

6. Dietary and nutritional programming.

7. Assistance with identifying and utilizing assistive technology.

8. Substance abuse and addiction issues.

9. Self-management and self-interaction skills.

10. Flexibility in programming to meet members' individual needs.

11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.

12. Community accessibility and safety.

13. Household maintenance.

14. Service support to the member's family or support system related to the member's neurobehavioral care.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum the training includes the following:

(1) Completion of the department-approved brain injury training modules.

(2) Member rights.

(3) Confidentiality and privacy.

(4) Dependent adult and child abuse prevention and mandatory reporter training.

(5) Individualized rehabilitation treatment plans.

(6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete cardiopulmonary resuscitation (CPR) training, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by 441—subparagraph 78.54(3)*"a"*(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training.

f. The organization shall have in place an outcome management system which measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.

(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.

(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement the following outcome-based standards for rights and dignity:

(1) Members are valued.

(2) The member and the member's treatment team mutually develop an individualized service plan (ISP) that takes into account the member's individual strengths, barriers and interests. The service plan shall include goals which are based on the member's need for services and shall address the neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment.

(3) The member and the member's treatment team evaluate the member's progress towards treatment goals regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

(4) The member and the member's legal representative have the right to file grievances regarding the provider's implementation of the organizational standards, or its employee's or contractual person's action which affects the member. The provider shall provide to members the policies and procedures for member grievances and appeals at the commencement of services and annually thereafter.

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with 481—subrule 63.23(4), rule 481—63.33(135C), and rule 481—63.37(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

1. Restraint, including chemical restraint, manual restraint or mechanical restraint;

2. Alarms added to a member's natural environment including doors, windows, refrigerators, cabinets, and other home appliances and fixtures;

3. Exclusionary time out;

4. Intensive staffing for control of behavior;

5. Limited access or contingency access to preferred items or activities naturally available in the member's environment;

6. Reprimand;

7. Response cost; and

8. Use of psychotropic medications to control the occurrence of an unwanted behavior.

(6) Members receive individualized services.

(7) Members or their legal representatives provide written consent regarding which personal information is shared and with whom.

(8) Members receive assistance with accessing financial management services as needed.

(9) Members receive assistance with obtaining preventive, appropriate and timely medical and dental care.

(10) The member's living environment is reasonably safe and located in the community.

(11) The member's desire for intimacy is respected and supported.

ITEM 2. Adopt the following **new** rule 441—78.56(249A):

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.56(2) *Member eligibility.* To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have a standardized comprehensive functional neurobehavioral assessment reviewed or completed by a licensed neuropsychologist, neurologist, M.D., or D.O. The neurobehavioral assessment shall document the member's need for community-based

neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had a department-approved, standardized comprehensive functional neurobehavioral assessment completed within the 90 days prior to admission. Each needs assessment will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury, which must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) *Covered services.*

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance abuse and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

(1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Compensatory strategies to assist in managing ADLS (activities of daily living);

(4) Behavioral supports;

(5) Assistance with obtaining and use of assistive technology;

(6) Assistance with the self-identification of antecedent triggers;

(7) Flexibility in programming to meet the member's individual needs;

(8) Assistance with re-learning coping and compensatory strategies;

(9) Assistance with the development and application of self-advocacy skills to navigate the service system;

(10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

(1) The IME medical services unit will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

g. Quality review. The IME medical services unit may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

78.56(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

ITEM 3. Adopt the following **new** provider category in subrule **79.1(2)** as follows:

Provider category	Basis of reimbursement	Upper limit
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: $21.11 per 15-minute unit.

ITEM 4. Adopt the following **new** subrule 79.1(28):

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

ITEM 5. Adopt the following **new** subparagraph **79.3(2)"d"(42)**:

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:

1. Department-approved standardized neurobehavioral assessment tool.
2. Community-based neurobehavioral treatment order.
3. Treatment plan.
4. Clinical records documenting diagnosis and treatment history.
5. Progress or status notes.
6. Service notes or narratives.
7. Procedure, laboratory, or test orders and results.
8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
9. Medication administration records.

[Filed 12/11/15, effective 2/10/16]
[Published 1/6/16]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 1/6/16.