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The Iowa Administrative Code (IAC) Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement is a compilation of updated Iowa Administrative Code chapters that reflect rule changes which have been adopted by agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17, 17A.4, and 17A.5 and published in the Iowa Administrative Bulletin bearing the same publication date as the one for this Supplement. To determine the specific changes to the rules, refer to the Iowa Administrative Bulletin. To maintain a loose-leaf set of the IAC, insert the chapters according to the instructions included in the Supplement.

In addition to the rule changes adopted by agencies, the chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay or suspension imposed by the ARRC pursuant to section 17A.8(9) or 17A.8(10); rescission of a rule by the Governor pursuant to section 17A.4(8); nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa; other action relating to rules enacted by the General Assembly; updated chapters for the Uniform Rules on Agency Procedure; or an editorial change to a rule by the Administrative Code Editor pursuant to Iowa Code section 2B.13(2).

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

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Education Department[281]

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Transportation Department[761]

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CHAPTER 37
EQUIPMENT DISTRIBUTION PROGRAM

199—37.1(477C) Purpose. This chapter describes the board's program established pursuant to Iowa Code section 477C.4 to secure, finance, and distribute telecommunications devices. The board's equipment distribution program serves eligible individuals who are deaf or hard-of-hearing or who have difficulty with speech.

The equipment distribution program will be limited by revenue considerations and annual budget amounts set by the board, with the advice of the dual party relay council established in Iowa Code section 477C.5. Before submitting a proposed annual budget to the board, the board's equipment distribution program project manager shall provide the council with the proposed budget for the council's review and discussion at a council meeting. The project manager will advise the board of any council recommendations regarding the proposed budget. When the budgeted amounts for a period are committed or expended, no further vouchers for equipment will be issued until the next period when the board budgets additional amounts.

[ARC 3665C, IAB 2/28/18, effective 4/4/18; ARC 6925C, IAB 3/8/23, effective 4/12/23]

199—37.2(477C) Program structure. The equipment distribution program will be conducted by a program administrator chosen by the board. Distribution of equipment will be made through a voucher system utilizing private vendors for equipment purchases. Vouchers to pay part or, depending upon the price, all of the cost of equipment will be issued by the program administrator to eligible recipients. After purchase using a voucher, the recipient will be the permanent owner of the equipment and responsible for enforcement of any warranties and for any repairs.

[ARC 3665C, IAB 2/28/18, effective 4/4/18]

199—37.3(477C) Equipment. The board will authorize and maintain a list of the types of equipment to be distributed through the program.

[ARC 3665C, IAB 2/28/18, effective 4/4/18]

199—37.4(477C) Application process and eligibility. Applications will be processed in queue as determined by the program administrator. No person will be entitled to equipment at a particular time merely because that person meets the eligibility requirements. Additional vouchers will not be issued during a period if unpaid vouchers are outstanding for the remaining funds budgeted for the period. To be eligible to receive a voucher for equipment under the program, a person must satisfy the following requirements. By signing the application form or otherwise averring to the accuracy of the information contained in the application, an applicant or the applicant's power of attorney certifies that the information provided therein is true.

37.4(1) Verification of need with initial application. An applicant's initial application shall include verification of the applicant's need for the equipment. The verification shall be made by an appropriate professional, including but not limited to a licensed physician; certified teacher in the fields of hearing, speech, or visual impairment; licensed and certified sign language interpreter; speech pathologist; audiologist or hearing aid specialist; or an appropriate state or federal agency representative.

37.4(2) The applicant must have, or have applied for, access to the service which will allow the applicant to use the requested equipment. Access to Internet service may be provided through a public Wi-Fi connection.

37.4(3) The applicant must be an individual and an Iowa resident.

37.4(4) The applicant must be at least five years of age or demonstrate an ability to use the equipment requested. No demonstration is required for those five years of age and older.

37.4(5) An applicant must agree to cooperate with studies to evaluate the effectiveness of the program.

37.4(6) An applicant's gross annual family income must be equal to or less than \$76,000 for a family of two. Family sizes above or below two will increase or decrease that amount in \$10,000 increments per family member change.

37.4(7) The applicant will be limited to a voucher for one type of equipment or equipment package.

37.4(8) Reapplication. Prior voucher recipients may reapply through the program to replace existing equipment or to obtain new equipment, as appropriate. Reapplication will be limited by a three-year waiting period. The reapplication period may be shortened by the board's equipment distribution program project manager in an individual case for good cause shown. At the time of reapplication for equipment, it is not necessary for the applicant's need for the equipment to be reverified by an appropriate professional. The program administrator shall verify that the applicant reapplying for equipment previously qualified for and continues to qualify for a voucher.

[ARC 3665C, IAB 2/28/18, effective 4/4/18; ARC 6925C, IAB 3/8/23, effective 4/12/23]

199—37.5(477C) Voucher system.

37.5(1) Amount. The voucher will state a standard amount for a particular piece of equipment.

a. The standard amount shall be determined and updated periodically by the program administrator.

b. The standard amount shall be 95 percent of the average retail market price for the piece of equipment, unless the retail market price is more than \$1,000, in which case the standard amount shall be 99 percent of the average retail market price. The standard amount may be increased to 100 percent if a person demonstrates to the program administrator that the person is unable to pay the matching amount.

37.5(2) Voucher use. The recipient of a voucher may purchase equipment from any vendor that will accept the voucher and may apply the voucher amount toward purchase of the brand and model of indicated equipment as the recipient chooses. An invoice for equipment purchased prior to the issuance of a voucher shall not be reimbursed.

37.5(3) Term. The voucher shall provide for a 40-day period for the voucher recipient to present the voucher to the vendor. The vendor, upon presentation of the voucher, shall have 60 days to complete the sale and delivery of the equipment and to return the voucher to the program administrator. The program administrator shall have 20 days to process and return the voucher to the board for payment. The program administrator, for good cause shown, may extend either the 40- or 60-day deadline, provided the voucher is returned to the board for payment within 120 days from the issuance of the voucher. The program administrator may authorize reimbursement for a voucher issued more than 120 days before the voucher is sent to the board for payment if the program administrator determines good cause exists for extending the 120-day deadline and provides supporting documentation to the board.

37.5(4) Payment. The voucher is not a negotiable instrument. Upon presentation of documentation by the vendor as required by the board, including but not limited to an invoice showing an amount due no greater than the voucher amount, the vendor will be issued a state warrant for the amount due.

[Editorial change: IAC Supplement 12/29/10; ARC 3665C, IAB 2/28/18, effective 4/4/18]

199—37.6(477C) Complaints. All complaints concerning the equipment distribution program will be resolved pursuant to the following:

37.6(1) The program administrator will make determinations concerning matters such as eligibility, type of equipment for particular applicants, or reimbursement of vendors.

37.6(2) The program administrator, after requiring interested persons to state verbally or in writing any complaint or dispute arising under the equipment distribution program, shall attempt to settle the matter informally within 45 days.

37.6(3) Should the informal dispute resolution process fail, the complainant may submit the complaint to the board for processing by the board's equipment distribution program project manager as provided in 199—Chapter 6. The project manager will provide a copy of the complaint to the program administrator and the consumer advocate. The project manager will issue a proposed resolution that describes the facts involved in the dispute, clearly states the proposed resolution, and gives notice that any interested person dissatisfied with the proposed resolution has 14 days after the proposed resolution is issued to file a written request for formal complaint proceedings before the board.

37.6(4) If no timely request for formal complaint proceedings is filed, the proposed resolution shall be deemed binding on all interested persons served with the proposed resolution.

37.6(5) The board will process requests for formal complaint proceedings as provided in rule 199—6.5(476).

[Editorial change: IAC Supplement 12/29/10; **ARC 3665C**, IAB 2/28/18, effective 4/4/18]

These rules are intended to implement Iowa Code section 477C.4.

[Filed emergency 10/7/94—published 10/26/94, effective 10/7/94]

[Filed 4/21/95, Notice 10/26/94—published 5/10/95, effective 6/14/95]

[Published 6/17/98 to update name and address of board]

[Filed 4/14/00, Notice 2/9/00—published 5/3/00, effective 6/7/00]

[Filed 5/16/07, Notice 4/11/07—published 6/6/07, effective 7/11/07]

[Editorial change: IAC Supplement 12/29/10]

[Filed **ARC 3665C** (Notice **ARC 3119C**, IAB 6/21/17), IAB 2/28/18, effective 4/4/18]

[Filed **ARC 6925C** (Notice **ARC 6596C**, IAB 10/19/22), IAB 3/8/23, effective 4/12/23]

CHAPTER 24
COMMUNITY COLLEGE ACCREDITATION

281—24.1(260C) Purpose. As set forth in Iowa Code section 260C.1, the purpose of accreditation of Iowa's community colleges is to confirm that each college is offering, to the greatest extent possible, educational opportunities and services, when applicable, but not be limited to:

1. The first two years of college work including preprofessional education.
2. Career and technical training.
3. Programs for in-service training and retraining of workers.
4. Programs for high school completion for students of post-high school age.
5. Programs for all students of high school age, who may best serve themselves by enrolling for career and technical training, while also enrolled in a local high school, public or private.
6. Programs for students of high school age to provide advanced college placement courses not taught at a student's high school while the student is also enrolled in the high school.
7. Student personnel services.
8. Community services.
9. Career and technical education for persons who have academic, socioeconomic, or other disabilities which prevent succeeding in regular career and technical education programs.
10. Training, retraining, and all necessary preparation for productive employment of all citizens.
11. Career and technical training for persons who are not enrolled in a high school and who have not completed high school.
12. Developmental education for persons who are academically or personally underprepared to succeed in their program of study.

[ARC 8644B, IAB 4/7/10, effective 5/12/10]

281—24.2(260C) Scope. Each community college is subject to accreditation by the state board of education, as provided in Iowa Code section 260C.47. The state board of education shall grant accreditation if a community college meets the standards established in this chapter.

281—24.3(260C) Definitions. For purposes of interpreting rule 281—24.5(260C), the following definitions shall apply:

“Applied liberal arts and sciences course.” An applied liberal arts and sciences course is a course that is classified as arts and sciences in Iowa's common course numbering system and that primarily consists of hands-on or occupational skill development, including but not limited to accounting, ceramics, criminal investigation, dance, drama, music, photography, and physical education.

“Department.” Department refers to the Iowa department of education.

“Director.” Director refers to the director of the department.

“Field of instruction.” Field of instruction indicates the discipline or occupational area within which an instructor teaches, which aligns with the content of the course being taught as indicated by the course prefix, title, or description.

“Full-time instructor.” An instructor is considered to be full-time if the community college board of directors designates the instructor as full-time. Determination of full-time status shall be based on local board-approved contracts.

“Higher Learning Commission.” The Higher Learning Commission is the regional accrediting authority recognized by the U.S. Department of Education. Iowa Code sections 260C.47 and 260C.48 require that the state accreditation process be integrated with that of the Higher Learning Commission.

“Joint enrollment.” Joint enrollment refers to any community college credit course offered to students enrolled in a secondary school. Courses offered for joint enrollment include courses delivered through contractual agreements between school districts and community colleges, courses delivered through the postsecondary enrollment options program, and college credit courses taken independently by tuition-paying secondary school students.

“Qualifying graduate field or major.” A qualifying graduate field or major represents an academic discipline in which an instructor must have earned credit in order to teach courses in specified fields of instruction.

“Relevant tested experience.” Relevant tested experience refers to the breadth, depth, and currency of work experience outside of the classroom in real-world situations relevant to the field of instruction. [ARC 8644B, IAB 4/7/10, effective 5/12/10; ARC 2945C, IAB 2/15/17, effective 3/22/17]

281—24.4(260C) Accreditation components and criteria—Higher Learning Commission. In order to be accredited by the state board of education and maintain accreditation status, a community college must meet the accreditation criteria of the Higher Learning Commission and additional state standards. Documents and materials provided in accordance with the accreditation requirements of the Higher Learning Commission shall also be provided to the department for the state accreditation process. [ARC 8644B, IAB 4/7/10, effective 5/12/10; ARC 0015C, IAB 2/22/12, effective 3/28/12]

281—24.5(260C) Accreditation components and criteria—additional state standards. To be granted accreditation by the state board of education, an Iowa community college shall also meet additional standards pertaining to minimum or quality assurance standards for faculty (Iowa Code section 260C.48(1)); faculty load (Iowa Code section 260C.48(2)); special needs and protected classes (Iowa Code section 260C.48(3)); career and technical education program evaluation (Iowa Code section 258.4(7)); facilities, parking lots and roads; strategic planning; quality faculty plan (Iowa Code section 260C.36); and senior year plus programs (Iowa Code chapter 261E).

24.5(1) Faculty.

a. Community college-employed instructors who teach college credit courses shall meet minimum standards and institutional quality faculty plan requirements. Standards shall at a minimum require that all community college instructors meet the following requirements:

(1) Instructors teaching courses in the area of career and technical education shall be registered, certified, or licensed in the occupational area in which the state requires registration, certification, or licensure and shall meet at least one of the following qualifications:

1. Possess a baccalaureate degree or higher in the field of instruction in which the instructor teaches classes, or possess a baccalaureate degree in any area of study if at least 18 of the credit hours completed were in the career and technical field of instruction in which the instructor teaches classes.

2. Possess an associate degree in the career and technical education field of instruction in which the instructor is teaching, if such degree is considered terminal for that field of instruction, and have at least 3,000 hours of recent and relevant work experience in the occupational area or related occupational area in which the instructor teaches classes.

3. Have special training and at least 6,000 hours of relevant tested experience in the occupational area or related occupational area in which the instructor teaches classes if the instructor possesses less than a baccalaureate degree in the area or related area of study or occupational area in which the instructor is teaching classes and the instructor does not meet the requirements of subparagraph 24.5(1)“a”(2).

(2) For purposes of paragraphs 24.5(1)“a”(1)“2” and “3,” if the instructor is a licensed practitioner who holds a career and technical endorsement under Iowa Code chapter 272, relevant work experience in the occupational area includes, but is not limited to, classroom instruction in a career and technical education subject area offered by a school district or accredited nonpublic school.

(3) Instructors in the area of arts and sciences shall meet one of the following qualifications:

1. Possess a master’s degree or higher from an accredited graduate school in each field of instruction in which the instructor is teaching classes.

2. Possess a master’s degree or higher from an accredited graduate school and have completed a minimum of 18 graduate semester hours in a combination of the qualifying graduate fields identified as related to the field of instruction in which the instructor is teaching classes. These 18 graduate semester hours must include at least 6 credits in the specific course content being taught, with at least 12 credits required for courses that serve as prerequisites for junior-level courses at transfer institutions.

3. For courses identified as applied liberal arts and sciences, possess at least a bachelor's degree and a combination of formal training and professional tested experience equivalent to 6,000 hours. The instructor shall hold the appropriate registration, certification, or licensure in occupational areas in which such credential is necessary for practice.

For purposes of this subparagraph, "accredited" means that an institution of higher education meets the standards established by an accrediting agency recognized under 34 CFR Part 602 and by Title IV of the federal Higher Education Opportunity Act, Pub. L. No. 110-315.

b. Developmental education and noncredit instructors are not subject to standards under this subrule. Adult education instructors shall meet minimum standards set forth in rule 281—23.6(260C).

c. A faculty standards council shall be convened by the department to review procedures for establishing and reviewing minimum instructor qualifications and definitions for "field of instruction," "applied liberal arts and sciences courses," "qualifying graduate field or major," and "relevant tested experience." Definitions shall be based on accepted practices of regionally accredited two- and four-year institutions of higher education.

(1) The council shall include faculty and academic administrators and meet at least annually. The council shall make recommendations to a committee consisting of the chief academic officers of Iowa's 15 community colleges. The committee shall adopt definitions and minimum faculty qualification standards to be utilized for the state accreditation process. Each community college shall adhere to the adopted definitions and minimum faculty qualification standards.

(2) When utilizing relevant tested experience to qualify an instructor to teach classes within a specific field of instruction, each community college shall maintain well-defined policies, procedures, and documentation in alignment with the adopted definitions and minimum faculty qualification standards. This documentation shall demonstrate that the instructor possesses the experience and expertise necessary to teach in the specified field of instruction and is current in the instructor's discipline. When tested experience is assessed, an hour of relevant work is equal to 60 minutes and one full-time year of relevant work is equal to 2,000 hours.

24.5(2) Faculty load.

a. Arts and sciences. The full-time teaching load of an instructor in arts and sciences courses shall be 15 credit hours within a traditional semester or the equivalent and shall not exceed a maximum of 16 credit hours within a traditional semester or the equivalent. An instructor may also have an additional teaching assignment beyond the maximum academic workload, provided the instructor and the community college administration mutually consent to this additional assignment and the total workload does not exceed the equivalent of 22 credit hours within a traditional semester or the equivalent.

b. Career and technical education. The full-time teaching load of an instructor in career and technical education programs shall not exceed an aggregate of 30 hours per week or the equivalent. An instructor may also teach the equivalent of an additional 3 credit hours, provided the instructor consents to this additional assignment. When the teaching assignment includes classroom subjects (nonlaboratory), consideration shall be given to establishing the teaching load more in conformity with that of paragraph 24.5(2) "a."

24.5(3) Special needs and protected classes. Community colleges shall provide equal access to the full range of program offerings and services including, but not limited to, recruitment, enrollment, and placement activities for students with special education needs or protected by state or federal civil rights regulations. Students with disabilities shall be given access to the full range of program offerings at a college through reasonable accommodations.

24.5(4) Career and technical education evaluation. The director of the department shall ensure that Iowa's community colleges annually review at least 20 percent of approved career and technical education programs. The community college career and technical program review and evaluation system must ensure that the programs:

- a.* Are compatible with educational reform efforts.
- b.* Are capable of responding to technological change and innovation.

- c. Meet educational needs of the students and employment community, including students with special education needs or protected by state or federal civil rights regulations.
- d. Enable students enrolled to perform the minimum competencies independently.
- e. Are articulated/integrated with the total school curriculum.
- f. Enable students with a secondary career and technical background to pursue other educational interests in a postsecondary setting, if desired.
- g. Provide students with support services and eliminate access barriers to education and employment for students with special education needs or protected by state or federal civil rights regulations.

24.5(5) Facilities, parking lots and roads.

a. *Facilities master planning.* Each community college shall present evidence of adequate planning, including a board-approved facilities plan. Planning includes tentative program approval, a master campus plan, written educational specifications, site plot showing location of proposed and existing facilities, elevations and floor plans.

b. *Accessibility and safety.* All new or remodeled facilities (buildings and programs offered in such facilities) and services in such facilities shall be made functional and usable for persons with special needs and shall comply with Iowa Code chapter 104A and the Americans With Disabilities Act, 42 U.S.C. § 12101, and address issues of campus safety and security as required by Iowa Code chapter 260C and by the federal Clery Act, 20 U.S.C. § 1092(f). All parking areas and roads shall comply with all state and federal rules and regulations dealing with roads, parking ramps, and accessibility requirements.

c. *Adequate facilities.* All administrative facilities, classrooms, laboratories, and related facilities shall be educationally adequate for the purpose for which they are designed.

d. *Library or learning resource center.* A library or learning resource center shall be planned as part of the master campus plan and space made for library or learning resource center services within the initial construction. The library or learning resource center shall be adequately staffed with qualified professionals and skilled nonprofessional personnel. The library or learning resource center materials collection of a community college shall be accessible and adequate in size and scope to serve effectively the number and variety of programs offered and the number of students enrolled, including students enrolled at distance and satellite sites. The library or learning resource center materials shall show evidence of having been selected by faculty as well as professional library or learning resource staff and shall be kept up-to-date. The budget of the library or learning resource center shall be appropriate for the programs and services offered by the community college.

e. *Student center.* An area of the college shall be provided where students may gather informally and where food is available.

24.5(6) Strategic planning. The community college shall prepare a strategic plan at least once every five years to guide the college and its decision making.

24.5(7) Quality faculty plan. The community college shall establish a quality faculty committee consisting of instructors and administrators to develop and maintain a plan for hiring and developing quality faculty. The committee shall have equal representatives of arts and sciences and career and technical faculty with no more than a simple majority of members of the same gender. Faculty shall be appointed by the certified employee organization representing faculty, if any, and administrators shall be appointed by the college's administration. If no faculty-certified employee organization representing faculty exists, the faculty shall be appointed by administration pursuant to Iowa Code section 260C.48(4). The committee shall submit the plan to the board of directors for consideration, approval and submittal to the department of education. Standards relating to quality assurance of faculty and ongoing quality professional development shall be the accreditation standards of similar accredited institutions of higher education that are consistent with the standards established pursuant to this rule and the faculty standards required under specific programs offered by the community college that are accredited by other accrediting agencies. For purposes of this subrule, "accredited" means that an institution of higher education meets the standards established by an accrediting agency recognized under 34 CFR Part 602 and by Title IV of the federal Higher Education Opportunity Act, Pub. L. No. 110-315.

a. For purposes of this subrule, the following definitions shall apply.

(1) "Counselor" means those who are classified as counselors as defined in the college's collective bargaining agreement or written policy.

(2) "Media specialist" means those who are classified as media specialists as defined in the college's collective bargaining agreement or written policy.

b. The institutional quality faculty plan is applicable to all community college-employed faculty teaching college credit courses, counselors, and media specialists. The plan requirements may be differentiated for each type of employee. The plan shall include, at a minimum, each of the following components:

(1) Plan maintenance. The quality faculty committee shall submit proposed plan modifications to the board of directors for consideration and approval. It is recommended that the plan be updated at least annually.

(2) A determination of the faculty and staff to be included in the plan including, but not limited to, all instructors teaching college credit courses, counselors, and media specialists.

(3) Orientation for new faculty. It is recommended that new faculty orientation be initiated within six months from the hiring date. It is recommended that the orientation of new faculty be flexible to meet current and future needs and provide options other than structured college courses for faculty to improve teaching strategies, curriculum development and evaluation strategies. It is recommended that the college consider developing a faculty mentoring program.

(4) Continuing professional development for faculty. It is recommended that the plan clearly specify required components including time frame for continuing professional development for faculty. It is recommended that the plan include the number of hours, courses, workshops, professional and academic conferences or other experiences such as industry internships, cooperatives and exchange programs that faculty may use for continuing professional development. It is recommended that the plan include prescribed and elective topics such as discipline-specific content and educational trends and research. Examples of topics that may be considered include dealing with the complexities of learners, skills in teaching adults, curriculum development, assessment, evaluation, enhancing students' retention and success, reaching nontraditional and minority students, improving skills in implementing technology and applied learning, leadership development, and issues unique to a particular college. The institutional quality faculty plan shall include professional development components for all instructional staff, counselors, and media specialists and may include reciprocity features that facilitate movement from one college to another.

(5) Procedures for accurate record keeping and documentation for plan monitoring. It is recommended that the plan identify the college officials or administrators responsible for the administration, record keeping and ongoing evaluation and monitoring of the plan. It is recommended the plan monitoring, evidence collected, and records maintained showing implementation of the plan be comprehensive in scope. It is recommended that the plan provide for the documentation that each faculty member appropriately possesses, attains or progresses toward attaining minimum competencies.

(6) Consortium arrangements where appropriate, cost-effective and mutually beneficial. It is recommended that the plan provide an outline of existing and potential consortium arrangements including a description of the benefits, cost-effectiveness, and method of evaluating consortium services.

(7) Specific activities that ensure that faculty attain and demonstrate instructional competencies and knowledge in their subject or technical areas. It is recommended that the plan identify faculty minimum competencies and explain the method or methods of determining and assessing competencies. It is recommended that the plan contain procedures for reporting faculty progress. It is recommended that faculty be notified at least once a year of their progress in attaining competencies.

(8) Procedures for collection and maintenance of records demonstrating that each faculty member has attained or documented progress toward attaining minimum competencies. It is recommended that the plan specify data collection procedures that demonstrate how each full-time faculty member has attained or has documented progress toward attaining minimum competencies. It is recommended that the plan incorporate the current department of education management information system

data submission requirements by which each college submits complete human resources data files electronically as a part of the college's year-end reporting.

(9) Compliance with the faculty accreditation standards of similar accredited institutions of higher education that are consistent with the standards established pursuant to Iowa Code section 260C.48 and with faculty standards required under specific programs offered by the community college that are accredited by other accrediting agencies. For purposes of this subparagraph, "accredited" means that an institution of higher education meets the standards established by an accrediting agency recognized under 34 CFR Part 602 and by Title IV of the federal Higher Education Opportunity Act, Pub. L. No. 110-315.

c. The department of education shall notify the community college when the department requires that a modified quality faculty plan be submitted. The department shall review the plan during the state accreditation evaluations to ensure each community college's compliance and progress in implementing a quality faculty plan as approved by the local board of directors. The department shall review the following:

(1) Documents submitted by the college that demonstrate that the plan includes each component required by paragraph "b" of this subrule.

(2) Documentation submitted by the college that the board of directors approved the plan.

(3) Documentation submitted by the college that the college is implementing the approved plan, including, but not limited to, evidence of plan monitoring, evaluation and updating; evidence that the faculty has attained, or is progressing toward attaining, minimum competencies and standards contained in Iowa Code section 260C.48; evidence that faculty members have been notified of their progress toward attaining minimum competencies and standards; and evidence that the college meets the minimum accreditation requirements for faculty required by the Higher Learning Commission.

(4) Documentation that the college administration encourages the continued development of faculty potential as defined in Iowa Code Supplement section 260C.36 as amended by 2008 Iowa Acts, House File 2679.

(5) Documentation of the human resources report submitted by the college through the department's community college management information system.

24.5(8) Senior year plus. The community college shall provide access to joint enrollment opportunities for high school age students. Each college shall comply with the appropriate standards defined in Iowa Code chapter 261E.

[ARC 8644B, IAB 4/7/10, effective 5/12/10; ARC 0015C, IAB 2/22/12, effective 3/28/12; ARC 2945C, IAB 2/15/17, effective 3/22/17; ARC 5327C, IAB 12/16/20, effective 1/20/21; ARC 6926C, IAB 3/8/23, effective 4/12/23]

281—24.6(260C) Accreditation process.

24.6(1) Components. The community college accreditation process shall include the following components:

a. Each community college shall submit information on an annual basis to the department of education to comply with program evaluation requirements adopted by the state board of education.

b. The department of education shall conduct a comprehensive on-site accreditation evaluation of each community college on a ten-year interval. An interim evaluation midway between comprehensive evaluations shall also be conducted. The department shall prepare a staggered evaluation schedule which sets no more than three comprehensive or interim evaluations in any one year. No comprehensive or interim evaluation shall be required for continued accreditation prior to a community college's first evaluation under the schedule. The department shall have the authority to conduct focus evaluation visits as needed.

24.6(2) Accreditation team. The size and composition of the accreditation team shall be determined by the director of the department, but the team shall include members of the department of education staff and staff members from community colleges other than the community college being evaluated for accreditation, and any other technical experts as needed.

24.6(3) Accreditation team action. After a visit to a community college, the accreditation team shall evaluate whether the accreditation standards have been met and shall make a report to the director

of the department and the state board of education, together with a recommendation as to whether the community college shall remain accredited. The accreditation team shall report strengths and opportunities for improvement, if any, for each standard and criterion and shall advise the community college of available resources and technical assistance to further enhance strengths and address areas for improvement. A community college may respond to the accreditation team's report.

24.6(4) State board of education consideration of accreditation. The state board of education shall determine whether a community college shall remain accredited. Approval of accreditation for a community college by the state board of education shall be based upon the recommendation of the director of the department after study of the factual and evaluative evidence on record pursuant to the standards and criteria described in this chapter, and based upon the timely submission of information required by the department of education in a format provided by the department of education. With the approval of the director of the department, a focus visit may be conducted if the situation at a particular college warrants such a visit.

a. Accreditation granted. Continuation of accreditation, if granted, shall be for a ten-year term; however, approval for a lesser term may be granted by the state board of education if the board determines that conditions so warrant.

b. Accreditation denied or conditional accreditation. If the state board of education denies accreditation or grants conditional accreditation, the director of the department of education, in cooperation with the board of directors of the community college, shall establish a plan prescribing the procedures that must be taken to correct deficiencies in meeting the standards and criteria and shall establish a deadline for correction of the deficiencies. The plan shall be submitted to the director within 45 days following the notice of accreditation denial or conditional accreditation. The plan shall include components which address correcting deficiencies, sharing or merger options, discontinuance of specific programs or courses of study, and any other options proposed by the state board of education or the accreditation team to allow the college to meet the accreditation standards and criteria.

c. Implementation of plan. During the time specified in the plan for its implementation, the community college remains accredited. The accreditation team shall revisit the community college to evaluate whether the deficiencies in the standards or criteria have been corrected and shall make a report and recommendation to the director and the state board of education. The state board of education shall review the report and recommendation, may request additional information, and shall determine whether the deficiencies have been corrected.

d. Removal of accreditation. The director shall give a community college which fails to meet accreditation standards, as determined by the state board of education, at least one year's notice prior to removal of accreditation. The notice shall be sent by certified mail or restricted certified mail addressed to the chief executive officer of the community college and shall specify the reasons for removal of accreditation. The notice shall also be sent to each member of the board of directors of the community college. If, during the year, the community college remedies the reasons for removal of accreditation and satisfies the director that the community college will comply with the accreditation standards and criteria in the future, the director shall continue the accreditation and shall transmit notice of the action to the community college by certified mail or restricted certified mail.

e. Failure to correct deficiencies. If the deficiencies have not been corrected in a program of a community college, the community college board of directors shall take one of the following actions within 60 days from removal of accreditation:

(1) Merge the deficient program or programs with a program or programs from another accredited community college.

(2) Contract with another accredited postsecondary educational institution for purposes of program delivery at the community college.

(3) Discontinue the program or programs which have been identified as deficient.

f. Appeal process provided. The action of the director to remove the state accreditation of a community college program may be appealed to the state board of education as provided in Iowa Code section 260C.47, subsection 7.

[ARC 8644B, IAB 4/7/10, effective 5/12/10; ARC 0015C, IAB 2/22/12, effective 3/28/12]

These rules are intended to implement Iowa Code section 258.4(7) and chapters 260C and 261E.

[Filed 7/27/06, Notice 6/7/06—published 8/16/06, effective 9/20/06]

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[Filed ARC 2945C (Notice ARC 2853C, IAB 12/7/16), IAB 2/15/17, effective 3/22/17]

[Filed ARC 5327C (Notice ARC 5209C, IAB 10/7/20), IAB 12/16/20, effective 1/20/21]

[Filed ARC 6926C (Notice ARC 6756C, IAB 12/14/22), IAB 3/8/23, effective 4/12/23]

CHAPTER 49
INDIVIDUAL CAREER AND ACADEMIC PLAN

281—49.1(279) Purpose. For the school year beginning July 1, 2016, and each succeeding school year, the board of directors of each school district shall ensure each student in grade 8 develops and, in each succeeding year until graduation, reviews and revises an individualized career and academic plan.

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16]

281—49.2(279) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Approved system*” means a vendor-provided career information and decision-making system which meets the requirements of rule 281—49.6(279).

“*Board*” means the board of directors of a public school district.

“*Career cluster*” means a nationally recognized framework for organizing and classifying career and technical education programs.

“*Comprehensive school improvement plan*” means the plan required of a school or school district pursuant to Iowa Code section 256.7(21)“a.”

“*Department*” means the Iowa department of education.

“*Director*” means the director of the Iowa department of education.

“*District plan*” means the career guidance plan developed by each school district detailing the delivery of career guidance in compliance with this chapter.

“*Educational program*” means the educational program as defined in rule 281—12.2(256).

“*Plan*” means the individualized career and academic plan established under this chapter which is created by each student of the school district in eighth grade and which, at a minimum, meets the requirements of rule 281—49.3(279).

“*Postsecondary education and training options*” means postsecondary programs and pathways related to career interests, including apprenticeships and on-the-job training; military training; and industry-based certification, licensure, and diploma and degree programs offered by accredited professional colleges, technical and community colleges, and public and private baccalaureate colleges and universities.

“*School counseling program*” means the school counseling program established by Iowa Code section 256.11(9A).

“*Student*” means an enrolled student as defined in rule 281—12.2(256).

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16]

281—49.3(279) Individualized career and academic plan.

49.3(1) Requirements. The plan shall, at a minimum, achieve all of the following:

a. Prepare the student for successful completion of the core curriculum developed by the state board of education pursuant to 281—Chapter 12 by the time the student graduates from high school.

b. Identify the student’s postsecondary education and career options and goals.

c. Identify the coursework and work-based learning needed in grades 9 through 12 to support the student’s postsecondary education and career options and goals.

d. Prepare the student to successfully complete, prior to graduation and following a timeline included in the plan, the essential components prescribed in rule 281—49.4(279).

e. Prior to graduation, advise the student how to successfully complete the Free Application for Federal Student Aid.

49.3(2) Progress report. The school district shall report annually to each student enrolled in grades 9 through 12, and, if the student is under the age of 18, to each student’s parent or guardian, the student’s progress toward meeting the goal of successfully completing the core curriculum and high school graduation requirements adopted by the state board of education pursuant to 281—Chapter 12 and toward achieving the goals of the student’s career and academic plan.

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16; ARC 6928C, IAB 3/8/23, effective 4/12/23]

281—49.4(279) Essential components. The district shall engage each student in activities which support the following essential components of the plan:

49.4(1) Self-understanding. Students shall engage in developmentally appropriate inventories and assessments that promote self-understanding, the connection to work, and engage in meaningful reflective activities about the results. Inventories and assessments may include, but are not limited to, interest inventories; work values assessments; personal values inventories; abilities, strengths, and skills assessments; career cluster assessments; learning styles inventories; and noncognitive skills assessments.

49.4(2) Career information. Students shall research careers based on self-understanding results and engage in meaningful reflection about the findings. Career information shall include, but is not limited to, state and national wage, earning, and employment outlook data for a given occupation; job descriptions, including such information as essential duties, aptitudes, work conditions, and physical demands; and training and education requirements.

49.4(3) Career exploration. Students shall engage in activities that reveal connections among school-based instruction, career clusters, and the world of work and engage in meaningful reflection. Career exploration experiences may be face-to-face or virtual and may include, but are not limited to, job tours, career days or career fairs, and other work-based learning activities.

49.4(4) Postsecondary exploration. Students shall engage in activities to explore relevant postsecondary education and training options related to career interests and engage in meaningful reflection on the exploration experience. Postsecondary exploration activities may be face-to-face or virtual and may include, but are not limited to, site or campus visits; career, employment, or college fairs; and visits with recruiters and representatives of postsecondary education and training options.

49.4(5) Career and postsecondary decision. Students shall complete relevant activities to meet their postsecondary goals consistent with the plan and stated postsecondary intention. Relevant career and postsecondary decision activities may include, but are not limited to, completion of required college or university admission or placement examinations; completion of relevant entrance applications and documents or job applications, résumés, and cover letters; completion of financial aid and scholarship applications; and review and comparison of award letters and completion requirements for different postsecondary options, such as annual financial aid requirements, the role of remedial courses, course-of-study requirements, and the role of the academic advisory.

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16]

281—49.5(279) District plan.

49.5(1) Components of district plan. The school district shall develop a written career guidance plan. The district plan shall include the following components:

a. The district shall, at a minimum, describe the following aspects of the district plan.

(1) The activities to be undertaken in each grade level to achieve the requirements of rule 281—49.3(279).

(2) Integration of the career guidance plan with the district's comprehensive school improvement plan and school guidance counseling program.

(3) At the district's discretion, any additional outcomes to be integrated into the career guidance system.

b. Designation of team. The superintendent of each school district shall designate a team of education practitioners to carry out the duties assigned to the school district under this rule. The district plan shall include a list, by job position, of the designated district team.

(1) Team composition. The team shall include, but not be limited to, a school administrator, a school counselor, teachers, including career and technical education teachers, and individuals responsible for coordinating work-based learning activities.

(2) Duties. The team shall be responsible for the following:

1. Implementation of the district plan.

2. Annually reviewing and, as necessary, proposing to the board of directors of the school district revisions to the district plan.

3. Coordination of activities which integrate essential components into classroom instruction and other facets of the school district's educational program.

4. Regularly consulting with representatives of employers, state and local workforce systems and centers, higher education institutions, and postsecondary training programs to ensure activities are relevant and align with the labor and workforce needs of the region and state.

49.5(2) Maintenance of district plan. The district plan shall regularly be reviewed and revised by the team and the board.

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16]

281—49.6(279) Career information and decision-making systems. Each district shall use a career information and decision-making system that meets the minimum requirements established in subrule 49.6(3).

49.6(1) Review process. The department shall establish a process for the review of vendor-provided career information and decision-making systems to determine which career information and decision-making systems meet the minimum requirements established in subrule 49.6(3).

49.6(2) State-designated system. The department shall establish a process for the review and approval of a single state-designated career information and decision-making system from among the systems approved through the process established in subrule 49.6(1) which districts may use in compliance with this chapter.

49.6(3) Minimum functions of approved systems. An approved system shall, at a minimum, support the requirements of rule 281—49.3(279) and meet the following minimum requirements:

a. Allow for the creation of student accounts, which allow a student to store and access the results and information gathered from the inventories, searches, and associated activities outlined in paragraphs “*b*” through “*d*” of this subrule.

b. Include developmentally appropriate inventories and assessments that promote self-understanding and the connection to work. Inventories and assessments shall include, but not be limited to, an interest inventory; a work values assessment; and an abilities, strengths, or skills assessment.

c. Include a search platform for career information. The platform shall allow a student to access and review career information related to the results of the inventories listed in paragraph “*b*” of this subrule. Career information shall include, but not be limited to, current and accurate state and national wage, earning, and employment outlook data for a given occupation; job descriptions, including such information as essential duties and aptitudes; and training and education requirements. The career information search platform shall, at a minimum, allow a student to sort information by wage and earning, career cluster, and training and education requirements.

d. Include a search platform for postsecondary information. Postsecondary information shall include, but not be limited to, a current, accurate, and comprehensive database of accredited professional colleges, technical and community colleges, and public and private baccalaureate colleges and universities; and include or provide links to apprenticeship and military opportunities. The postsecondary information search platform shall, at a minimum, allow a student to sort information by program and degree type, institution type, location, size of enrollment, and affiliation and appropriate institutional characteristics, such as designation as a historically black college and university or Hispanic-serving institution, and religious affiliation.

e. Track basic utilization for the functions outlined in paragraphs “*a*” through “*d*” of this subrule. Districts shall have the ability to generate and export a report on the utilization statistics.

f. Ensure compliance with applicable federal and state civil rights laws.

g. Disclose the source and age of, as well as frequency of updates to, all information and data.

h. Provide auxiliary services including, but not limited to:

- (1) A process for districts to submit comments, feedback, and modification requests to the vendor.
- (2) Technical assistance during regular school district operating hours.
- (3) Appropriate training for users.

49.6(4) *Supplemental systems.* The department shall maintain a list of supplemental systems which districts may use to satisfy components of rule 281—49.3(279).

a. The department shall establish a process for the review of supplemental systems. The review shall, at a minimum, identify the components of rule 281—49.3(279) and paragraphs 49.6(3) “b,” “c,” and “d” which are satisfied through the supplemental system. All supplemental systems shall comply with paragraphs 49.6(3) “f” and “g.”

b. A district which chooses to utilize a supplemental system shall specify which components of rule 281—49.3(279) are satisfied through the use of the supplemental system in the district plan required under rule 281—49.5(279). A district which chooses to utilize a supplemental tool must continue to utilize and make available to students an approved system.

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16; ARC 4164C, IAB 12/5/18, effective 1/9/19]

281—49.7(279) Compliance. The director shall monitor school districts for compliance with the provisions of this chapter through the accreditation process established for school districts under 281—Chapter 12.

49.7(1) *Maintenance of student records.* Each school district shall maintain evidence of student completion of the requirements of the plan established in rule 281—49.3(279) in the student’s cumulative record as required by 281—subrule 12.3(4). Evidence shall consist of a copy of the student’s plan developed in eighth grade which is signed by the student’s parent or guardian.

49.7(2) *Reporting.* The board of directors of each school district shall submit to the local community, and to the department as a component of the school district’s comprehensive school improvement plan required by 281—Chapter 12, an annual report on student utilization of the district’s career information and decision-making system. The board shall report to the department at least annually, and in a manner and frequency required by the department, regarding student participation in work-based learning programs established by the board, including registered apprenticeships, quality pre-apprenticeships, internships, on-the-job training, and projects through the Iowa clearinghouse for work-based learning.

49.7(3) *Department report.* The department shall include in its annual condition of education report a review of school district and student performance required under this chapter.

49.7(4) *Corrective action.* If a school district is not in substantial compliance with the provisions of this chapter, the school district shall submit an action plan to the director for approval. The plan must outline the steps to be taken to ensure substantial compliance with the provisions of this chapter.

[ARC 2620C, IAB 7/20/16, effective 6/21/16; ARC 2749C, IAB 10/12/16, effective 11/16/16; ARC 6928C, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code section 279.61 as amended by 2016 Iowa Acts, House File 2392.

[Filed Emergency ARC 2620C, IAB 7/20/16, effective 6/21/16]

[Filed ARC 2749C (Notice ARC 2627C, IAB 7/20/16), IAB 10/12/16, effective 11/16/16]

[Filed ARC 4164C (Notice ARC 4049C, IAB 10/10/18), IAB 12/5/18, effective 1/9/19]

[Filed ARC 6928C (Notice ARC 6758C, IAB 12/14/22), IAB 3/8/23, effective 4/12/23]

CHAPTER 80
STANDARDS FOR PARAEducATOR PREPARATION PROGRAMS

281—80.1(272) General statement. Programs of preparation leading to certification of paraeducators in Iowa are subject to approval by the state board of education.
[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.2(272) Definitions. The following definitions are used throughout this chapter:

“Authorized official” means an individual with the authority within the institution and the unit to monitor and ensure compliance with this chapter.

1. If the unit is within a community college, an institution of higher education under the state board of regents, or an accredited private institution of higher education, the official must maintain, oversee and be responsible for the program within the unit.

2. If the unit is within an Iowa public school district or area education agency, the official must have one or more of the following credentials issued by the board of educational examiners: a teacher license (with the exception of a substitute teaching license), an administrator license, a professional services license, an elementary professional school counselor endorsement, a secondary professional school counselor endorsement, a school nurse endorsement, a special education support personnel authorization, or a statement of professional recognition. Other authorizations or certificates issued by the board of educational examiners shall not satisfy the requirements of this paragraph.

“Department” means the department of education.

“Director” means director of the department of education.

“Diverse groups” means one or more groups of individuals possessing certain traits or characteristics, including but not limited to age, color, creed, national origin, race, religion, marital status, sex, sexual orientation, gender identity, physical attributes, physical or mental ability or disability, ancestry, political party preference, political belief, socioeconomic status, or familial status.

“Institution” means an Iowa public school district, area education agency, community college, institution of higher education under the state board of regents or an accredited private institution as defined in Iowa Code section 261.9(1) offering a paraeducator preparation program(s).

“Paraeducator candidate” means an individual who is enrolled in a paraeducator preparation program leading to certification as a generalist, generalist with area(s) of concentration, or advanced paraeducator.

“Paraeducator preparation program” means the program of paraeducator preparation leading to certification of paraeducators.

“State board” means Iowa state board of education.

“Unit” means the organizational entity within an institution with the responsibility of administering the paraeducator preparation program(s).

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.3(272) Institutions affected. All institutions engaged in preparation of paraeducators and seeking state board approval of the institutions’ paraeducator preparation program(s) shall meet the standards contained in this chapter.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.4(272) Criteria for Iowa paraeducator preparation programs. Each institution seeking approval of its paraeducator preparation program(s) shall submit to the board evidence of the extent to which the program meets the standards contained in this chapter. After the state board has approved an institution’s paraeducator preparation program(s), students who complete the program(s) may be recommended by the authorized official of that institution for issuance of the appropriate certificate.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.5(272) Application; approval of programs. Approval of paraeducator preparation programs by the state board shall be based on the recommendation of the director after study of the factual and evaluative evidence of record about each program in terms of the standards contained in this chapter.

Approval, if granted, shall be for a term of seven years; however, approval for a shorter term may be granted by the state board if it determines conditions so warrant. If approval is not granted, the applicant institution will be advised concerning the areas in which improvement or changes appear to be essential for approval. In this case, the institution shall be given the opportunity to present factual information concerning its programs at the next regularly scheduled meeting of the state board. The institution may also reapply at its discretion to provide evidence of the actions taken toward suggested improvement.

Any application submitted under this rule shall be submitted by the authorized official.

[ARC 1966C, IAB 4/15/15, effective 5/20/15; ARC 6927C, IAB 3/8/23, effective 4/12/23]

281—80.6(272) Periodic reports. In addition to reports required by this chapter, the department may ask institutions placed on the approved programs list to make periodic reports necessary to keep records of each paraeducator preparation program up to date, to provide information necessary to carry out research studies relating to paraeducator preparation, and for any other purpose the department deems advisable.

Any reports submitted under this rule shall be submitted by the authorized official.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.7(272) Reevaluation of paraeducator preparation programs. Each paraeducator preparation program shall be reviewed and reevaluated at least once every seven years, at a shorter interval specified pursuant to rule 281—80.5(272), or at any time deemed necessary by the director. Recommendations as to whether to grant continued approval shall be governed by rule 281—80.5(272).

[ARC 1966C, IAB 4/15/15, effective 5/20/15; ARC 6927C, IAB 3/8/23, effective 4/12/23]

281—80.8(272) Approval of program changes. Upon application by an institution, the director is authorized to approve minor additions to, or changes within, the institution's approved paraeducator preparation program. When an institution proposes revisions that exceed the primary scope of its program, the revisions shall become operative only after approval by the state board.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.9(272) Organizational and resource standards. Organization and resources shall adequately support the preparation of paraeducator candidates to enable them to meet state standards in accordance with the provisions of this rule.

80.9(1) The unit provides resources and support necessary for the delivery of a quality certification program, including:

a. A commitment to a work culture, policies, and faculty/staff assignments that promote and support best practices in education;

b. Resources to support a quality hands-on (clinical) experience;

c. Resources to support professional development opportunities for certified paraeducators and unit faculty;

d. Resources to support technological and instructional needs to enhance candidate learning; and

e. A commitment of sufficient administrative, clerical, and technical staff to ensure implementation of a quality program.

80.9(2) The unit provides evidence of collaboration with members of the professional community, including the unit's advisory committee comprised of school administrators, classroom teachers, currently employed paraprofessionals and others, to design, deliver, and evaluate programs to prepare paraeducators.

80.9(3) When a unit is a part of a college or university, the unit maintains ongoing collaboration with the appropriate departments of the institution, especially regarding content knowledge.

80.9(4) The unit has primary responsibility for all paraeducator preparation programs offered through any delivery model.

80.9(5) The unit has a clearly articulated appeals process for decisions affecting candidates. This process is communicated to all candidates and staff. The unit may use an institutionwide appeals process to meet the requirements of this subrule.

80.9(6) The unit's use of staff in teaching roles is purposeful and managed to ensure integrity, quality, and continuity of the program(s).

80.9(7) The unit ensures that resources are equitable for all program components, regardless of delivery or location.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.10(272) Diversity standards. The unit shall ensure that the paraeducator preparation program meets the following diversity standards.

80.10(1) The unit provides an environment and experiences to paraeducator candidates to support candidate growth in knowledge, skills and dispositions to help diverse groups of PK-12 students learn.

80.10(2) The unit establishes and maintains a climate that promotes and supports diversity.

80.10(3) The unit's plans, policies, and practices document its efforts in establishing and maintaining a diverse staff and paraeducator candidate pool that strives to represent the diverse makeup of the community at large.

80.10(4) In addition to the requirements of rule 281—80.12(272), the unit shall gather data about its implementation of this rule, use those data to make program improvements, and share those data and improvements with the schools and communities it serves.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.11(272) Faculty standards. Unit staff qualifications and performance shall facilitate the unit's role in the preparation of a professional paraeducator in accordance with the provisions of this rule.

80.11(1) The unit documents the alignment of teaching duties for each faculty member with that member's preparation, knowledge, experiences and skills appropriate for training paraeducators to serve in a school setting.

80.11(2) The institution shall hold unit staff accountable for teaching the critical concepts and principles of the discipline.

80.11(3) For the purpose of implementing each of the requirements of this chapter, unit faculty shall maintain ongoing, actual involvement in settings where paraeducators are employed.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.12(272) Program assessment and evaluation standards. The unit's assessment system shall appropriately monitor individual candidate performance and use that data in concert with other program information to improve the unit and its programs in accordance with the provisions of this rule.

80.12(1) Each paraeducator candidate's knowledge and skills shall be measured against state certification standards adopted by the board of educational examiners under Iowa Code section 272.12 and the unit's learning outcomes for any certificate for which the unit may recommend the candidate.

80.12(2) Programs shall submit curriculum exhibits for approval by the department.

80.12(3) The unit shall establish a standard of satisfactory performance of paraeducator candidates, which shall comply with the following requirements.

a. The unit uses measures for candidate assessment that are fair, reliable and valid.

b. The unit assesses candidates on their demonstration and attainment of unit standards.

c. The unit uses a variety of assessment measures for assessment of candidates on each unit standard.

d. The unit provides candidates with formative feedback on their progress toward attainment of unit standards.

e. The unit assesses content knowledge and its application as candidates work with students, teachers, parents, and other professional colleagues in school settings.

f. The unit assesses candidates at the same level of performance across programs, regardless of the place or manner in which the program is delivered.

80.12(4) The unit shall conduct a survey of graduates and their employers to ensure that its graduates are well prepared for their assigned roles.

80.12(5) The unit shall have a clearly defined, cohesive assessment system and regularly review, analyze and revise its assessment practices.

80.12(6) The unit shall collect and analyze aggregated candidate and program data, use those data to make program improvements, and share those data and improvements with stakeholders on a regular basis.

80.12(7) An annual report including a composite of evaluative data collected by the unit shall be submitted to the department by September 30 of each year.

80.12(8) When it publicly reports data, the unit shall comply with all applicable privacy laws, including the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g.
[ARC 1966C, IAB 4/15/15, effective 5/20/15]

281—80.13(272) Clinical practice standards. The unit and its school partners shall provide clinical experience opportunities that assist candidates in becoming successful paraeducators in accordance with the provisions of this rule.

80.13(1) Paraeducator clinical experiences support learning in the context in which paraeducators will practice.

80.13(2) Paraeducator clinical experiences include the following:

a. A minimum of ten hours of experience in a state-approved school or educational facility under the supervision of a licensed educator.

b. Opportunities for paraeducator candidates to observe and be observed by others in the application of skills and knowledge.

[ARC 1966C, IAB 4/15/15, effective 5/20/15]

These rules are intended to implement Iowa Code section 256.7(22).

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HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498],
see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization
numbering scheme in general, IAC Supp. 2/11/87.

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CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa health and wellness plan, effective January 1, 2014, and administered by the department of human services (department) pursuant to Iowa Code chapters 249A and 249N. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—74.1(249A,249N) Definitions. The following definitions apply to this chapter in addition to the definitions in 441—Chapter 75.

“*Countable income*” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. §1396a(e)(14).

“*Enrollment period*” means the 12-month period for which Iowa health and wellness plan eligibility is established.

“*Essential health benefits*” means the essential health benefits defined at 42 U.S.C. §18022.

“*Iowa dental wellness plan*” means the managed care dental benefit program set forth in 441—Chapter 73.

“*Iowa health and wellness plan*” means the medical assistance program set forth in this chapter for individuals with countable income that does not exceed 133 percent of the federal poverty level.

“*Iowa wellness plan*” means the benefits and services provided to Iowa health and wellness plan members.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medically exempt individual*” means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR 440.315 as amended to May 16, 2022.

“*Minimum essential coverage*” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

“*Prepaid ambulatory health plan*” has the meaning set forth in 42 CFR 438.2 as amended to May 16, 2022.

“*Qualified employer-sponsored coverage*” shall be defined pursuant to 42 U.S.C. §1396e1(b).

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.2(249A,249N) Eligibility factors. Except as more specifically provided in this chapter, Iowa health and wellness plan eligibility shall be determined according to the requirements of 441—Chapter 75.

74.2(1) Persons covered. Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa health and wellness plan shall be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the federal poverty level for their household size;
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and
- d. Are not pregnant at the time of application or reenrollment.

74.2(2) Parents or caretakers of dependent children. All children under the age of 21 living with a parent or caretaker who will be claimed as a dependent by the parent or caretaker for state or federal income tax purposes must be enrolled in Medicaid, in the Children’s Health Insurance Program (CHIP),

or in other minimum essential coverage as a condition of the parent's or caretaker's eligibility for Iowa health and wellness plan benefits.

74.2(3) *Citizenship.* To be eligible for Iowa health and wellness plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.3(249A,249N) Application. Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa health and wellness plan.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.4(249A,249N) Financial eligibility.

74.4(1) *Countable income.* Individuals are financially eligible for the Iowa health and wellness plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.5(249A,249N) Enrollment period.

74.5(1) *Effective dates of eligibility.* Iowa health and wellness plan eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,249N).

74.5(2) *Reinstatement.* Enrollment for the Iowa health and wellness plan may be reinstated without a new application in accordance with 441—Chapter 76.

74.5(3) *Presumptive eligibility.* The enrollment period of 12 consecutive months shall not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with 441—Chapter 76.

74.5(4) *Retroactive enrollment.* Medical assistance shall be available to a pregnant woman or an infant (under one year of age), or a resident of a nursing facility licensed under Iowa Code chapter 135C, for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—Chapter 76.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.6(249A,249N) Reporting changes.

74.6(1) *Reporting requirements.* In addition to the reporting requirements in 441—Chapter 76, as a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.
- d. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
- e. A child under the age of 21 living with the member loses minimum essential coverage if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
- f. The member is pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with 441—Chapters 75 and 11. Program expenditures may include, but are not limited to, premiums and capitation payments.

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 16.3(1); or

b. The enrollment period has expired and the member is not eligible for a new enrollment period.
[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.7(249A,249N) Reenrollment. A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—Chapter 76.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.8(249A,249N) Terminating enrollment. Iowa health and wellness plan enrollment shall end when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the federal poverty level.
10. The Iowa health and wellness plan is discontinued according to the requirements in rule 441—74.14(249A,249N).
11. The member does not pay monthly contributions as required by subrule 74.11(2).

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.9(249A,249N) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—Chapter 75.

74.9(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—Chapter 75.

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the department or the managed care organization, and an adjustment shall be made to a previously submitted claim.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.10(249A,249N) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed to the extent permitted by 441—Chapter 7.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,249N).

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.11(249A) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to an \$8 copayment by the member, which shall be subtracted from the Iowa health and wellness plan payment otherwise due to the provider.

74.11(2) Monthly contributions. Members enrolled in the Iowa health and wellness plan with household income at or above 50 percent of the federal poverty level (FPL) are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to 441—Chapter 75, as a percentage of the FPL for the household. Monthly contribution amounts are as follows:

- (1) For a member with household income between 50 and 100 percent of the FPL, \$5;

(2) For a member with household income above 100 percent of the FPL, \$10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

(1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.

(2) The member is determined by the department to be a medically exempt individual pursuant to subrule 74.12(2).

(3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.

(4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as amended to May 16, 2022, as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

d. Billing and payment. Form 470-5285 or 470-5285(S) shall be used for billing and collection of the monthly contribution.

(1) Method of payment. Members shall submit contribution payments to the following address: Iowa Medicaid, Iowa Health and Wellness Plan Monthly Contributions, P.O. Box 14485, Des Moines, Iowa 50306-3485. Members can also submit contributions through the department's website.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution for each month is due on the last calendar day of the month that the monthly contribution is to cover.

2. If the last calendar day falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department shall apply monthly contributions payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An Iowa health and wellness plan member with household income between 50 and 100 percent of the FPL who fails to pay the assessed monthly contributions and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) An Iowa health and wellness plan member with household income above 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall have the member's eligibility terminated. In addition, the member shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions may reenroll for Medicaid benefits pursuant to 441—Chapter 76.

3. Unpaid premiums shall not be considered a collectible debt by the state if, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment.

f. Refund of monthly contributions.

(1) Monthly contributions paid for any period shall be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2) "c" or when a member's Iowa health and wellness plan coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in the Iowa health and wellness plan; or
2. The member dies.

(2) The amount of any refund shall be offset by any outstanding monthly contributions owed.

(3) The refund shall be paid within two calendar months from the date of termination from the program.

74.11(3) Aggregate annual limits on copayments and monthly contributions. The total aggregate annual amount of copayments and monthly contributions for an individual shall not exceed 5 percent of the household's countable annual income determined pursuant to 441—Chapter 75.

74.11(4) Healthy behaviors. An Iowa health and wellness plan member who completes a wellness examination and health risk assessment during any enrollment year shall have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dental provider consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

b. A health risk assessment is an assessment offered by a managed care plan through which the member is receiving Iowa health and wellness plan benefits.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.12(249A) Benefits and service delivery. Covered benefits and the service delivery method shall be determined by the member's health status.

74.12(1) Iowa wellness plan services. Members shall be enrolled in the Iowa health and wellness plan unless the member is determined by the department to be a medically exempt individual.

a. Covered Iowa wellness plan services are essential health benefits; all other benefits required pursuant to 42 U.S.C. §1396u-7(b)(1)(B), including prescription drugs; and dental services consistent with 441—Chapter 78.

b. Members enrolled in the Iowa health and wellness plan shall be subject to enrollment in managed care, other than program for all-inclusive care for the elderly (PACE) programs, pursuant to 441—Chapter 73.

c. Dental services shall be provided under the Iowa dental wellness plan as set forth in 441—Chapter 73 through a contract with one or more dental prepaid ambulatory health plans. The department may restrict member access to those dental prepaid ambulatory health plans with which the department contracts. The dental prepaid ambulatory health plan shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) Medically exempt individuals. An Iowa health and wellness plan member who has been determined by the department to be a medically exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

b. A provider with a current national provider identifier number, an employee of the department, a designee of the department of corrections, a managed care organization, or a mental health and disability

services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5198.

c. Upon receipt of Form 470-5194 or 470-5198, the department shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR 440.315 as amended to May 16, 2022.

74.12(3) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective, employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.
[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.13(249A,249N) Claims and reimbursement methodologies. Payment for services provided under the Iowa wellness plan services shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member’s managed care organization and the provider.
[ARC 6933C, IAB 3/8/23, effective 5/1/23]

441—74.14(249A,249N) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa wellness plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[ARC 6933C, IAB 3/8/23, effective 5/1/23]

These rules are intended to implement Iowa Code chapters 249A and 249N.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

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[Filed ARC 6933C (Notice ARC 6765C, IAB 12/28/22), IAB 3/8/23, effective 5/1/23]

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

b. Reserved.

c. Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."

d. Acupuncture treatments.

e. Reserved.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Reserved.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.
- (4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma.

However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- (1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13) “*e.*” On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Reserved.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician’s services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician’s professional service.

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member’s home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules in 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants’ professional licensure rules in 645—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2) “*n.*” Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs “*b*” through “*f*” shall be effectively presented to a blind, deaf, hard-of-hearing, or otherwise disabled individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16) “*b*” shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

- (1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or
- (2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or
- (3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(4))

78.1(19) Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary

based on the condition of the patient and the criteria established by the IME medical services unit and the department. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) “f”)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph “a.”

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) Reserved.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 5418C**, IAB 2/10/21, effective 4/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) Qualified prescriber. All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(38).

78.2(2) Prescription required. As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions or drug orders shall be available for audit by the department.

78.2(3) Qualified source. All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) Prescription drugs. Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Reserved.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

78.2(5) Nonprescription drugs.

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 81 mg, chewable
Aspirin tablets 81 mg, 325 mg, and 650 mg oral
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaiifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Levonorgestrel 1.5 mg
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride liquid 1 mg/7.5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
 Vitamins, single and multiple with prior authorization
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

78.2(6) Quantity prescribed.

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the

pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and

- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)“b”(1) to (10) except for 78.2(4)“b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)“b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Payment will be made for medically necessary inpatient acute psychiatric intensive care services that meet the criteria in this subrule, pursuant to 441—paragraph 79.1(5) "i." This inpatient rate is only applicable to individuals 18 to 64 years of age. All inpatient acute psychiatric intensive care services shall require prior authorization.

a. "Acute psychiatric intensive care" is defined as care provided for a condition with rapid onset that is accompanied by severe symptoms and is generally of brief duration, requiring emergency treatment and critical care.

b. To meet the need for acute psychiatric intensive care, the patient must:

- (1) Have a serious mental illness as defined in 441—subrule 77.47(1);
- (2) Have a current, severe, imminent risk of serious harm to self or others; and
- (3) Display additional complexity of need related to:

1. Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries; or

2. A history of violence or current aggression that is secondary to mental illness; or

3. A request for patient transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms; or

4. Lack of responsiveness to typical interventions or a condition that is treatment refractory; or

5. Disorganized psychotic state or manic thought process that impairs the ability to function or risks the safety of the patient or others; or

6. Behavior that causes disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); or

7. High elopement risk; or

8. Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the patient and others around the patient safe.

c. The individual must have a documented need for acute intensive care requiring increased or specialized staffing, equipment, or facilities, based on two or more of the following:

(1) Fall precaution protocol in place;

(2) Restraints or seclusion room requirements;

(3) Requiring assistance with activities of daily living;

(4) Requirements for complex nursing care;

(5) Acutely impaired cognitive functioning from baseline;

(6) Documentation of interventions to address acute complex mental illness and comorbidities;

(7) Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure;

(8) Elopement risk precaution protocol in place.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. *Recipient selection and education.*

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

- Intake.
- Preparation and waiting period.
- Preadmission.
- Hospitalization.
- Discharge planning.
- Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

- Anesthesiology.
- Cardiology.
- Dialysis.
- Gastroenterology.
- Hepatology.
- Immunology.
- Infectious diseases.
- Nephrology.
- Neurology.
- Pathology.
- Pediatrics.
- Psychiatry.
- Pulmonary medicine.
- Radiology.
- Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3),

with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)“*a.*”

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Reserved.

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 6781C, IAB 12/28/22, effective 1/1/23]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) Diagnostic services. Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Reserved.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Reserved.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) “a”(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) “a”(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) “a”(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed,

the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(3)“c”)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician’s reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months’ postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months’ postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(3) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3) "c")

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe

handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

78.4(11) *Emergency services.* Payment shall be made for emergency services, as defined in and pursuant to the requirements set forth in 42 CFR 438.114, as amended to April 7, 2022.

78.4(12) *Annual benefit maximum.*

a. Members 21 years of age or older have an annual benefit maximum of \$1,000 per state fiscal year for coverage of dental services set forth in this rule. Payment for services exceeding the \$1,000 annual benefit maximum is the responsibility of the member.

b. The following services do not count toward the annual benefit maximum:

- (1) Preventive services as set forth in subrule 78.4(1);
- (2) Diagnostic services as set forth in subrule 78.4(2);
- (3) Fabrication of removable dentures and related services as set forth in paragraphs 78.4(7) “a” to “c” and 78.4(7) “f” to “l”;
- (4) Anesthesia as set forth in paragraph 78.4(9) “f,” when provided in conjunction with oral surgery codes approved for payment; or
- (5) Emergency services as set forth in subrule 78.4(11).

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 6389C, IAB 6/29/22, effective 9/1/22]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.

- c. Molded digital orthotic.
- d. Shoe padding when appliances are not practical.
- e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f. Rams horn (hypertrophic) nails.
- g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or

clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Reserved.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a. Corrected curve lenses, unless clinically contraindicated.
- b. Standard plastic, plastic and metal combination, or metal frames.
- c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(4))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

- a.* Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b.* Glasses for occupational eye safety.
- c.* A second pair of glasses or spare glasses.
- d.* Cosmetic surgery and experimental medical and surgical procedures.
- e.* Sunglasses.
- f.* Progressive bifocal or trifocal lenses.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

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

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

78.9(2) Supervisory visits. Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) Skilled nursing services. Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or

housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.* Rescinded IAB 3/29/17, effective 5/3/17.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.

- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

- (1) Child or sibling victim of child abuse or neglect.
- (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

- 1. Respite care, which is a temporary intermission or period of rest for the caregiver.
- 2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- 3. Services provided to other persons in the member's household.
- 4. Services requiring prior authorization that are provided without regard to the prior authorization process.
- 5. Transportation services.

6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)"k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)“*n*” for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)“*f*” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser.

Bathtub/shower chair, bench. See 78.10(5)“*g*” and “*j*” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)“*j*” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)“*a*” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)“*c*” for prior authorization requirements.

Insulin infusion pump. See 78.10(5)“*b*” and 78.10(5)“*e*” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)“*i*” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)“a” and 78.10(2)“c.”

Patient lift. See 78.10(5)“h” for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)“f” for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member’s condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;

3. Positioning accessories;
 4. Specialized skin protection seat and back cushions; and
 5. Anti-rollback devices.
- (3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:
1. Lap belt or safety belt;
 2. Battery charger, single mode;
 3. Complete set of tires/wheels and casters, any type;
 4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
 5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
 6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
 7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
 8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 10. Non-expandable controller or standard proportional joystick (integrated or remote); and
 11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).
- (4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:
1. Shoulder harness/straps or chest straps/vest;
 2. Elevating legrest;
 3. Angle adjustable footplates;
 4. Adjustable height armrests; and
 5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).
- (5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.
- 78.10(3) Prosthetic devices.** Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.
- a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.
 - b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:
 - (1) Artificial eyes.
 - (2) Artificial limbs.
 - (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
 - (4) Hearing aids. See rule 441—78.14(249A).

- (5) Orthotic devices. See 78.10(3)“c” for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.
- (8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
- (9) Tracheotomy tubes.
- (10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

- (1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
 - 1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
 - 2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

- Catheter (indwelling Foley).
- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)“e” for prior authorization requirements.
- Dialysis supplies.
- Disposable catheterization trays or sets (sterile).
- Disposable irrigation trays or sets (sterile).
- Disposable saline enemas (e.g., sodium phosphate type).
- Dressings.
- Elastic antiembolism support stocking.
- Enema.
- Hearing aid batteries.
- Incontinence products (for members three years of age and older).
- Oral nutritional products. See 78.10(5)“m” for prior authorization requirements.
- Ostomy appliances and supplies.
- Respirator supplies.
- Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Rescinded IAB 12/30/20, effective 3/1/21.

e. DME rebate agreements. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged

from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

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 evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

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

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 6310C**, IAB 5/4/22, effective 7/1/22]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.
- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,
- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;

2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“*Insert*” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1) "b"(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1) "b"(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) "b."

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs "c" to "h" below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified

occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Reserved.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will the IME or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy.

A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b" (7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b" (8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical,

functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Reserved.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Reserved.

b. Education, which shall include as appropriate education about the following:

- (1) High-risk medical conditions.
- (2) High-risk sexual behavior.
- (3) Smoking cessation.
- (4) Alcohol usage education.
- (5) Drug usage education.
- (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*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.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(2) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Certified employment specialist*” or “*CES*” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“*Child and Adolescent Level of Care Utilization System*” or “*CALOCUS*” means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 16 to 18.

“*Comprehensive service plan*” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“*Customized employment*” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“*Department*” means the Iowa department of human services.

“*Emergency*” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“*HCBS*” means home- and community-based services.

“*Individual employment*” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“*Individual placement and support*” or “*IPS*” means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition-2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.

4. Attention to worker preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments.

5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.

6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.

7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

“*Integrated community employment*” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are

similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“Integrated health home services” means the provision of services to enrolled members as described in subrule 78.53(2).

“Intensive residential service homes” or *“intensive residential services”* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in 441—subrule 25.6(8).

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“ISIS” means the department’s individualized services information system.

“Level of Care Utilization System” or *“LOCUS”* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 19 and older.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

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

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“Severe and persistent mental illness” means the same as defined in rule 441—25.1(331).

“Supported employment” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“Supported self-employment” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“Sustained employment” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. LOCUS/CALOCUS actual disposition. The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

b. Risk factors. The member has at least one of the following risk factors:

(1) The individual has a history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the individual’s life; or

(2) The individual has a history of continuous professional psychiatric supportive care other than hospitalization; or

(3) The individual has a history of involvement with the criminal justice system; or

(4) Services available in the individual's community have not been able to meet the individual's needs; or

(5) The individual has a history of unemployment or employment in a sheltered setting or poor work history; or

(6) The individual has a history of homelessness or is at risk of homelessness.

c. Need for assistance. The individual has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least 12 months:

(1) The individual needs assistance to obtain or maintain employment.

(2) The individual requires financial assistance to reside independently in the community.

(3) The individual needs significant assistance to establish or maintain a personal social support system.

(4) The individual needs assistance with at least one of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.

(5) The individual needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual or others.

d. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

e. Needs assessment. The LOCUS or CALOCUS tool has been completed in the LOCUS online system, and using the algorithm developed by Deerfield Solutions to derive the actual disposition score based on the comprehensive assessment and social history (CASH) completed by the integrated health home (IHH) or community-based case manager (CBCM) during a face-to-face interview with the member and the member's representative as applicable, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The LOCUS/CALOCUS information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the LOCUS or CALOCUS, before services begin and annually thereafter, and more frequently if significant observable changes occur in the member's situation, condition or circumstances.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4) and 441—paragraph 90.4(1) "b" before services begin and annually thereafter, and when there is a significant observable change in the member's situation, condition, or circumstances.

f. Plan for service. The department or the member's managed care organization has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated by the IME or the member's managed care organization shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1) "b." A service plan may change when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member's LOCUS/CALOCUS actual disposition, the LOCUS/CALOCUS composite score, and each individual domain score for each of the six LOCUS/CALOCUS domains.

(3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and
3. The number of units of service to be received by the member.
- (5) Identify for a member receiving home-based habilitation:
 1. The member's living environment at the time of enrollment;
 2. The number of hours per day of on-site staff supervision needed by the member; and
 3. The number of other members who will live with the member in the living unit.
- (6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“f.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities to address daily living needs;
- (3) Assistance with symptom management and participation in mental health treatment;
- (4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;
- (5) Assistance with accessing and participating in substance use disorder treatment and services;
- (6) Assistance with medication administration and medication management;
- (7) Assistance with understanding communication whether verbal or written;
- (8) Community inclusion and active participation in the community;
- (9) Transportation;
- (10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;
- (11) Social and leisure skill development;
- (12) Personal care; and
- (13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member’s home and community.

(1) A member may live in the member’s own home, within the home of the member’s family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.25(5).

(2) A member living with the member’s family or legal representative is not subject to the criteria in 441—paragraphs 77.25(8) “c” and “d.”

(3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member’s most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

2. The member meets the criteria in 441—subparagraph 25.6(8) “c”(3).

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 17.5 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside the family home may only receive home-based habilitation services in residential settings with 16 or fewer beds licensed by the department of inspections and appeals.

(3) The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

(4) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

e. Additional criteria for receiving home-based habilitation services for transition-age youth 17.5 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Individuals 17.5 to 18 years of age shall receive 24-hour site supervision and support.
- Individuals under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.

- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member's parent or guardian has consented to home-based habilitation services.

4. The member is able to pay room and board costs (funding sources may include, but are not limited to, supplemental security income, child support, adoptions subsidy, or private funds).

5. A licensed setting, such as those approved to provide residential-based supported community living, is not available.

f. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. "Day habilitation" means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation,

volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member's interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,
- (12) Assistance with developing and maintaining natural relationships in the community,
- (13) Assistance with identifying and using natural supports,
- (14) Assistance with accessing financial literacy and benefits education,
- (15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

e. Duration. Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. “Prevocational services” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member’s experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member’s local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member’s family, guardian or legal representative to introduce them to supported employment and explore the member’s employment goals and experiences,

2. Business tours,

3. Informational interviews,

4. Job shadows,

5. Benefits education and financial literacy,

6. Assistive technology assessment, and

7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member’s individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching,

small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9) "a"(1). This time limit can be extended as stated in paragraphs 78.27(9) "e"(1) "1" through "6." If the criteria in paragraphs 78.27(9) "e"(1) "1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) *Supported employment services.*

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10) "a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.

3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).

12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.

13. Transportation of the member during service hours.

14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10) "b"(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

d. Individual placement and support (IPS).

(1) IPS shall include the following activities, which shall be described and documented in the member's employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.
2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.
3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.

4. Rapid job search and systematic job development. CESs help members seek jobs directly, and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.

5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.

6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.

2. Outcome #2: First day of successful job placement.

3. Outcome #3: 45 days successful job retention.

4. Outcome #4: 90 days successful job retention.

e. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

f. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,302.53 per month.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

g. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility or of the LOCUS/CALOCUS actual disposition score by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5809C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 5889C, IAB 9/8/21, effective 11/1/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6310C, IAB 5/4/22, effective 7/1/22; ARC 6624C, IAB 11/2/22, effective 1/1/23; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Rescinded IAB 12/30/20, effective 3/1/21.

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) "l."

d. Reserved.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) "f."

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) "a."

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2) "c")

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) "m."

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) "c."

k. DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5) "e."

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) “*n.*”

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) “*g.*”

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) “*h.*”

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) “*i.*”

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) “*j.*”

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs, subject to the requirements of 78.10(2) “*d.*”

78.28(2) Notwithstanding the provisions of 78.28(1) “*a.*” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

a. Buprenorphine,

b. Buprenorphine and naloxone combination,

c. Methadone,

d. Naltrexone, and

e. Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) “*b.*”

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) “*d.*”

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) “*e.*”

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) “*f.*”

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) “*g.*”

b. The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*b.*”

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*d.*”

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*c.*”

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*e.*”

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) “*k.*”

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) “*l.*”

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) “*m.*”

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) “*n.*”

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “*a.*”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) "b."

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) "c."

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) "d"(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) "d"(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) "d."

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) "g."

78.28(4) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross reference 78.14(7) "d"(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) "d"(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.

2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12) “*a.*,” prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department of human services.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a.* Emergency service.
- b.* Outpatient surgery.
- c.* Laboratory, X-ray and other diagnostic services.
- d.* General or family medicine.
- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of

substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term

commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further

continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization

program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a

WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 6222C, IAB 3/9/22, effective 5/1/22]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would

typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) “f” and the skilled activities listed in paragraph 78.34(7) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,872.85 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) Consumer choices option. The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or

goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.

4. Basic individual respite care.
 5. Specialized medical equipment.
 6. Supported community living.
 7. Supported employment.
 8. Transportation.
- (6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:
1. Consumer-directed attendant care (unskilled).
 2. Home and vehicle modification.
 3. Specialized medical equipment.
 4. Transportation.
- (7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.
- (8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.
- (9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.
- (10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).
- (11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)“b”(7) or the utilization adjustment factor in subparagraph 78.34(13)“b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.
- (12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.
- c. Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.
- d. Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:
- (1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
 23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
 24. Residential services provided to three or more members living in the same residential setting.
 - (4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)"b"(11).
 - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."
- f. Savings plan.* A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.
- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.
 5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.
 - (2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.
 - (3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:
 1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or community-based case manager.
 - (4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.

(2) Verify employee qualifications.

(3) Specify additional employee qualifications.

(4) Determine employee duties.

(5) Determine employee wages and benefits.

(6) Schedule employees.

(7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.
 1. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:
 - (1) Receive Medicaid funds in an electronic transfer.
 - (2) Process and pay invoices for approved goods and services included in the individual budget.
 - (3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
 - (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
 - (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
 - (6) Verify for the member an employee's citizenship or alien status.
 - (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
 - (8) Assist the member in completing required federal, state, and local tax and insurance forms.
 - (9) Establish and manage documents and files for the member and the member's employees.
 - (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet (Form 470-4429) or use Form 470-4429. All other employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.

4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter

83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance

with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

- a. Chore services are limited to the following services:
 - (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
 - (2) Minor repairs to walls, floors, stairs, railings and handles;
 - (3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
 - (4) Lawn mowing and removal of snow and ice from sidewalks and driveways.
- b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) "f" and the skilled activities listed in paragraph 78.37(15) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per

day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) “f” and the skilled activities listed in paragraph 78.38(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.

- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
 - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,917.79 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) "f" and the skilled activities listed in paragraph 78.41(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

- (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
 - e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) Vaccines administered to children. Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) Vaccines administered to adults. Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) Verification and reporting. Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 5175C, IAB 9/9/20, effective 6/1/21]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be

made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,872.85 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

- 1. An in-home medical communications transceiver.
- 2. A remote, portable activator.
- 3. A central monitoring station with backup systems staffed by trained attendants at all times.
- 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

- 1. A portable communications transceiver or transmitter to be worn or carried by the member.
- 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social

isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,872.85 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a.* A complete assessment of both appropriate and maladaptive behaviors.
- b.* Development of a structured behavioral intervention plan which should be identified in the ITP.
- c.* Implementation of the behavioral intervention plan.
- d.* Ongoing training and supervision to caregivers and behavioral aides.
- e.* Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)“f” and the skilled activities listed in paragraph 78.43(13)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.

- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical

care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4897C**, IAB 2/12/20, effective 3/18/20; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5597C**, IAB 5/5/21, effective 7/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21; **ARC 5896C**, IAB 9/8/21, effective 8/17/21; **ARC 6122C**, IAB 12/29/21, effective 3/1/22; **ARC 6735C**, IAB 12/14/22, effective 11/15/22; **ARC 6937C**, IAB 3/8/23, effective 5/1/23]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)“f” and the skilled activities listed in paragraph 78.46(1)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,872.85 per year may be made to certified providers upon satisfactory completion of the service.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
 - (1) The necessary components of a system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
 - (2) The service shall be identified in the member's service plan.
 - (3) A unit of service is a one-time installation fee or one month of service.
 - (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,872.85 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child’s history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child’s needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child’s strengths and preferences;
- (2) Consider the child’s physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child’s medical, social, educational, and other service needs.

These actions may include activities such as ensuring the active participation of the child and working with the child or the child’s authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;

(4) The nature, content, and units of case management services received;

(5) Whether the goals specified in the care plan have been achieved;

(6) Whether the family has declined services in the care plan;

(7) Time lines for providing services and reassessment; and

(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Reserved.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) Covered services. Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Reserved.

78.50(3) Delivery of services. Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

a. Reserved.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.
- (5) Academic services.
- (6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.53(249A) Health home services.

78.53(1) Definitions.

“Chronic condition” means, for purposes of this rule, one of the conditions outlined in subparagraph 78.53(3) “a”(1).

“Chronic condition health home” means a health home that meets the criteria in 441—subrule 77.47(2).

“Health home” means a chronic condition health home or an integrated health home.

“Integrated health home” means a health home that meets the criteria in 441—subrule 77.47(3).

“Person-centered care plan” means a care plan created through the person-centered planning process, directed by the member or the member's guardian or representative, for a member receiving non-intensive care management or chronic condition health home services, to identify the member's strengths, capabilities, preferences, needs, goals, and desired outcomes.

“Person-centered service plan” or “service plan” means a service plan (1) created through the person-centered planning process in accordance with subrule 78.27(4), rule 441—83.127(249A) and 441—paragraph 90.4(1) “b”; (2) directed by the member or the member's guardian or representative; (3) for a member receiving intensive care management services; and (4) for the purposes of identifying the member's strengths, capabilities, preferences, needs, and desired outcomes.

78.53(2) Covered services. A health home provides team-based, whole person, person-centered, coordinated care for all aspects of the member's life and for transitions of care that the member may experience. A health home provides the following core services:

- a. *Comprehensive care management.* Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care, and community support services, using a comprehensive person-centered care plan or service plan that addresses all clinical and nonclinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

- b. *Care coordination.* Care coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support, lifestyle modification, and behavior changes. The health home must work with providers to coordinate, direct, and ensure results are communicated back to the health home.

c. Health promotion. Health promotion includes the education and engagement of a member in making decisions that promote health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle.

d. Comprehensive transitional care. Comprehensive transitional care is the facilitation of services for the member that provides support when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, self-care, or another health home).

e. Individual and family support. Individual and family support services include communication with the member and the member's family and caregivers to maintain and promote quality of life, with particular focus on community living options. Support will be provided in a culturally appropriate manner.

f. Referral to community and social support services. Referral to community and social support services includes coordinating or providing recovery services and social health services available in the community, including resources for understanding eligibility for various health care programs, disability benefits, and identifying housing programs.

78.53(3) Member eligibility for health home services.

a. Chronic condition health home member eligibility criteria.

(1) To be eligible for chronic condition health home services, the member must have one of the following chronic conditions and be at risk of having a second chronic condition:

1. A mental health disorder.
2. A substance use disorder.
3. Asthma.
4. Diabetes.
5. Heart disease.
6. Being overweight, as evidenced by:
 - Having a body mass index (BMI) over 25 for an adult, or
 - Weighing over the 85th percentile for the pediatric population.
7. Hypertension.
8. Chronic obstructive pulmonary disease.
9. Chronic pain.

(2) "At risk" means a documented family history of a verified heritable condition described above, a diagnosed medical condition with an established comorbidity to a condition described above, or a verified environmental exposure to an agent or condition known to be the cause of a condition from the conditions described above.

b. Integrated health home eligible member criteria. To be eligible for integrated health home services, the member must have a serious mental illness or serious emotional disturbance, as such terms are defined in 441—subrule 77.47(1).

78.53(4) Member identification and enrollment.

a. Eligible members are identified through a referral from the department, lead entity, primary care provider, hospital, other providers, the member, or the member's authorized representative.

b. The health home confirms eligibility for health home services by obtaining assessment documentation from the member's licensed mental health professional or the patient tiering assignment tool (PTAT).

c. The health home must explain to the member, in a format easily understood by the member, how the team works together with the member at the center to improve the member's care, as well as all team member roles and responsibilities.

d. The health home must advise members of their ability and the process to opt out of health home services at any time.

e. Eligible members must agree to participate in the health home program, and the health home must document the member's agreement in the member's record before submitting an enrollment request. A member cannot be in more than one health home at the same time.

f. The health home must assess the member's continued eligibility for health home services on an annual basis to ensure the member remains eligible to participate in the program.

78.53(5) Health home documentation. A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A). At a minimum, the health home must document the following:

a. Eligibility. Eligibility documentation includes but is not limited to the following:

- (1) How the member presented to the health home, including the referral.
- (2) Identified needs and plan to assess for eligibility.
- (3) Documentation that the member is eligible for health home services. If a member is not eligible, the health home must document the plan to support the member.
- (4) Qualifying diagnosis that makes the member eligible for health home services.
- (5) Member agreement and understanding of the program.
- (6) Enrollment request.
- (7) Enrollment with the health home.
- (8) Plan to complete the comprehensive assessment.
- (9) Documentation of continued eligibility, reviewed annually and maintained in the member's service record.

b. Comprehensive assessment. The comprehensive assessment must include all aspects of a member's life and satisfy the following requirements:

(1) The comprehensive assessment must be completed within 30 days of enrollment, and at least every 365 days, or more frequently when the member's needs or circumstances change significantly or at the request of the member or member's support.

(2) The comprehensive assessment for members enrolled to receive non-intensive care management or enrolled in the chronic condition health home must include:

1. Assessment of the member's current and historical information provided by the member, the lead entity, and other health care providers that support the member;
2. Assessment of physical and behavioral health needs, medication reconciliation, functional limitations, and appropriate screenings;
3. Assessment of the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors; and
4. Assessment of the member's readiness for self-management using screenings and assessments with standardized tools.

(3) The comprehensive assessment for members enrolled to receive intensive care management must be in a format designated by the department and must include:

1. The member's relevant history, including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to complete the comprehensive assessment.

2. The member's physical, cognitive, and behavioral health care and support needs; strengths and preferences; available service and housing options; and, if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.

3. Documentation that no state plan HCBS is provided that would otherwise be available to the member through other Medicaid services or other federally funded programs.

4. For members receiving state plan HCBS and HCBS approved under 441—Chapter 83, documentation that HCBS provided through the state plan and waiver are not duplicative.

c. Person-centered service plan and person-centered care plan.

(1) For members receiving non-intensive care management or enrolled in the chronic condition health home, documentation must include a person-centered care plan that meets the requirements as defined in subrule 78.53(1) and the health home state plan amendment.

(2) For members receiving intensive care management, documentation must include a service plan that meets the requirements of rule 441—78.27(249A) or 441—83.127(249A) and 441—paragraph 90.4(1) "b."

(3) Documentation must reflect an update of the plan no less often than every 365 days and when significant changes occur in the member's support needs, situation, condition, or circumstances.

d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2).

e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs.

f. Continuity of care.

(1) The health home must maintain a continuity of care document in each enrolled member's record and provide this document to the department, the lead entity, and the member's treating providers upon request.

(2) The continuity of care document must include, at a minimum, all aspects of the member's medical and behavioral health needs, treatment plan, and medication list.

g. Disenrollment. Members are able to opt out of health home services at any time. The health home must document a member's request to disenroll from health home services, the reason for disenrollment, how the member's needs will be supported after disenrollment, and that the health home has advised the member of the ability to re-enroll if circumstances change.

78.53(6) Payment.

a. Payment will be made for health home services when:

(1) The member is eligible for Medicaid and enrolled in the health home for the month of service, and

(2) The health home provides at least one of the six core health home services described in subrule 78.53(2) during the month, and

(3) The health home maintains the documentation outlined in subrule 78.53(5).

b. A unit of service is one member month.

c. The health home must report the informational-only code in addition to the billing procedure code and modifier for one or more of the core services provided to the member during the month on the claim for payment.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0360C, IAB 10/3/12, effective 12/1/12; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2166C, IAB 9/30/15, effective 11/4/15; ARC 6310C, IAB 5/4/22, effective 7/1/22]

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 an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member’s managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury and 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).

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

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of

care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician

before the claim for service is submitted for reimbursement.

(12) Form 470-5686 is utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

- a. Services provided to members aged 21 and older.
- b. Services that require prior authorizations that are provided without regard to the prior authorization process.
- c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
- d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
- e. Transportation services.

f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 6390C, IAB 6/29/22, effective 9/1/22]

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member's health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

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

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

These rules are intended to implement Iowa Code chapter 249A.

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¹ Two ARCs

² Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

⁴ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁵ 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.

⁶ Two ARCs

⁷ Two ARCs

⁸ 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**.

⁹ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

¹⁰ Two or more ARCs

¹¹ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

¹² May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

¹³ July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

- ¹⁴ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Rescinded IAB 10/10/18, effective 12/1/18.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to paragraph 79.1(15) "f."

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

i. Inflation factor. When the department's reimbursement methodology for any provider includes an inflation factor, this inflation factor shall not exceed the amount by which the consumer price index for all urban consumers increased during the calendar year ending December 31, 2002.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 7/1/21.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Applied behavior analysis	Fee schedule	Fee schedule in effect 7/1/22.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/22.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
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.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<p>1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below.</p> <p>2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.</p> <p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.</p> <p>Except as noted, limits apply to all waivers that cover the named provider.</p>
<p>HCBS waiver service providers, including:</p> <p>1. Adult day care</p>	<p>For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule</p> <p>For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)</p>	<p>Effective 7/1/22, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider’s rate in effect 6/30/22 plus 4.25%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/22 rate: Veterans Administration contract rate or \$1.58 per 15-minute unit, \$25.33 per half day, \$50.44 per full day, or \$75.63 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/22, for intellectual disability waiver: The provider’s rate in effect 6/30/22 plus 4.25%, converted to a 15-minute or half-day rate. If no 6/30/22 rate, \$2.12 per 15-minute unit or \$33.76 per half day.</p> <p>For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1) “c,” for the member’s acuity tier, determined pursuant to 79.1(30).</p>
<p>2. Emergency response system: Personal response system</p>	Fee schedule	Effective 7/1/22, provider’s rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: Initial one-time fee: \$56.18. Ongoing monthly fee: \$43.69.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: Initial one-time fee: \$56.18. Ongoing monthly fee: \$43.69.
3. Home health aides	Fee schedule	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25% or maximum Medicaid rate in effect 6/30/22 plus 4.25%. For intellectual disability waiver effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25% or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$5.61 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: \$94.98 per visit.
6. Respite care when provided by: Home health agency: Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, not to exceed \$340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, not to exceed \$340.15 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed \$340.15 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$9.67 per 15-minute unit, not to exceed \$340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$5.16 per 15-minute unit, not to exceed \$340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed \$340.15 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$9.67 per 15-minute unit, not to exceed \$340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$5.16 per 15-minute unit, not to exceed \$340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed \$340.15 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Nursing facility	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed \$340.15 per day.
Adult day care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$4.37 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: \$8.75 per meal. Maximum of 14 meals per week.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/22: \$1,145.48 lifetime maximum. For intellectual disability waiver effective 7/1/22: \$5,727.37 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/22: \$6,872.85 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Fee schedule in effect 7/1/22.
12. Nutritional counseling	Fee schedule	Effective 7/1/22 for non-county contract: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$9.46 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/22: \$124.81 per unit.
14. Senior companion	Fee schedule	Effective 7/1/22 for non-county contract: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$2.04 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$5.78 per 15-minute unit, not to exceed \$133.70 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$5.78 per 15-minute unit, not to exceed \$133.70 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Individual	Fee agreed upon by member and provider	Effective 7/1/22, \$3.87 per 15-minute unit, not to exceed \$89.99 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$12.36 per 15-minute unit.
Group	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$12.35 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/22, provider's rate in effect 6/30/22 plus 4.25%.
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/22: \$10.02 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 11.727%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/22: \$10.02 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30)
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/22. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/22, \$6,872.85 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: \$12.36 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$12.35 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/22.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Fee schedule	Effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Fee schedule	Effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$10.02 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 11.727%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.78 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/22, \$6,872.85 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$10.02 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$26.82 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: \$74.46 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: \$17.35 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$28.16 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s)	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule	Effective 7/1/22: Fee schedule in effect 6/30/22 plus 4.25%.
2. Home-based habilitation	Fee schedule	Fee schedule in effect 7/1/22.
3. Day habilitation	Fee schedule	Effective 7/1/22: \$3.57 per 15-minute unit or \$69.40 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect 7/1/22.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/22. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.
Individual placement and support supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed \$3,302.53 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r”	Effective 7/1/22: The Medicaid LUPA fee schedule rate published on the department's website.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) "g" and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) "c"	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1) "h" 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare). 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) "d"(1) "1" and (2) "1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) "f." The direct care rate component limit under 441—81.6(16) "f"(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) "f"(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c.”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/21: Non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1) "c"). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5) "n."

79.1(5) Reimbursement for hospitals.

a. *Definitions.*

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) "x." Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with

the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)“y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share rate” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“DRG weight” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“Final payment rate” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5) "f."

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5) "f."

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)“r.” Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)“r.” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital’s trimmed claims that match the hospital’s base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children’s hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Reserved.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than

an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r," and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

i. Payment for certified physical rehabilitation hospitals and units, psychiatric units, and acute psychiatric intensive care services. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5) "r" and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5) "a." No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5) "j."

(2) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(3) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(4) Acute psychiatric intensive care services. Services that meet the criteria at 441—subrule 78.3(8) shall be reimbursed as follows:

1. Services provided in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" will be paid based on the hospital-specific per diem rate as calculated pursuant to subparagraph 79.1(5) "i"(1) plus

a percentage increase as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

2. Services not provided in a psychiatric unit certified pursuant to paragraph 79.1(5) “r” will be paid based on the hospital-specific DRG payment rate as calculated pursuant to paragraph 79.1(5) “b” plus an add-on per diem rate as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5) “y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital’s average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected

to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) “y” and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital

disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and
2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.

(13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's

low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the

difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) "a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) "k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- Y The condition was present or developing at the time of the order for inpatient admission.
- N The condition was not present or developing at the time of the order for inpatient admission.
- U Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
- W Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5) “y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2) “e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7) “a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).
- (16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) “c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7) “c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7) “c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;
2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;
3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or
4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;
2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;
3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or
4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or
2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)“d” through “h,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”;

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee; or

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies’ average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

2. The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)“*a*” because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's “best price” pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“*a*” through “*f*.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“*a*” through “*f*,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) *HCBS consumer choices financial management.* Rescinded IAB 5/8/19, effective 7/1/19.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person’s services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent’s compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall

be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)“*k.*” This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility’s Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident’s room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices’ “cap period” (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in “1” and “2.”

4. Comparing the amount in “3” with interim payments made to the hospice for inpatient care during the “cap period.”

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS children’s mental health waiver family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency under an HCBS intellectual disability waiver, brain injury waiver, or health and disability waiver.

a. Reporting requirements.

(1) Providers shall submit the complete Form 470-5477. The provider shall email the report and required supplemental information to costaudit@dhs.state.ia.us. The provider shall mail one signed copy of the certification page to the Iowa Medicaid Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(2) Regardless of the period for the provider’s fiscal year, the provider shall submit a financial and statistical report for the period of July 1, 2021, through June 30, 2022. For provider fiscal periods beginning on or after July 1, 2022, the provider shall submit a financial and statistical report coinciding with the provider’s fiscal year.

(3) The provider shall submit the financial and statistical report on or before the last day of the third month following the end of the cost reporting period.

(4) A certified home health agency enrolled to deliver HCBS that is required to submit a Medicare cost report may request a 60-day extension for submitting the financial and statistical cost report. All other providers may request a 30-day extension for submitting the financial and statistical report. All requests must be submitted in writing to the Iowa Medicaid provider cost audit and rate setting unit by the financial and statistical report due date. No other extensions will be granted.

(5) If a provider terminates its participation in any HCBS program or service, the provider shall submit a final financial and statistical report on or before the sixtieth day following the date of termination for retrospective adjustment in accordance with subparagraph 79.1(15)“*f*”(1).

(6) Providers failing to submit a financial and statistical report that meets the requirements of this paragraph within the time frames set forth in subparagraph 79.1(1)“*a*”(3) or 79.1(1)“*a*”(4), as applicable, shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) Providers shall submit a completed financial and statistical report in an electronic format that can be opened using the extension xls or.xlsx. The provider shall submit supplemental documentation in a generally accepted business format.

(8) Along with its financial and statistical report, the provider shall include a working trial balance that corresponds to the data contained on the financial and statistical report. Financial and statistical reports submitted without a working trial balance will be considered incomplete.

(9) The provider’s financial data within the financial and statistical report shall be based on the provider’s financial records. When the records are not based on the accrual basis of accounting, the provider shall make adjustments necessary to convert the information to an accrual basis for reporting.

(10) Providers of multiple programs or services shall submit a cost allocation schedule. The schedule must identify an allocation method for each expense account, including the statistics used in the calculation.

(11) Providers shall not report costs to any waiver service that are costs of any other program or public or private funding sources, including but not limited to the Medicaid state plan; Medicare; other state, local or federal funded programs; and private funding sources. Providers shall not report costs of HCBS waiver services as a cost of any other public or private funding source.

(12) Iowa Medicaid or its designee may review or audit financial and statistical reports as filed to determine the actual cost of services in accordance with generally accepted accounting principles or Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, subject to the exceptions and limitations in the department's administrative rules and financial and statistical report instructions.

(13) Failure to maintain records to support the financial and statistical report and make them available to the department or its designee upon request may result in adjustment, payment reduction, or sanction including but not limited to termination of the provider's HCBS certification.

(14) When adjustments made to prior reports indicate noncompliance with reporting instructions or the provider has a history of inadequate documentation to support the financial and statistical report, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918 and have an approved service plan for the member.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Twenty percent identified cost limitation.

1. The following identified costs are not subject to the 20 percent limitation; however, the following costs are used to calculate the limitation:

- Wages, benefits, and payroll taxes.
- Direct care transportation expense—with and without member present.
- Direct care development, training, and supplies.
- Member-specific assistance.
- Member-specific equipment repair or purchase.

2. For each waiver service, the sum of reported costs not identified in numbered paragraph 79.1(15)“b”(3)“1” is limited to 20 percent of the identified costs in numbered paragraph 79.1(15)“b”(3)“1.”

(4) Mileage reimbursement for business use of personal employee vehicles shall be limited to the federal Internal Revenue Service's (IRS's) published mileage rate in effect during the cost reporting period.

(5) Compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function and do not exceed the maximum allowed compensation as described in numbered paragraphs 79.1(15)“b”(5)“5” and “6.”

1. “Ownership” is defined as an interest of 5 percent or more. For this purpose, the following persons are considered immediate relatives: husband, wife, natural or adoptive parent, natural or adoptive child, natural or adoptive sibling, step-parent, step-child, step-sibling, parent-in-law, child-in-law, sibling-in-law, grandparent, or grandchild. Adequate time records shall be maintained.

2. “Compensation” means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the

W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to Iowa Medicaid or its designee. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. Providers shall report all compensation paid to related parties, including payroll taxes, on the financial and statistical report.

3. “Reasonableness” requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable providers, and depends upon the facts and circumstances of each case.

4. “Necessary” requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

5. The maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, is equal to the intermediate care facility for persons with an intellectual disability maximum compensation for facilities with 60 beds or more pursuant to 441—subparagraph 82.5(11)“e”(4).

6. The maximum allowed compensation for any other owner or immediate relative is 60 percent of the amount allowed in numbered paragraph 79.1(15)“b”(5)“5.”

7. The provider shall maintain records in the same manner for an owner or immediate relative compensated by the agency as are maintained for any employee of the agency, including but not limited to employment records, timekeeping, and payroll records.

8. The maximum allowed compensation for owners and immediate relatives shall be adjusted by the percentage of the average workweek devoted to business activity during the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report. If an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one owner or immediate relative allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one agency.

9. Costs applicable to services, facilities, and supplies furnished to the provider by a person or organization related to the provider by common ownership or control are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

- “Related” means that the agency, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

- Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

- Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

- A provider may lease a facility from a related person or organization. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its cost the costs of ownership of the facility. This includes depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.

- An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence that the criteria in numbered paragraph 79.1(15)“b”(5)“10” have been met.

10. The agency must demonstrate the following with convincing evidence. Where all of the conditions below are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

- The supplying organization is a bona fide separate organization;

- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;

- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and

- The charge to the agency is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

c. Prospective rates for new providers.

(1) "New providers" means providers who have not submitted an annual report including at least six months of actual, historical costs of operations for any service as listed in subrule 79.1(15).

(2) New providers shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period.

(3) Projected costs of any new service, as listed in subrule 79.1(15), shall be submitted on Form 470-5477.

(4) Prospective rates shall be subject to retrospective adjustment as provided in paragraph 79.1(15)"f."

(5) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph 79.1(15)"d."

d. Prospective rates for established providers.

(1) "Established providers" means providers who have submitted an annual report including six months of actual, historical costs of operation.

(2) The prospective rate will be adjusted annually, effective the first day of the third month after the month during which the annual financial and statistical report is submitted to the department.

(3) The provider's prospective rate shall be the lower of:

1. The provider's reasonable and proper actual cost-based rate as calculated by the provider's most recent financial and statistical report and adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end,

2. In the first year of reporting six months of actual, historical costs of operation, or a year in which the provider's base rate is recalculated, the base rate is equal to the amount calculated in numbered paragraph 79.1(15)"d"(3)"1,"

3. In a year in which the provider's base rate is not recalculated, the prior period base rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end, or

4. The upper rate limit pursuant to subrule 79.1(2).

(4) Recalculation of base rates (rebasings).

1. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency, the base rates will be recalculated based on the reasonable and proper actual costs of operation as calculated by the fiscal year 2022 financial and statistical report.

2. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency; and 15-minute HCBS intellectual disability waiver supported community living services, the base rates will be recalculated based on the reasonable and proper costs of operation for the provider's fiscal year ending on or after January 1, 2024.

3. Subsequent to the recalculation of base rates in numbered paragraph 79.1(15)"d"(4)"2," a provider's base rate shall be recalculated no less than every three years.

(5) Prospective rates shall be subject to retrospective adjustment as provided in paragraph 79.1(15)"f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) For fee for service, retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for 15-minute HCBS intellectual disability waiver supported community living services; HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency under an HCBS intellectual disability waiver, brain injury waiver, and health and disability waiver, as reported on Form 470-5477, subject to the upper rate limit allowed in subrule 79.1(2).

(2) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent for fee for service shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) If a provider does not remit the amount of the overpayment identified in subparagraph 79.1(15) "f"(2) within 30 days after notice, the department will deduct the amount owed from future payments.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments

for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

- (1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Reserved.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Reserved.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after January 1, 2016.

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

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.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"*Coinsurance*" means a percentage of costs of a covered health care service that has to be paid.

"*Copayment*" means a fixed amount a member pays for a covered health care service.

"*Deductible*" means the amount paid for covered health care services before the insurance plan starts to pay.

"*Eligible member*" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"*Health insurance premium payment (HIPP) program*" or "*HIPP program*" has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "*c*" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "*f*" and "*g*," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30) "*g*," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCL tier: Members residing in a residential-based supported community living (RBSCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
 - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
 - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
 - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
 - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
 - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
 - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
 - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)“c.”

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17; **ARC 2932C**, IAB 2/1/17, effective 3/8/17; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3158C**, IAB 7/5/17, effective 7/1/17; **ARC 3161C**, IAB 7/5/17, effective 7/1/17; **ARC 3162C**, IAB 7/5/17, effective 7/1/17; **ARC 3160C**, IAB 7/5/17, effective 7/1/17; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3294C**, IAB 8/30/17, effective 10/4/17; **ARC 3295C**, IAB 8/30/17, effective 10/4/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3292C**, IAB 8/30/17, effective 10/4/17; **ARC 3293C**, IAB 8/30/17, effective 10/4/17; **ARC 3481C**, IAB 12/6/17, effective 12/1/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 3551C**, IAB 1/3/18, effective 2/7/18; **ARC 3716C**, IAB 3/28/18, effective 5/2/18; **ARC 3790C**, IAB 5/9/18, effective 6/13/18; **ARC 4067C**, IAB 10/10/18, effective 11/14/18; **ARC 4065C**, IAB 10/10/18, effective 12/1/18; **ARC 4066C**, IAB 10/10/18, effective 12/1/18; **ARC 4068C**, IAB 10/10/18, effective 12/1/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 4974C**, IAB 3/11/20, effective 4/15/20; **ARC 5175C**, IAB 9/9/20, effective 6/1/21; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5809C**, IAB 7/28/21, effective 9/1/21; **ARC 5896C**, IAB 9/8/21, effective 8/17/21; **ARC 6122C**, IAB 12/29/21, effective 3/1/22; **ARC 6625C**, IAB 11/2/22, effective 1/1/23; **ARC 6735C**, IAB 12/14/22, effective 11/15/22; **ARC 6781C**, IAB 12/28/22, effective 1/1/23; **ARC 6937C**, IAB 3/8/23, effective 5/1/23]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “*Person*” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“*Termination from participation*” means a permanent exclusion from participation in the medical assistance program.

“*Withholding of payments*” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or

accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

a. The department may impose any of the following sanctions on any person:

- (1) A term of probation for participation in the medical assistance program.
- (2) Termination from participation in the medical assistance program.
- (3) Suspension from participation in the medical assistance program.
- (4) Suspension of payments in whole or in part.
- (5) Prior authorization of services.
- (6) Review of claims prior to payment.

b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and

suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a. Seriousness of the offense.
- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) *Notice of violation.*

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, 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. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs

for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

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

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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 shall 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. Required records shall include any records required to maintain the provider's license in good standing.

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

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

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

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Unless otherwise indicated below, the provider may document the services in any format so long as the documentation adequately substantiates the medical necessity and that the services were rendered. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) "c" or "d," 441—paragraph 77.33(6) "d," 441—paragraph 77.34(5) "d," 441—paragraph 77.37(15) "d," 441—paragraph 77.39(13) "e," 441—paragraph 77.39(14) "d," 441—paragraph 77.46(5) "i," or 441—subparagraph 78.9(10) "a"(1).
5. Medication administration record (MAR). The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service.
7. Narrative description of any incidents or illnesses or unusual or atypical occurrences that occur during service provision.
8. Any supplies dispensed as part of the service.

9. The first and last name and professional credentials, if any, of the person providing the service.
10. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

11. For 24-hour care, documentation for every shift of the services provided.

(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. Basis for service requirements for specific services. The health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Other service documentation as applicable.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.
3. Other service documentation as applicable.

(9) Clinic services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
 7. Other service documentation as applicable.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.

5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
 1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.

4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician, nurse practitioner, physician assistant, or clinical nurse specialist orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Notice of decision for service authorization.
 2. Service notes or narratives.
 3. Social history.
 4. Comprehensive service plan.
 5. Reassessment of member needs.
 6. Incident reports in accordance with 441—subrule 24.4(5).
 7. Other service documentation as applicable.
- (34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
8. Other service documentation as applicable.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Waiver of informed consent.
 3. Prior authorization documentation.
 4. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
 4. Other service documentation as applicable.
- (40) Health home services:
 1. Member's eligibility.
 2. Comprehensive assessment.
 3. Comprehensive care management plan for members receiving chronic condition health home services, or comprehensive person-centered care plan or service plan for members receiving integrated health home services.
 4. Care coordination and health promotion plan.
 5. Comprehensive transitional care plan, including appropriate follow-up, if relevant.
 6. Continuity of care document.
 7. Documentation of member and family support (including authorized representatives).
 8. Documentation of referral to community and social support services, if relevant.
 9. Service notes or narratives.
 10. Other documentation as applicable, including as outlined in 441—subrule 78.53(5).
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- (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.
 10. Other service documentation as applicable.
- (43) Child care medical services:
1. Plan of care.
 2. Certification and recertification.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
 5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
 6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).
- (44) Subacute mental health services.
1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Medication administration records (residential services).
- (45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.
1. Assessment.
 2. Individual stabilization plan.
 3. Service notes or narratives (history and physical, therapy records, discharge summary).
 4. Medication administration records (residential services).
- e. Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.
- (1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
 - (2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
 - (3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.
 - (4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.
- 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.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 6310C, IAB 5/4/22, effective 7/1/22; ARC 6563C, IAB 10/5/22, effective 9/16/22]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“Authorized representative,” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“Claim” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“Clinical record” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“Confidence level” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“Customary and prevailing fee” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“Extrapolation” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“Fiscal record” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“Overpayment” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“Procedure code” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“Random sample” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“Underpayment” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“Universe” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) Audit or review of clinical and fiscal records by the department. Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at

www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) Audit or review procedures. The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar 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 calendar 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) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(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. The department may elect to conduct announced or unannounced on-site reviews or 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) Notice is not 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 the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

- (1) Comparing clinical and fiscal records with each claim.
- (2) Interviewing members who received goods or services and employees of providers.
- (3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department’s procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph “a” of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. *Disagreement with sampling results.* When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

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

[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

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.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—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.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) Procedures.

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council, 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. The department shall provide staff support and independent technical assistance to the council .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

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

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17; ARC 4975C, IAB 3/11/20, effective 4/15/20; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using Form 470-5595, Outpatient Prior Authorization Request, 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 must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

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 470-0829, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-0829 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 of prescription drugs 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.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d).

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.

a. 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:

- (1) The conditions for payment outlined in the provider manual with reference to coverage and duration.
- (2) The determination made by the Medicare program unless specifically stated differently in state law or rule.
- (3) The recommendation to the department from the appropriate advisory committee.
- (4) Whether there are other less expensive procedures which are covered and which would be as effective.
- (5) The advice of an appropriate professional consultant.

b. 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(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 16. 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.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20; ARC 5362C, IAB 12/30/20, effective 3/1/21]

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.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)“*b*,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“*a*,” medical assistance funds are not incorrectly paid when an individual who serves as a member’s legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

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

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 6310C, IAB 5/4/22, effective 7/1/22]

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 73.

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

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

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. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

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

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. 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.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application Form 470-5273, or as a supplement to a previously submitted application, providers of health home services must submit Form 470-5100, Health Home Provider Agreement, or Form 470-5160, Integrated Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) "a" (1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) "c." Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within

the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application 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 with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

79.14(10) 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, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application 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(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 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, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment 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 or repayment to the department within 30 days of notification by the department that the fine has been imposed.

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

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 1153C**, IAB 10/30/13, effective 1/1/14; **ARC 1695C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 6310C**, IAB 5/4/22, effective 7/1/22]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1) "a";

- (2) The rights of employees to be protected as whistle blowers; and
- (3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

- (1) The name, address, and national provider identification numbers under which the entity receives payment;
- (2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and
- (3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

- (1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or
- (2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

- (1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or
- (2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

- (1) An eligible professional, listed as:

1. A physician,

2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children's hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the Hawki program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at www.imeincentives.com. The applicant shall use the website to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation website.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration website. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the website. Providers shall access the website to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record

incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) Requirements for prescribing controlled substances.

79.17(1) *Review of Iowa prescription monitoring program database.* A prescribing practitioner, as defined in Iowa Code section 124.550, or the prescribing practitioner's designated agent, shall review patient information in the Iowa prescription monitoring program (PMP) database prior to issuing a prescription for a controlled substance as defined in 42 U.S.C. 1396w-3a, inclusive of Schedules II, III and IV, unless the patient is receiving inpatient hospice care or long-term residential facility care. Review shall be conducted in accordance with all requirements under the prescribing practitioner's specific professional licensing authority.

79.17(2) *Documentation.* The prescribing practitioner shall include documentation in the patient file to demonstrate compliance with subrule 79.17(1). Subject to the requirements under Iowa Code chapter 124, subchapter VI, if the prescribing practitioner is not able to conduct a review of the PMP database despite a good-faith effort, the prescribing practitioner must document in the patient file such good-faith effort, including the reasons why the prescribing practitioner was not able to conduct the review. The prescribing practitioner shall submit such documentation to the Iowa Medicaid program upon request.

This rule is intended to implement Iowa Code chapters 124 and 249A.

[ARC 5901C, IAB 9/8/21, effective 10/1/21]

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- [Filed Emergency ARC 8894B, IAB 6/30/10, effective 7/1/10]
- [Filed Emergency ARC 8899B, IAB 6/30/10, effective 7/1/10]
- [Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]
- [Filed ARC 9127B (Notice ARC 8896B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]
- [Filed Emergency ARC 9134B, IAB 10/6/10, effective 10/1/10]
- [Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
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- [Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]
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- [Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
- [Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
- [Filed Emergency After Notice ARC 9531B (Notice ARC 9431B, IAB 3/23/11), IAB 6/1/11, effective 5/12/11]
- [Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]
- [Filed Emergency ARC 9706B, IAB 9/7/11, effective 8/17/11]
- [Filed Emergency ARC 9708B, IAB 9/7/11, effective 8/17/11]
- [Filed Emergency ARC 9710B, IAB 9/7/11, effective 8/17/11]
- [Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]
- [Filed Emergency ARC 9712B, IAB 9/7/11, effective 9/1/11]
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- [Filed Emergency ARC 9719B, IAB 9/7/11, effective 9/1/11]
- [Filed Emergency ARC 9722B, IAB 9/7/11, effective 9/1/11]
- [Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
- [Filed ARC 9886B (Notice ARC 9713B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
- [Filed ARC 9887B (Notice ARC 9715B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
- [Filed ARC 9958B (Notice ARC 9707B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]
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- [Filed Emergency ARC 9996B, IAB 2/8/12, effective 1/19/12]
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[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0355C (Notice ARC 0197C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
[Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed ARC 0581C (Notice ARC 0436C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed Emergency ARC 0585C, IAB 2/6/13, effective 1/9/13]
[Filed ARC 0665C (Notice ARC 0547C, IAB 1/9/13), IAB 4/3/13, effective 6/1/13]
[Filed ARC 0708C (Notice ARC 0568C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0711C (Notice ARC 0570C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0712C (Notice ARC 0569C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0710C (Notice ARC 0588C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0713C (Notice ARC 0584C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
[Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]
[Filed ARC 0824C (Notice ARC 0669C, IAB 4/3/13), IAB 7/10/13, effective 9/1/13]
[Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0840C, IAB 7/24/13, effective 7/1/13]
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[Filed Emergency ARC 0864C, IAB 7/24/13, effective 7/1/13]
[Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
[Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
[Filed ARC 1058C (Notice ARC 0863C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1057C (Notice ARC 0839C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
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[Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1150C (Notice ARC 0918C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1152C (Notice ARC 0910C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1154C (Notice ARC 0919C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1155C (Notice ARC 0912C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1153C (Notice ARC 0917C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1481C (Notice ARC 1391C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
[Filed Emergency ARC 1519C, IAB 7/9/14, effective 7/1/14]
[Filed Emergency ARC 1521C, IAB 7/9/14, effective 7/1/14]
[Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]

- [Filed ARC 1609C (Notice ARC 1518C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
- [Filed ARC 1608C (Notice ARC 1520C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
- [Filed ARC 1695C (Notice ARC 1621C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1697C (Notice ARC 1619C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1699C (Notice ARC 1617C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1977C (Notice ARC 1818C, IAB 1/7/15), IAB 4/29/15, effective 7/1/15]
- [Filed ARC 2026C (Notice ARC 1921C, IAB 3/18/15), IAB 6/10/15, effective 8/1/15]
- [Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
- [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
- [Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
- [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
- [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
- [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
- [Filed Emergency ARC 2846C, IAB 12/7/16, effective 11/15/16]
- [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
- [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
- [Filed ARC 2932C (Notice ARC 2847C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 3006C (Notice ARC 2899C, IAB 1/18/17), IAB 3/29/17, effective 6/1/17]
- [Filed Emergency ARC 3158C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3161C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3162C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3160C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3159C, IAB 7/5/17, effective 7/1/17]
- [Filed ARC 3292C (Notice ARC 3164C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed ARC 3293C (Notice ARC 3166C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed ARC 3294C (Notice ARC 3165C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed ARC 3295C (Notice ARC 3167C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed ARC 3296C (Notice ARC 3163C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed Emergency ARC 3358C, IAB 10/11/17, effective 10/1/17]
- [Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]
- [Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]
- [Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]
- [Filed ARC 3554C (Notice ARC 3357C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]
- [Filed ARC 3716C (Notice ARC 3598C, IAB 1/31/18), IAB 3/28/18, effective 5/2/18]
- [Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18), IAB 5/9/18, effective 6/13/18]
- [Filed ARC 4067C (Notice ARC 3923C, IAB 8/1/18), IAB 10/10/18, effective 11/14/18]
- [Filed ARC 4065C (Notice ARC 3911C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]
- [Filed ARC 4066C (Notice ARC 3909C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]
- [Filed ARC 4068C (Notice ARC 3906C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]
- [Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]¹²
- [Filed ARC 4751C (Notice ARC 4600C, IAB 8/14/19), IAB 11/6/19, effective 12/11/19]
- [Filed ARC 4899C (Notice ARC 4763C, IAB 11/20/19), IAB 2/12/20, effective 3/18/20]³
- [Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]
- [Filed ARC 4974C (Notice ARC 4819C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]
- [Filed ARC 4975C (Notice ARC 4818C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]
- [Filed ARC 5175C (Notice ARC 4964C, IAB 3/11/20), IAB 9/9/20, effective 6/1/21]
- [Filed ARC 5305C (Notice ARC 5167C, IAB 9/9/20), IAB 12/2/20, effective 2/1/21]

- [Filed ARC 5362C (Notice ARC 5229C, IAB 10/21/20), IAB 12/30/20, effective 3/1/21]
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 [Filed ARC 6122C (Notice ARC 5903C, IAB 9/8/21), IAB 12/29/21, effective 3/1/22]
 [Filed ARC 6310C (Notice ARC 6206C, IAB 2/23/22), IAB 5/4/22, effective 7/1/22]
 [Filed Emergency After Notice ARC 6563C (Notice ARC 6419C, IAB 7/27/22), IAB 10/5/22, effective 9/16/22]
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- ¹ Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Two ARCs
- ³ 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.
- ⁴ Two or more ARCs
- ⁵ 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.
- ⁶ 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.
- ⁷ 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**.
- ⁸ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁹ Two ARCs
- ¹⁰ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹¹ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).
- ¹² July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹³ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020.

CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]

[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*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 resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Clock hour*” means 60 minutes.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“*Department*” means the Iowa department of human services.

“Direct care component” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. “Direct care component” also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“Discharged resident” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“Facility” means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 as amended to December 4, 2017, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“Facility-based nurse aide training program” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“Facility cost report period case-mix index” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“Iowa Medicaid enterprise” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Level I review” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

“Level II review” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$750,000. The \$750,000 threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$750,000 threshold.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or *“MDS”* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.6(16) “f.” MDS is described in subrule 81.13(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Non-state government owned nursing facility” or *“NSGO nursing facility”* is a nursing facility owned by a governmental entity that is not the state.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“Nurse aide training and competency evaluation programs (NATCEP)” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Poor performing facility (PPF)” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;

2. Has a history of substantiated complaints during the last two years;

3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

“*Primary instructor*” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“*Program coordinator*” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“*Rate determination letter*” means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Skills performance record*” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“*Special population nursing facility*” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with medical complexity.

“*Surgical or other invasive procedure*” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“*Terminated from the Medicare or Medicaid program*” means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 3717C, IAB 3/28/18, effective 7/1/18; ARC 4052C, IAB 10/10/18, effective 9/12/18; ARC 6934C, IAB 3/8/23, effective 5/1/23; ARC 6935C, IAB 3/8/23, effective 5/1/23]

441—81.2 Reserved.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.3(1) “*b*,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) Reserved.

81.3(3) *Preadmission review.* The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person’s attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person’s physical condition, and the person is not a danger to self or others. If the person’s nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person’s illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson’s disease, Huntington’s chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person’s caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

- (6) The person has dementia in combination with an intellectual disability.
 - (7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.
 - (8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.
 - (9) The person:
 1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
 2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
 3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
 4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.
- b.* Outcome of Level II review. The Level II review shall determine:
- (1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;
 - (2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14) "b," using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and
 - (3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14) "c," using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.
- c.* The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.
- d.* Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:
- (1) Only if a Level I review was completed prior to admission;
 - (2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3) "a" has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.
- e.* Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.
- f.* A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident's knowledge of the potential for PHI to become public and that the resident

knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) "a" and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.4(249A) Arrangements with residents.

81.4(1) Reserved.

81.4(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5) "c.") The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record,

to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

441—81.5(249A) Discharge and transfer. (See paragraph 81.13(6) "c.")

81.5(1) Notice. When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.5(2) Case activity report. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician's orders for care.
- f. The resident's personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.5(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.6(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of “direct patient care costs” and “support care costs.” Costs associated with food and dietary wages shall be included in the “support care costs” subcategory.

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider’s reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility’s established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider’s records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3) “*e.*”

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider’s fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

f. When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility’s fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting

unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

81.6(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.6(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient

and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11)“h”(4) to 81.6(11)“h”(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator’s salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association Useful Life Guide.

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to

adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses; or

2. Actual rent payments.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) “*a.*”

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) “*d.*” The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider’s reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.6(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days’ prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new

partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.6(14) Payment to new facility. The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

81.6(15) Payment to new owner. An existing facility with a new owner shall continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the

facility's fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility's fiscal year will end.

81.6(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph "a") determines the per diem direct care and non-direct care component costs. The second step (paragraph "b") normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph "c") calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph "d") calculates the potential excess payment allowance. The fifth step (paragraph "e") calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph "h," that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph "h," in step six (paragraph "f"). The seventh step (paragraph "g") calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state government owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state government owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities shall be inpatient days as determined in subrule 81.6(7) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state government owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average

difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph "d," not to exceed the rate component limits determined by the methodology in paragraph "f."

(1) For non-state government owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph "d."

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph "d" and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph "h."

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs "d" and "e," in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state government owned nursing facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable

and when considered in combination with each other are deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, "direct care staff" is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. "Direct care staff" does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification

Standard	Measurement Period	Value	Source
Subcategory: Resident Satisfaction			
<p>Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
<p>Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.</p>	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
Subcategory: Staffing			
<p>Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p>Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
<p>Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results

Standard	Measurement Period	Value	Source
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	IME medical services unit report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from a report submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16)"g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “*f.*”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “*f.*” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services; or
3. Improving infection control by replacing or enhancing an HVAC system, as defined in Iowa Code section 105.2.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent. Medicaid patient day utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total patient days as reported on the facility’s most current financial and statistical report. Medicaid hospice patient days shall be counted toward the total nursing facility Medicaid patient days.

2. The facility meets the accountability measure criteria set forth in paragraph “*g.*” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.
2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned facilities shall be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities shall be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

i. Quality incentive payment program (QIPP). The QIPP add-on rate shall be made to a qualified non-state government owned nursing facility (NSGO nursing facility) to promote, maintain, and improve resident quality of care and health outcomes.

(1) An NSGO nursing facility shall qualify for participation in the QIPP if all the following conditions are met:

1. The NSGO nursing facility has executed a participation agreement with the department.
2. The NSGO nursing facility has provided proof that the entity holds the NSGO nursing facility's license and has complete operational responsibility for the NSGO nursing facility.
3. The NSGO nursing facility has filed a certification of eligibility application for the QIPP add-on rate program with the department and has received approval from the department for participation in the program.
4. The NSGO nursing facility is in compliance with all care criteria requirements.

5. The non-state government entity (NSGE) has executed a nursing facility provider contract with an NSGO nursing facility.

6. The NSGE has provided and identified the source of state share dollars for the intergovernmental transfer (IGT).

7. The NSGO nursing facility has provided proof of ownership, if applicable, as the licensed operator of the NSGO nursing facility.

8. The NSGO nursing facility has provided to the department an executed management agreement between the NSGE and the NSGO nursing facility manager if applicable.

(2) If at any time a provider is determined not eligible due to not meeting survey standards, the provider will be disqualified for the remainder of the year.

(3) An NSGO nursing facility shall qualify for participation in the QIPP if all the following quality measures are met:

Quality Measures	Metrics	Tracking/Scoring	Data Resource
Staffing	<p>Metric 1: Nursing facility maintains an additional four or more hours of registered nurse (RN) coverage per day beyond the CMS minimum standard (8 hrs/day). Does not include managerial hours.</p> <p>Metric 2: Nursing facility's per-resident day certified nursing assistants (CNAs), rehabilitation aid, and other contracted aid services are at or above one-half standard deviation above the statewide mean of per-resident-day CNA hours. CNA hours include those of CNAs, rehabilitation aid, and other contracted aide services. CNA hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p> <p>Metric 3: Nursing facility's per-resident day total nursing hours are at or above one-half standard deviation above the statewide mean of per-resident-day total nursing hours. Nursing hours include those of RNs and licensed practical nurses (LPNs) including restorative nurses. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Staffing metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Payroll-based journal (PBJ) or cost reports
Infection Control	<p>Metric 1: Nursing facility has an infection control program that includes antibiotic stewardship. The program incorporates policies and training as well as monitoring, documenting, and providing staff with feedback.</p> <p>Metric 2: Percentage of residents with urinary tract infections (UTIs) at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on minimum data set (MDS) data as applied to the nationally reported quality measures.</p>	Infection control metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Nursing facility will be required to provide its infection control policy and procedure. In addition, facilities will need to provide information regarding training, monitoring, documentation and monitoring of required elements to meet this metric on a periodic basis

	<p>Metric 3: Percentage of residents with up-to-date pneumonia vaccine measured against a fixed benchmark that is set as the most recently published national average for the related MDS quality metric.</p>		CASPER Report MDS Assessment Care Compare
<p>Quality Measures</p>	<p>Metric 1: Percentage of high-risk residents with pressure ulcers (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.</p> <p>Metric 2: Percentage of residents who had a fall with major injury (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.</p> <p>Metric 3: Percentage of residents who received antipsychotic medications are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.</p> <p>Metric 4: Percentage of residents who required increased activities of daily living (ADL) assistance (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.</p>	<p>Quality measures metrics 1, 2, 3, and 4 must be met for the facility to be eligible for per diem rate add-on payment.</p>	CASPER Report MDS Assessment Care Compare
<p>State Survey Results</p>	<p>Number of deficiencies is at or below the state of Iowa average number of nursing facility deficiencies <u>AND</u> the facility has no deficiencies with a scope of F, H, I, J, K, or L.</p>	<p>State survey results must be met for the facility to be eligible for per diem rate add-on payment.</p>	<p>Department of inspections and appeals (DIA) surveys</p>
<p>Quality Assurance Performance Improvement (QAPI) Report</p>	<p>Nursing facility must submit QAPI reports on quarterly basis.</p>	<p>QAPI results must be submitted for the facility to be eligible for per diem rate add-on payment.</p>	<p>QAPI reports</p>

(4) A provider must submit the Intent to Participate Agreement on or before September 30 each year and include all necessary documentation related to the quality measures.

1. Upon receipt of the participation agreement, the department will complete a determination of eligibility based on the care criteria defined above.

2. Providers will be notified of their eligibility annually within 60 days of the agreement due date.

(5) The nursing facility QIPP add-on rate provided to a participating NSGO nursing facility under the QIPP shall not exceed Medicare payment principles pursuant to 42 CFR 447.272 and shall be calculated pursuant to 42 CFR 438.6. The QIPP add-on rate shall be calculated and paid as follows:

1. The methodology utilized to calculate the upper payment limit shall be based on the data available during the calculation period.

2. The eligible amount used in determining the QIPP add-on rate shall be the difference between the state Medicaid payment and the Medicare upper payment limit as determined, on an annual basis, using all Medicaid claims, including fee-for-service (FFS) and Medicaid managed care claims.

3. The difference calculated under numbered paragraph “2” shall be divided by total patient days pursuant to subrule 81.6(7).

4. The QIPP add-on rate shall be paid prospectively.

(6) A participating NSGO nursing facility shall notify the department of any change of ownership that may affect the participating NSGO nursing facility’s continued eligibility for the QIPP a minimum of 30 days prior to such change.

1. If a participating NSGO nursing facility changes ownership to a privately owned entity, on or after the first day of the QIPP add-on rate calculation period, the privately owned provider is no longer eligible for the QIPP add-on rate.

2. A participating facility must meet the CMS and Iowa Medicaid requirements to be classified as an NSGO nursing facility. All changes of ownership must be a fair market value transaction.

3. If it is determined that a provider is not a qualified NSGO nursing facility per CMS and Iowa Medicaid, the provider shall repay all QIPP add-on payments to the department.

(7) Providers that do not meet eligibility requirements above will be notified of the metrics that were not met.

(8) A participating NSGO nursing facility shall secure allowable intergovernmental transfer funds from a participating NSGE to provide the state share amount. The process for the intergovernmental transfer shall comply with the following:

1. The department, or the department’s designee, shall notify the participating NSGO nursing facility of the state share amount to be transferred in the form of an intergovernmental transfer for purposes of seeking federal financial participation for the QIPP add-on rate, within 15 business days after the end of each month. The participating NSGO shall have until the end of the month to remit payment of the state share amount in the form of an intergovernmental transfer to the department or the department’s designee.

2. If there is any outstanding intergovernmental transfer amount at the end of the payment period, the provider will not be able to participate in the QIPP the following year.

81.6(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility’s fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility’s fiscal year and the midpoint of the facility’s fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) Inflation factor. The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

81.6(19) Case-mix index calculation.

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

81.6(20) Medicare crossover claims for nursing facility services.

a. *Definitions.* For purposes of this subrule:

"*Crossover claim*" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"*Medicaid-allowed amount*" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"*Medicaid reimbursement*" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"*Medicare payment amount*" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. *Crossover claims.* Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.6(21) Nursing facility quality assurance payments.

a. *Quality assurance assessment pass-through.* Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. *Quality assurance assessment rate add-on.* Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$15 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. *Use of the pass-through and add-on.* As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. End date. If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4428C, IAB 5/8/19, effective 7/1/19; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 6226C, IAB 3/9/22, effective 5/1/22; ARC 6934C, IAB 3/8/23, effective 5/1/23; ARC 6935C, IAB 3/8/23, effective 5/1/23]

441—81.7(249A) Continued review.

81.7(1) Level of care. The IME medical services unit shall review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

81.7(2) PASRR. As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and

c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.3(3) "b."

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.8 Reserved.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.9(2) Retention. Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Except for Medicaid accountability measures payment established in paragraph 81.6(16) "g," facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) Authorization of payment. The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Reserved.

81.10(4) Periods authorized for payment.

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. Ventilator patients.

(1) Definition. For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) Reimbursement. In-state nursing facilities shall receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.6(16) "f"(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

- (1) The wrong surgical or other invasive procedure is performed on a resident; or
- (2) A surgical or other invasive procedure is performed on the wrong body part; or
- (3) A surgical or other invasive procedure is performed on the wrong resident.

81.10(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2) “d,” medical supplies except for those listed in 441—paragraph 78.10(4) “b,” oxygen except under circumstances specified in 441—paragraph 78.10(2) “a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2) “a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;
- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.
- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4) "j" and shall not discharge a resident due to nonpayment for such days.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 0714C, IAB 5/1/13, effective 7/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4900C, IAB 2/12/20, effective 3/18/20]

441—81.11(249A) Billing procedures.

81.11(1) Claims. Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through Iowa Medicaid's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident's managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

81.13(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. to d. Reserved.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

81.13(3) Distinct part requirement. All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) Civil rights. The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. Free choice. The resident has the right to:

(1) Choose a personal attending physician.

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) The facility must respect the resident's right to personal privacy, including the right to privacy in the resident's oral (that is, spoken or sign language), written, and electronic communications.

(3) Except as provided in subparagraph (4) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(4) The resident's right to refuse release of personal and clinical records does not apply to the following:

1. The release of personal and clinical records to a health care institution to which the resident is transferred; or

2. A record release that is required by law.

f. Grievances. A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. Examination of survey results. A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. Work. The resident has the right to:

(1) Refuse to perform services for the facility.

(2) Perform services for the facility if the resident chooses, when:

1. The facility has documented the need or desire for work in the plan of care.

2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

3. Compensation for paid services is at or above prevailing rates.

4. The resident agrees to the work arrangement described in the plan of care.

i. Mail. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident, whether delivered by a postal service or by other means, including the right to:

(1) Privacy of such communications consistent with this section; and

(2) Access to stationary, postage, and writing implements at the resident's own expense.

j. Access and visitation rights.

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.

2. Any representative of the state.

3. The resident's individual physician.

4. The state long-term care ombudsman.

5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.

6. The agency responsible for the protection and advocacy system for mentally ill individuals.

7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.

8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident'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 nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

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

q. Electronic communication. The resident has the right to have reasonable access to and privacy in the resident's use of electronic communications, including, but not limited to, email and video communications, and for Internet research:

(1) If accessible to the facility;

(2) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident; and

(3) To the extent that such use may comply with state and federal law.

81.13(6) Admission, transfer and discharge rights.

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident's case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall include the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)"a"(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)"a," and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) Resident behavior and facility practices.

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

* (1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) Quality of life. A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

a. Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

b. Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. Participation in resident and family groups.

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. Comprehensive assessments.

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.

2. Customary routine.

3. Cognitive patterns.
 4. Communication.
 5. Vision.
 6. Mood and behavior patterns.
 7. Psychosocial well-being.
 8. Physical functioning and structural problems.
 9. Continence.
 10. Disease diagnoses and health conditions.
 11. Dental and nutritional status.
 12. Skin condition.
 13. Activity pursuit.
 14. Medications.
 15. Special treatments and procedures.
 16. Discharge potential.
 17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
 18. Documentation of participation in assessment.
 19. Additional specification relating to resident status as required in Section S of the MDS.
- (3) Frequency. Assessments shall be conducted:
1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
 2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.
 3. In no case less often than once every 12 months.
- (4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.
- (5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.
- (6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.
- (7) Automated data processing requirement.
1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.
 - Admission assessment.
 - Annual assessment updates.
 - Significant change in status assessments.
 - Quarterly review assessments.
 - A subset of items upon a resident's transfer, reentry, discharge, and death.
 - Background (face sheet) information, if there is no admission assessment.
 2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Reserved.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision impairment or the deaf or hard of hearing or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

g. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

h. Accidents. The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

i. Nutrition. Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

j. Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

l. Unnecessary drugs.

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or

3. Without adequate monitoring; or

4. Without adequate indications for its use; or

5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:

(1) It is free of significant medication error rates of 5 percent or greater.

(2) Residents are free of any significant medication errors.

81.13(11) Nursing services. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph “c,” licensed nurses.

2. Other nursing personnel.

(2) Except when waived under paragraph “c,” the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.

(1) Except when waived under paragraph “c,” the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph “c,” the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph “b,” or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph “a,” if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph “c” is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) Dietary services. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) Physician services. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph "e," all required physician visits shall be made by the physician personally.

d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident's comprehensive plan of care, the facility shall:

- (1) Provide the required services; or
- (2) Obtain the required services from an outside provider of specialized rehabilitative services.

b. Specialized services for mental illness. "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) May be provided only by a specialized licensed or certified practitioner;

- (5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

- (6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. "Specialized services for intellectual disability" means services that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;

- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) Must be supervised by a qualified intellectual disability professional; and

- (5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.13(15) Dental services. The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

- (1) Routine dental services to the extent covered under the state plan.
- (2) Emergency dental services.

b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) Pharmacy services. The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

a. Procedures. A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

b. Service consultation. The facility shall employ or obtain the services of a licensed pharmacist who:

- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

c. Drug regimen review.

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

e. Storage of drugs and biologicals.

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

f. Consultant pharmacists. When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) Infection control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. *Infection control program.* The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

b. *Preventing spread of infection.*

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. *Linens.* Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) Physical environment. The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. *Life safety from fire.* Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. *Emergency power.*

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. *Space and equipment.* The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. *Resident rooms.* Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

f. Resident call system. The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted.

(2) Be well ventilated, with nonsmoking areas identified.

(3) Be adequately furnished.

(4) Have sufficient space to accommodate all activities.

h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

(2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.

(3) Equip corridors with firmly secured handrails on each side.

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Licensure. A facility shall be licensed under applicable state and federal law.

b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.
2. Responsible for management of the facility.

e. Required training of nurse aides.

(1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;
2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or
3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or
2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

- (2) The facility shall:
 1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.
 2. Promptly notify the attending physician of the findings.
 3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
 4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.
 - l. *Clinical records.*
 - (1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.
 - (2) Clinical records shall be retained for:
 1. The period of time required by state law.
 2. Five years from the date of discharge when there is no requirement in state law.
 3. For a minor, three years after a resident reaches legal age under state law.
 - (3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.
 - (4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:
 1. Transfer to another health care institution.
 2. Law.
 3. Third-party payment contract.
 4. The resident.
 - (5) The clinical record shall contain:
 1. Sufficient information to identify the resident.
 2. A record of the resident's assessments.
 3. The plan of care and services provided.
 4. The results of any preadmission screening conducted by the state.
 5. Progress notes.
 - m. *Disaster and emergency preparedness.*
 - (1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.
 - (2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.
 - n. *Transfer agreement.*
 - (1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:
 1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
 2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
 - (2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
 - o. *Quality assessment and assurance.*
 - (1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

- (2) The quality assessment and assurance committee:
 1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
 2. Develops and implements appropriate plans of action to correct identified quality deficiencies.
- (3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.
- (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
 - p. Disclosure of ownership.*
 - (1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.
 - (2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:
 1. Persons with an ownership or control interest.
 2. The officers, directors, agents, or managing employees.
 3. The corporation, association, or other company responsible for the management of the facility.
 4. The facility's administrator or director of nursing.
 - (3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—81.14(249A) Audits.

81.14(1) *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.14(2) *Audit of proper billing and handling of patient funds.*

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals, and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “d,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a” and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.15 Reserved.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) Deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections and appeals if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours’ duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.16(2) State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) “e” and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2)“f,” the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2)“b”(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2)“b”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved, such program shall, at a minimum:

(1) Consist of no less than 75 clock hours of training, and

(2) Include at least the subjects specified in 81.16(3) "b," and

(3) Include at least 30 hours of didactic theory instruction, which may be provided in a classroom setting or through online course curricula, and

(4) Include at least 16 hours of laboratory experience provided in a face-to-face environment that complements the didactic theory curricula, and

(5) Include 30 hours of supervised clinical training in a face-to-face environment and supervised by a department of inspections and appeals-approved instructor in a manner not inconsistent with the licensing requirements of the Iowa board of nursing. In extenuating circumstances, a laboratory setting may be utilized in place of face-to-face clinical training subject to the department's approval, and

(6) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the department of inspections and appeals-approved instructor, and

(7) Meet the following requirements for department of inspections and appeals-approved instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed by registered nurses under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions as set forth in 42 CFR 483.152(5) may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of department of inspections and appeals-approved instructors to students shall not exceed one registered nurse, or licensed practical nurse functioning as an assistant to a registered nurse, who is in the proximate area in the clinical setting, for every 15 students in the clinical setting, and

(8) Contain information regarding competency evaluation through written or oral examination and skills demonstration.

- b. The curriculum of the nurse aide training program shall include:
- (1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:
 1. Communication and interpersonal skills.
 2. Infection control.
 3. Safety and emergency procedures including the Heimlich maneuver.
 4. Promoting residents' independence.
 5. Respecting residents' rights.
 - (2) Basic nursing skills:
 1. Taking and recording vital signs.
 2. Measuring and recording height and weight.
 3. Caring for the residents' environment.
 4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.
 5. Caring for residents when death is imminent.
 - (3) Personal care skills, including, but not limited to:
 1. Bathing.
 2. Grooming, including mouth care.
 3. Dressing.
 4. Toileting.
 5. Assisting with eating and hydration.
 6. Proper feeding techniques.
 7. Skin care.
 8. Transfers, positioning, and turning.
 - (4) Mental health and social service needs:
 1. Modifying aide's behavior in response to residents' behavior.
 2. Awareness of developmental tasks associated with the aging process.
 3. How to respond to resident behavior.
 4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
 5. Using the resident's family as a source of emotional support.
 - (5) Care of cognitively impaired residents:
 1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).
 2. Communicating with cognitively impaired residents.
 3. Understanding the behavior of cognitively impaired residents.
 4. Appropriate responses to the behavior of cognitively impaired residents.
 5. Methods of reducing the effects of cognitive impairments.
 - (6) Basic restorative services:
 1. Training the resident in self-care according to the resident's ability.
 2. Use of assistive devices in transferring, ambulation, eating and dressing.
 3. Maintenance of range of motion.
 4. Proper turning and positioning in bed and chair.
 5. Bowel and bladder training.
 6. Care and use of prosthetic and orthotic devices.
 - (7) Residents' rights:
 1. Providing privacy and maintenance of confidentiality.
 2. Promoting the residents' rights to make personal choices to accommodate their needs.
 3. Giving assistance in resolving grievances and disputes.
 4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
 5. Maintaining care and security of residents' personal possessions.

6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.

7. Avoiding the need for restraints in accordance with current professional standards.

c. Prohibition of charges.

(1) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may not be charged for any portion of the program including any fees for textbooks, course materials, or nurse aide competency evaluations.

(2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

1. Add all costs incurred by the nurse aide for the course, books, and competency evaluations.

2. Divide the total arrived at in paragraph "1" above by 12 to prorate the costs over a one-year period and establish a monthly rate.

3. The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:

(1) Notify the department of inspections and appeals:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.

2. When a facility or other training entity will no longer be offering nurse aide training courses.

3. Whenever the person coordinating the training program is hired or terminates employment.

(2) Keep a list of faculty members and their qualifications available for department review.

(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.

(4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.

(5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) Nurse aide competency evaluation. A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

b. Content of the competency evaluation program.

(1) Written or oral examinations. The competency evaluation shall:

1. Allow an aide to choose between a written and oral examination.

2. Address each of the course requirements listed in 81.16(3) "b."

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5) "c."

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) "c"(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals. Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 6391C, IAB 6/29/22, effective 9/1/22]

441—81.17 Reserved.

441—81.18(249A) Sanctions.

81.18(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director's designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

- (1) The number of assessments willingly and knowingly falsified.
- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) Use of independent assessors. If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

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

441—81.19 Reserved.

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.20(1) Out-of-state providers. Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state government owned nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

81.20(3) Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

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

[**ARC 8995B**, IAB 8/11/10, effective 9/15/10; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 6934C**, IAB 3/8/23, effective 5/1/23; **ARC 6934C**, IAB 3/8/23, effective 5/1/23]

441—81.21(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule

441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) *Beginning date of payment.* When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.
[ARC 6226C, IAB 3/9/22, effective 5/1/22]

441—81.24 to 81.30 Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

“*CMS*” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“*Deficiency*” means a nursing facility's failure to meet a participation requirement.

“*Department*” means the Iowa department of human services.

“*Immediate jeopardy*” means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“*New admission*” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

441—81.32(249A) General provisions.

81.32(1) Purpose of remedies. The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) Basis for imposition and duration of remedies. The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) Number of remedies. The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) Plan of correction requirement.

a. Except as specified in paragraph “b,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) Disagreement regarding remedies. If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) Notification requirements.

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

b. Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

81.32(7) Informal dispute resolution.

a. Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

b. Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

81.33(2) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

- (1) No actual harm with a potential for minimal harm.
- (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
- (3) Actual harm that is not immediate jeopardy.
- (4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

- (1) Are isolated.
- (2) Constitute a pattern.
- (3) Are widespread.

81.33(3) Other factors which may be considered in choosing a remedy within a remedy category. Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) Available remedies. In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.

4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) Selection of remedies.

81.35(1) Categories of remedies. Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) Application of remedies. After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3)“a,”81.35(4)“a,” and 81.35(5)“a,” for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3)“b,”81.35(4)“b,” and 81.35(5)“b,” as applicable.

81.35(3) Category 1.

a. Category 1 remedies include the following:

- (1) Directed plan of correction.
- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) Category 2.

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) Category 3.

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) Plan of correction.

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) Appeal of a determination of noncompliance.

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.

81.36(1) Terminate agreement or appoint temporary manager. If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) Other remedies. The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) Notification of CMS. In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility’s noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) Transfer of residents. The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) Notification of physicians and state board. If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) Termination of agreement or limitation of participation. If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

- a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;
- b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and
- c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) Termination. If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

81.37(3) Denial of payment. Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) Failure to comply. The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

- a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).
- b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) Repeated noncompliance. For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) Standard surveys to which this provision applies. Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) Program participation.

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

(1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) Compliance. Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

- (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
- (2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) *Qualifications.* The temporary manager must:

a. Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.

b. Not have been found guilty of misconduct by any licensing board or professional society in any state.

c. Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.

d. Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) *Payment of salary.* The temporary manager's salary:

a. Is paid directly by the facility while the temporary manager is assigned to that facility.

b. Shall be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.

(2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.

(3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.

c. May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) *Failure to relinquish authority to temporary management.*

a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).

b. A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) *Duration of temporary management.* Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.

81.40(1) *Optional denial of payment.* Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) *Required denial of payment.* Payment for all new admissions shall be denied when:

a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) *Resumption of payments.* Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) Resumption of payments. No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) Restriction. No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) Secretarial authority to deny all payments.

81.41(1) CMS option to deny all payment. If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) Resumption of payment. When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) State monitoring.

81.42(1) State monitor. A state monitor:

a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

b. Is an employee or a contractor of the department of inspections and appeals.

c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

d. Is not an employee of the facility.

e. Does not function as a consultant to the facility.

f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) Use of state monitor. A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) Discontinuance of state monitor. State monitoring is discontinued when:

a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

b. Termination procedures are completed.

441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) Required training. The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

a. The facility has a pattern of deficiencies that indicate noncompliance; and

b. Education is likely to correct the deficiencies.

81.44(2) Action following training. After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) Payment. The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) *Closure during an emergency.* In an emergency, the department and the department of inspections and appeals have the authority to:

- a. Transfer Medicaid and Medicare residents to another facility; or
- b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) *Required transfer in immediate jeopardy situations.* When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) *All other situations.* Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) *When facility requests a hearing.*

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) *When facility does not request a hearing.* If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(3) *When facility waives a hearing.* If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(4) *Accrual and computation of penalties.* Accrual and computation of penalties for a facility that:

- a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);
- b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) *Collection.* The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.

4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) *Waiver of a hearing.* The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) *Reduction of penalty amount.*

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) *Amount of penalty.* The penalties are within the following ranges, set at \$50 increments:

a. Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) “*b.*”

b. Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) *Basis for penalty amount.* The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

81.50(3) *Decreased penalty amounts.* Except as specified in 81.50(4) “*b.*” if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) *Increased penalty amounts.*

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) *Review of the penalty.* When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

a. Set a penalty of zero or reduce a penalty to zero.

b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) *Factors affecting the amount of penalty.* In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

a. The facility's history of noncompliance, including repeated deficiencies.

b. The facility's financial condition.

c. The factors specified in rule 441—81.33(249A).

d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

81.50(7) Authority to settle penalties. The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) When penalty begins to accrue. The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) Duration of penalty. The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;

b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or

c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) Penalty due. The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) Notice after facility achieves compliance. When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

a. The amount of penalty per day;

b. The number of days involved;

c. The total amount due;

d. The due date of the penalty; and

e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) Notice to terminated facility. In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

a. Final administrative decision is made;

b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or

c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) Accrual of penalties when there is no immediate jeopardy.

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph "a," if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) Accrual of penalties when there is immediate jeopardy.

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) Documenting substantial compliance.

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.

81.52(1) *When payments are due.*

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

- (1) The facility achieves substantial compliance before the final administrative decision; or
- (2) The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

- (1) The facility achieves substantial compliance before the hearing request was due; or
- (2) The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

- (1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
- (2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:

- (1) The final administrative decision is made before the facility came into compliance;
- (2) The facility did not file a timely hearing request before it came into substantial compliance; or
- (3) The facility waived its right to a hearing before it came into substantial compliance.

e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

- (1) The final administrative decision was made;
- (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
- (3) The facility waived its right to a hearing.

f. In the cases specified in paragraph “*d.*” the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) *Deduction of penalty from amount owed.* The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) *Interest.* Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.53(249A) Use of penalties collected by the department. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

[ARC 9402B, IAB 3/9/11, effective 4/1/11; ARC 3717C, IAB 3/28/18, effective 7/1/18]

441—81.54(249A) Continuation of payments to a facility with deficiencies.**81.54(1) Criteria.**

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

(1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;

(2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and

(3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)“*a*” are not met.

81.54(2) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)“*a*” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) Period of continued payments. If the conditions in 81.54(1)“*a*” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) Failure to achieve substantial compliance. If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) Disagreement over whether facility has met requirements.

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:

(1) CMS finds the facility is in substantial compliance with the participation requirements; and

(2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:

(1) CMS finds that a facility has not achieved substantial compliance; and

(2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS’s survey findings take precedence, CMS may:

(1) Impose any of the alternative remedies specified in rule 441—81.34(249A);

(2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and

(3) Stop federal financial participation to the department for a nursing facility.

81.55(2) Disagreement over decision to terminate.

a. CMS’s decision to terminate the participation of a facility takes precedence when:

(1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and

(2) CMS, but not the department of inspections and appeals, finds that the facility’s participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

b. The department of inspections and appeals’ decision to terminate a facility’s participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility’s participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

- a. A facility is not in substantial compliance; and
- b. The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

b. The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

b. The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

b. The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) *Facility in compliance.* If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) *Effect of termination.* Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) *Basis of termination.*

- a.* A facility's provider agreement may be terminated if a facility:
- (1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or
 - (2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

- b.* A facility's provider agreement shall be terminated if a facility:
- (1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or
 - (2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)“*a.*”

81.57(3) Notice of termination. Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

- a.* At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and
- b.* At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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- ¹ Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
- ² Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
- ³ Effective date of 81.13(7) "c"(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- ⁴ Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- ⁵ 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**.

OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

[ARC 2471C, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.
- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Substantial gainful activity” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“Third-party payments” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. Rescinded IAB 1/2/19, effective 2/6/19.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1) “b.”

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “*b*” and 75.5(4) “*c*” shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member’s need for service based on the member’s needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1) “*d*” and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member’s service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$3,014.69	\$1,035.79	\$4,040.52

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) (state plan private duty nursing or personal care services for persons aged 20 and under) shall be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member’s case manager no earlier than two months before, and no later than six months after, the member’s twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member’s waiver budget shall be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted managed care organization during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department shall determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services shall become effective on the later of the first day of the month of the member’s twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget shall extend up to the first of the month following the member's twenty-fifth birthday and shall remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4209C, IAB 1/2/19, effective 2/6/19; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange

services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) “a” and “c” do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) “c”(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client’s total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1) “b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) “b,” or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”
- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.
- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.
- e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.10 and 83.11 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an

agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Interdisciplinary team” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.

- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “b” and 75.5(4) “c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.

2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. Service plan. An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.

2. The funding source for the service.

3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5419C, IAB 2/10/21, effective 4/1/21]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1) “d,” indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) Effective date of eligibility.

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client’s total income.

83.24(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs are not met by services provided.
- d. Needed services are not available or received from qualifying providers.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes

other than respite care.

c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.

- d. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
[ARC 3234C, IAB 8/2/17, effective 9/6/17; ARC 5419C, IAB 2/10/21, effective 4/1/21]

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Electronic visit verification system*” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.
- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Be diagnosed by a physician as having AIDS or HIV infection.
- b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment as listed in 83.42(1)“b” shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The designated case manager shall review the assessment of the person’s need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1)“b” and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$2,026.03.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical

institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) Limitation on payment. If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.

- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) “b” or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
[ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.50 Reserved.

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

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“*Department*” means the Iowa department of human services.

“*Direct service*” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“*Electronic visit verification system*” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“*Fiscal accountability*” means the development and maintenance of budgets and independent fiscal review.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Health*” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“*Immediate jeopardy*” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“*Intellectual disability*” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

“*Intermediate care facility for persons with an intellectual disability (ICF/ID)*” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Intermittent supported community living service*” means supported community living service provided not more than 52 hours per month.

“*Maintenance needs*” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“*Managed care*” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.

2. Coordinating access.
3. Containing costs.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical assessment*” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“*Medical institution*” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Medical intervention*” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“*Medical monitoring*” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“*Natural supports*” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“*Organization*” means the entity being certified.

“*Organizational outcome*” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“*Outcome*” means an action or event that follows as a result or consequence of the provision of a service or support.

“*Procedures*” means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified intellectual disability professional*” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.

10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a person-centered, outcome-based plan of services which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"SIS assessment" means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

- (5) Not reside in a medical institution.
 - i.* For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
 - j.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.
 - k.* To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer's family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - l.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).
 - m.* For residential-based supported community living services, meet all of the following additional criteria:
 - (1) Be less than 18 years of age.
 - (2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:
 1. Social history;
 2. Case history that includes previous placements and service programs;
 3. Medical history that includes major illnesses and current medications;
 4. Current psychological evaluations and consultations;
 5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
 6. Any current court orders in effect regarding the child;
 7. Any legal history;
 8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
 9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
 10. Whether the interdisciplinary team is in agreement with the proposed placement.
- (3) Either:
 1. Be residing in an ICF/ID;
 2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)"a"; or
 3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

- n.* For day habilitation, be 16 years of age or older.
- o.* For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2) “*a*” shall have a department service worker or case manager:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant’s needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager’s control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor’s off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant’s priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

d. The state reserves payment slots each waiver year (July 1 to June 30) for use by children who must reside outside the family home in a residential-based supported community living licensed residential care facility. The state also reserves payment slots each waiver year (July 1 to June 30) for use by members living in an ICF/ID, nursing facility, or out-of-state placement, or transitioning from the Money Follows the Person Grant, who choose to access services in the intellectual disability waiver program and leave the ICF/ID, nursing facility, or out-of-state placement to live in the community.

(1) Applicants who currently reside in an ICF/ID or nursing facility and have resided in that setting for four or more months may request a reserved capacity slot through the intellectual disability waiver.

(2) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots shall have the person's name maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the

beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on the person's order on the waiting list. [ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5728C, IAB 6/30/21, effective 9/1/21]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 120 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.65 Reserved.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

- (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
- (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
- (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.
- i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:
- (1) Score on subsection 1A: Exceptional Medical Support Needs.
 - (2) Score on subsection 1B: Exceptional Behavioral Support Needs.
 - (3) Sum total of standard scores on the following subsections:
 1. Subsection 2A: Home Living Activities;
 2. Subsection 2B: Community Living Activities;
 3. Subsection 2E: Health and Safety Activities; and
 4. Subsection 2F: Social Activities.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2) paragraph "d," "g," or "h," apply.

- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.70 and 83.71 Reserved.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“Adaptive” means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a brain injury aged 18 years or over.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“Assessment” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Behavior” means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Brain injury” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

“Case management services” means those services established pursuant to Iowa Code chapter 225C.

“Child” means a person with a brain injury aged 17 years or under.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided from one to three hours a day for not more than four days a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Organization” means the entity being certified.

“*Organizational outcome*” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“*Outcome*” means an action or event that follows as a result or consequence of the provision of a service or support.

“*Procedures*” means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified brain injury professional*” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

“*Service coordination*” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC), Form 470-4694, and Form 470-5572, the Mayo-Portland Adaptability Inventory (MPAI), are available on request from the member's managed care organization or the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer's family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.
- n. For individual supported employment and long-term job coaching services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Not reside in a medical institution.
 - (4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.
- o. For small-group supported employment services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
- (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
- (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
- (5) Not reside in a medical institution.
- p.* For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) Need for services.

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

- (1) The assessment shall be based, in part, on information provided to the IME medical services unit.
- (2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.
- (3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.
- (4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

- (1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.
- (2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.
- (3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.
- (4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person’s needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an intermediate care facility for persons with an intellectual disability (ICF/ID), a skilled nursing facility, or an ICF and have resided in that setting for four or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department shall reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state on July 1, 2019, and for all new applications received on or after July 1, 2019. Applicants may request an emergency need reserved capacity slot by submitting the completed Home- and Community-Based Services (HCBS) Brain Injury Waiver Emergency Need Assessment, Form 470-5583, to the IME medical services unit.

- (1) Emergency need criteria are as follows:
 1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
 2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.
 3. The applicant is living in a homeless shelter, and no alternative housing options are available.
 4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.
 5. The applicant cannot meet basic health and safety needs without immediate supports.
- (2) Urgent need criteria are as follows:
 1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.
 2. The caregiver will be unable to continue to provide care within the next 60 days.
 3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.
 4. The applicant is living in temporary housing and plans to move within 31 to 120 days.
 5. The applicant is losing permanent housing and plans to move within 31 to 120 days.
 6. The caregiver will be unable to be employed if services are not available.
 7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
 8. The applicant has behaviors that put the applicant at risk.
 9. The applicant has behaviors that put others at risk.
 10. The applicant is at risk of facility placement when needs could be met through community-based services.
- (3) Applicants who meet an emergency need criterion shall be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(4) "e"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.
- (4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.82(4) "e"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.
- (5) Applicants who do not meet emergency or urgent need criteria shall remain on the waiting list, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.
- (6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new emergency needs assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.
 - f.* To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.
 - (1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 4974C, IAB 3/11/20, effective 4/15/20; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5728C, IAB 6/30/21, effective 9/1/21]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1) "f," indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the consumer's managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional

inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.

- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The brain injury waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.

- f.* Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g.* The consumer receives services from other Medicaid providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).
 [ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.90 and 83.91 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a physical disability aged 18 years to 64 years.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Assessment” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Department” means the Iowa department of human services.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Guardian” means a guardian appointed in probate court for an adult.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Physical disability*” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Rescinded IAB 2/7/01, effective 2/1/01.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)“*h*,” as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$761.95 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department

or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) Computation of client participation. Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage,

self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer’s interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) Annual assessment. The IME medical services unit or a managed care organization shall review the member’s need for continued care annually and recertify the member’s need for long-term care services, pursuant to paragraph 83.102(1) “h” and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) “h” and other supporting documentation as relevant.

a. The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer’s service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer’s needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer’s annual service plan.

- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.110 and 83.111 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN’S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, abilities, desires, and goals.

“*Care coordinator*” means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)“*b.*”

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Electronic visit verification system*” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Integrated health home*” means the provision of services to enrolled members as described in 441—subrule 78.53(1).

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator or managed care organization.

83.122(4) Financial eligibility. The consumer must be eligible for Medicaid as follows:

- a.* Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or
- b.* Be eligible under the special income level (300 percent) coverage group; or
- c.* Become eligible through application of the institutional deeming rules; or
- d.* Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) Choice of program. The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) Need for service. The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$2,165.87 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22; ARC 6735C, IAB 12/14/22, effective 11/15/22; ARC 6937C, IAB 3/8/23, effective 5/1/23]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) Program limit. The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number

of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

e. The state reserves payment slots each waiver year (October 1 to September 30) for use by members living in a state of Iowa mental health institute (MHI), a psychiatric residential treatment facility (PRTF), or an out-of-state facility placement who choose to access services in the children's mental health waiver program and leave the MHI, PRTF, or out-of-state placement to live within their family home. For the purpose of reserved capacity within the children's mental health waiver program, an MHI is defined in Iowa Code section 226.1 and a PRTF is defined in 42 CFR 483.352.

(1) Applicants who currently reside in an MHI, PRTF, or out-of-state placement and have resided in that setting for four or more months may request a reserved capacity slot through the children's mental health waiver program.

(2) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

83.123(2) Approval of waiver eligibility.

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5728C, IAB 6/30/21, effective 9/1/21]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review.

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) Payment slot. When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.128(249A) Adverse service actions.

83.128(1) Denial. An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

83.128(2) Termination. A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.
- e. Service providers are not available.

83.128(3) Reduction. Reduction of services shall apply as specified in 441—paragraphs 130.5(3) "a" and "b."
[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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CHAPTER 172
FAMILY-CENTERED SERVICES

PREAMBLE

These rules define and describe procedures for delivery of family-centered services. The rules describe the service definitions, eligibility criteria, and procedures for client appeals.

[ARC 9491B, IAB 5/4/11, effective 7/1/11; ARC 5248C, IAB 11/4/20, effective 1/1/21]

441—172.1(234) Definitions.

“Agency” means the Iowa department of human services.

“Agency child welfare service case” means at least one child in a household is involved in agency services with an agency-assigned social work case manager.

“Agency worker” means the agency child welfare worker who has been assigned responsibility for a child and family’s case, either to perform a child abuse assessment, family assessment, or child in need of assistance (CINA) assessment or assume case management responsibility for ongoing agency child welfare service cases.

“Candidate for foster care” means a child who is identified in a prevention plan as being at imminent risk of entering foster care but who can remain safely in the child’s home or in a kinship placement as long as services or programs that are necessary to prevent the entry of the child into foster care are provided. “Candidate for foster care” includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.

“Child,” “children,” or “youth” means a person or persons who meet the definition of a child in Iowa Code section 234.1(2).

“Child abuse” means one or more of the categories of child abuse defined in Iowa Code section 232.68.

“Child abuse assessment” means an assessment process by which the agency responds to all accepted reports of child abuse that allege child abuse as defined in Iowa Code section 232.68(2) “a”(1) through (3) and (5) through (11); or that allege child abuse as defined in Iowa Code section 232.68(2) “a”(4) that also allege imminent danger, death, or injury to a child. A child abuse assessment results in a disposition and a determination of whether a case meets the definition of child abuse and a determination of whether criteria for placement on the registry are met.

“Child in need of assistance” or “CINA” means a child adjudicated by juvenile court to be a child in need of assistance pursuant to Iowa Code section 232.2.

“Child vulnerability” means the degree that a child cannot on the child’s own avoid, negate, or minimize the impact of present or impending danger.

“Contractor” means a private organization authorized to do business in Iowa that has entered into a contract with the agency to provide one or more of the services defined in this chapter. “Contractor” refers to the organization that is named as the responsible party in the contract and whose authorized representative has signed the contract.

“Family assessment” means an assessment process by which the agency responds to all accepted reports of child abuse that allege child abuse as defined in Iowa Code section 232.68(2) “a”(4), but do not allege imminent danger, death, or injury to a child. A family assessment does not include a determination of whether a case meets the definition of child abuse and does not include a determination of whether criteria for placement on the registry are met.

“Family-centered services” means the services provided by contract pursuant to this chapter.

“Family preservation services” or “FPS” means short-term, intensive, home-based crisis interventions targeted to families that have children at imminent risk of removal and placement in foster care. Family preservation services combine skill-based interventions and flexibility so that services are available to families according to their individual needs.

“Fictive kin” means a person who is unrelated to a child by blood, adoption, or marriage, but who has an emotionally significant relationship with the child or the child’s family.

“Household” means the place where a child resides.

“*Kinship caregiver*” means a relative or fictive kin providing care for a child.

“*Kinship navigator services*” means the services and supports providing information, referral, and follow-up to kinship caregivers who are caring for and raising children to link kinship caregivers to benefits and other resources they need.

“*Non-agency-involved case*” means a case in which no one in the household is involved with an agency-assigned social work case manager.

“*Permanency*” means a child has a safe, stable, custodial environment in which to grow up and a lifelong relationship with a nurturing caregiver.

“*Protective capacities*” means the family strengths or resources that reduce, control, or prevent risks from arising or from having an unsafe impact on a child.

“*Risk*” means the probability or likelihood that a child will experience maltreatment.

“*Safe*” means that no signs of present or impending danger to a child are identified or that one or more signs of present or impending danger are identified but the child’s degree of vulnerability or the caregiver’s protective capacities offset the current threat. The child is not likely to be in imminent danger of maltreatment.

“*SafeCare®*” means an evidence-based training curriculum for parents who are at risk or have been reported for child abuse. Through SafeCare®, parents receive weekly home visits to improve skills in several areas, including home safety, health care, and parent-child interaction.

“*Solution Based Casework®*” or “*SBC*” means an evidence-based, family-centered model of child welfare assessment, case planning, and ongoing casework. The goal of SBC is to work in partnership with the family to help identify the family’s strengths, to focus on everyday life events, and to help the family build the skills necessary to manage difficult situations.

“*Solution focused meeting*” means a gathering of family members, friends, and formal and informal supports, with the assistance of a trained facilitator, to draw on past successes of the family in problem solving and work in partnership with the family to enhance safety of the children.

[ARC 9491B, IAB 5/4/11, effective 7/1/11; ARC 1156C, IAB 10/30/13, effective 1/1/14; ARC 5248C, IAB 11/4/20, effective 1/1/21; ARC 6936C, IAB 3/8/23, effective 5/1/23]

441—172.2(234) Purpose and scope. Family-centered services are services designed to prevent the child from entering foster care and to assist the family when the needs of the child, parent, or kinship caregiver are directly related to the safety, permanency, or well-being of the child. The outcome of the services may be to maintain the child with a parent or in the home of the kinship caregiver, to reunify the child safely with a parent or kinship caregiver, or to achieve permanent family connections for the child.

172.2(1) Family-centered services provide interventions and supports based on identified needs of children and families that have come to the agency’s attention because of:

a. Evaluation of the findings of a child abuse assessment report and the family’s risk assessment score; or

b. The child’s adjudication as a child in need of assistance pursuant to Iowa Code section 232.2; or

c. The child’s placement out of home under the agency’s care and supervision.

172.2(2) Family-centered services shall be designed to:

a. Identify and build on the family’s strengths and enhance the family’s protective capacities;

b. Address the risk factors that affect the child’s safety, permanency, and well-being;

c. Strengthen family connections to community resources and informal support systems in order to promote greater self-reliance; and

d. Remain culturally competent and respectful of the family’s cultural, ethnic, and racial identity and values.

172.2(3) Family-centered services shall utilize evidence-based interventions to the greatest possible extent.

172.2(4) Family-centered services shall include the following persons:

a. A child eligible for services under this rule, as defined by the agency;

b. Any sibling of that child who resides in the same household at the time of service referral or moves into the household during the service delivery period; and

c. A parent, stepparent, or kinship caregiver of the child.

172.2(5) Family-centered services shall include SBC for agency child welfare service cases when criteria in subrule 172.2(1) are met.

172.2(6) Based on child and family needs, a child and family with an open agency child welfare service case that are receiving SBC may also be approved to receive the following additional services, which are referred separately:

a. SafeCare®.

b. Family preservation services.

c. Solution focused meeting (SFM) and youth transition decision-making (YTDM) meeting facilitation.

172.2(7) Case management. During the time that a child and the child's family are approved to receive family-centered services on an open agency child welfare service case, the agency worker shall be responsible for maintaining contact with the child and family to ensure that:

a. The factors that present risks of harm to the safety and well-being of all children in the family are being adequately addressed; and

b. Services and supports are in place to achieve the child's permanency goal.

[ARC 9491B, IAB 5/4/11, effective 7/1/11; ARC 5248C, IAB 11/4/20, effective 1/1/21; ARC 6936C, IAB 3/8/23, effective 5/1/23]

441—172.3(234) Authorization. When the agency has approved provision of family-centered services for a child and family, the agency worker shall notify the contractor by issuing the referral and authorization for child welfare services form. This authorization form shall indicate:

1. The specific service category authorized; and

2. The duration of the authorization.

[ARC 9491B, IAB 5/4/11, effective 7/1/11; ARC 1156C, IAB 10/30/13, effective 1/1/14; ARC 5248C, IAB 11/4/20, effective 1/1/21]

441—172.4(234) Reimbursement. Rescinded ARC 5248C, IAB 11/4/20, effective 1/1/21.

441—172.5(234) Client appeals. Clients may appeal the agency's decision pursuant to 441—Chapter 7 when:

1. The client's application for services as described in this chapter is denied, or

2. The services are terminated.

[ARC 9491B, IAB 5/4/11, effective 7/1/11]

441—172.6(234) Reviews and audits. Rescinded ARC 5248C, IAB 11/4/20, effective 1/1/21.

These rules are intended to implement Iowa Code section 234.6.

[Filed 5/16/07, Notice 1/31/07—published 6/6/07, effective 10/1/07]

[Filed emergency 11/14/07—published 12/5/07, effective 11/15/07]

[Filed 2/13/08, Notice 12/5/07—published 3/12/08, effective 4/16/08]

[Filed ARC 9491B (Notice ARC 9353B, IAB 2/9/11), IAB 5/4/11, effective 7/1/11]

[Filed ARC 1156C (Notice ARC 0915C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]

[Filed ARC 2885C (Notice ARC 2771C, IAB 10/12/16), IAB 1/4/17, effective 3/1/17]

[Filed ARC 5248C (Notice ARC 5131C, IAB 8/12/20), IAB 11/4/20, effective 1/1/21]

[Filed ARC 6936C (Notice ARC 6768C, IAB 12/28/22), IAB 3/8/23, effective 5/1/23]

CHAPTER 1
ORGANIZATION
[Prior to 1/7/04, see 581—21.1]

495—1.1(97B) Organization. The agency shall administer the retirement system created by Iowa Code chapter 97B. Specific powers and duties of the agency, CEO, board, committee, and agency staff are set forth in Iowa Code chapter 97B and these administrative rules.

Operational units within the agency shall develop and administer policies and procedures governing retirement system programs, including accounting functions for the collection of funds from employers and employee members; disbursement of retirement benefits, death benefits, lump sum payments, and disability retirement benefits; training to employers and subsequent review of employer records for compliance with Iowa Code chapter 97B, rules and policies; preparation and release of informational newsletters and the annual report; and investment of funds contributed to the retirement system by employers and employee members. The retirement system is also the state administrator to the federal Social Security Administration pursuant to Iowa Code chapter 97C.

[ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—1.2(97B) Definitions. Unless otherwise prescribed by federal or state regulations, the terms used in this chapter shall have the following meanings:

“*Agency*” means the Iowa public employees’ retirement system (IPERS) created as an independent agency within the executive branch of state government to administer Iowa Code chapter 97B.

“*Board*” means the IPERS’ investment board as created in Iowa Code section 97B.8A.

“*Chief benefits officer*” means the person employed by IPERS’ chief executive officer, following consultation with the committee, to administer benefits programs and other member services provided under the retirement system.

“*Chief executive officer*” means the administrator of the agency appointed pursuant to Iowa Code section 97B.3 and whose term shall be determined pursuant to Iowa Code section 97B.3.

“*Chief investment officer*” means the person employed by IPERS’ chief executive officer, following consultation with the board, to administer the investment program of the retirement system.

“*Committee*” means the benefits advisory committee created pursuant to Iowa Code section 97B.8B.

“*Internal Revenue Code*” means the Internal Revenue Code as defined in Iowa Code section 422.3.

“*IPERS*” means the agency or the system as the context requires.

“*System*” means the Iowa public employees’ retirement system created pursuant to Iowa Code chapter 97B.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—1.3(97B) Administration. The chief executive officer, through the chief investment officer and the chief benefits officer, shall administer Iowa Code chapters 97, 97B, and 97C. The chief executive officer shall execute contracts on behalf of IPERS and shall, after consultation with the board and other agency staff, establish and administer the budget and such other duties as are required or permitted in Iowa Code section 97B.4. The chief executive officer may make expenditures, reports, and investigations as necessary to carry out the powers and duties created in Iowa Code chapter 97B and may obtain, as necessary, the specialized services of individuals or organizations on a contract-for-service basis. The chief executive officer shall be the agency’s statutory designee with respect to rule-making power.

1.3(1) Location. IPERS’ headquarters is located at 7401 Register Drive, Des Moines, Iowa. General correspondence, inquiries, requests for information or assistance, complaints, or petitions shall be addressed to: Chief Executive Officer, Iowa Public Employees’ Retirement System, P.O. Box 9117, Des Moines, Iowa 50306-9117.

1.3(2) Business hours. Business hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding officially designated holidays.

[ARC 6949C, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code chapter 97B.

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

[Filed ARC 6949C (Notice ARC 6823C, IAB 1/11/23), IAB 3/8/23, effective 4/12/23]

CHAPTER 4
EMPLOYERS

[Prior to 6/9/04, see 581—Ch 21]

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. "Political subdivision" means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. "Instrumentality of the state or a political subdivision" means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. "Public agency" means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS-covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

- a.* Former name;
- b.* Former address;
- c.* IPERS account number;
- d.* New name, address, and telephone number of the employer;
- e.* Reason for the change if other than a change of reporting official; and
- f.* Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

- a. Complete name and address of the dissolved entity;
- b. Assigned IPERS account number;
- c. Last date on which wages were paid;
- d. Date on which the entity dissolved;
- e. Reason for the dissolution;
- f. Whether or not the entity expects to pay wages in the future;
- g. Whether the entity is being absorbed by another covered employer;
- h. Name and address of absorbing employer if applicable; and
- i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) Patient advocates. For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Required information. Records shall show with respect to each employee:

- a. Employee's name, address, gender, and social security account number, and other demographic information that may be required;
- b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
- c. Total amount of wages paid on each date including noncash wage equivalents;
- d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
- e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
- f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.

a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.

b. Effective July 1, 2021, employers shall report the termination date and date of final paycheck for all terminating employees to IPERS with the final wage report for such employee. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.

c. The Iowa department of administrative services and the Iowa department of corrections shall notify IPERS prior to adding additional job classifications to the protection occupation class. The notification shall include the effective date, names and social security numbers of the employees involved.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) Payment of contributions. For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS-covered employer,

the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) *Wage reports.* For wages paid on or after July 1, 2008, all IPERS-covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or state-observed holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via IPERS' employer self-service Internet application or as a paper report. However, for those employers submitting reports other than via IPERS' employer self-service Internet application, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) *Deadlines for payment of contributions.*

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or state-observed holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) *Request for time extension.* A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or state-observed holiday, the contribution or wage report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the wage report or timely pay a contribution because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self-service Internet application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of \$20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self-service Internet application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code

sections 97B.9 and 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or state-observed holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17)(A) and the cost-of-living adjustments to that maximum permitted under Section 401(a)(17)(B) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

[ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—4.4(97B) *Accrual of interest and application of employer payments.* Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of \$20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) *Credit memos voided.* Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) *Contribution rates.* The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) *Contribution rates for regular class members.*

a. The following contribution rates were established by the Iowa legislature for all regular class members for the indicated periods:

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011
Combined rate	9.95%	10.45%	10.95%	11.45%	13.45%
Employer	6.05%	6.35%	6.65%	6.95%	8.07%
Employee	3.90%	4.10%	4.30%	4.50%	5.38%

b. Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

	Effective July 1, 2019	Effective July 1, 2020	Effective July 1, 2021	Effective July 1, 2022	Effective July 1, 2023
Combined rate	15.73%	15.73%	15.73%	15.73%	15.73%
Employer	9.44%	9.44%	9.44%	9.44%	9.44%
Employee	6.29%	6.29%	6.29%	6.29%	6.29%

4.6(2) Contribution rates for sheriffs and deputy sheriffs are as follows.

	Effective July 1, 2019	Effective July 1, 2020	Effective July 1, 2021	Effective July 1, 2022	Effective July 1, 2023
Combined rate	19.02%	18.52%	18.02%	17.52%	17.02%
Employer	9.51%	9.26%	9.01%	8.76%	8.51%
Employee	9.51%	9.26%	9.01%	8.76%	8.51%

4.6(3) Contribution rates for protection occupations are as follows.

	Effective July 1, 2019	Effective July 1, 2020	Effective July 1, 2021	Effective July 1, 2022	Effective July 1, 2023
Combined rate	16.52%	16.02%	15.52%	15.52%	15.52%
Employer	9.91%	9.61%	9.31%	9.31%	9.31%
Employee	6.61%	6.41%	6.21%	6.21%	6.21%

4.6(4) Members employed in a “protection occupation” shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a “correctional officer” position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another “correctional officer” position that meets this definition. Movement to a position that does not meet this definition shall cancel “protection occupation” coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions

as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a “peace officer” by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

n. Effective July 1, 2014, an employee of the insurance division of the department of commerce who as a condition of employment is required to be certified by the Iowa law enforcement academy and who is required to perform the duties of a peace officer as provided in Iowa Code section 507E.8.

o. Effective July 1, 2014, an employee of a judicial district department of correctional services whose condition of employment requires the employee to be certified by the Iowa law enforcement academy and who is required to perform the duties of a parole officer as provided in Iowa Code section 906.2.

p. Effective July 1, 2016, a peace officer employed by an institution under the control of the state board of regents whose position requires law enforcement certification pursuant to Iowa Code section 262.13.

q. Effective July 1, 2016, a person employed by the department of human services as a psychiatric security specialist at a civil commitment unit for sexually violent offenders facility.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff's or deputy sheriff's eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[ARC 7591B, IAB 2/25/09, effective 7/1/09; ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21; ARC 6215C, IAB 2/23/22, effective 3/30/22; ARC 6949C, IAB 3/8/23, effective 4/12/23]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees using IPERS' employer self-service Internet application. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, and employer identification number. When an employee terminates employment with a covered employer, the employer shall provide the termination date and the date of the employee's final paycheck.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff. Rescinded ARC 2981C, IAB 3/15/17, effective 4/19/17.

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, chapter 170, section 51, as amended by 2010 Iowa Acts, House File 2518, sections 36 and 41.

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CHAPTER 6
COVERED WAGES
[Prior to 6/9/04, see 581—Ch 21]

495—6.1(97B) IRS requirements. Wages as discussed in this chapter shall not exceed the amount permitted for a given year under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code, which are incorporated herein by this reference.

[ARC 9397B, IAB 2/23/11, effective 3/30/11]

495—6.2(97B) Definition of wages. “Wages” means all compensation earned by employees including, except as otherwise provided under this chapter, vacation pay; sick pay; back pay; amounts deducted from the employee’s pay at the employee’s discretion for tax-sheltered annuities, dependent care and cafeteria plans; and the cash value of wage equivalents. This definition applies to these rules, regulations, interpretations, forms and other IPERS publications unless the context otherwise requires.

495—6.3(97B) IPERS coverage for various forms of compensation. The following is a list of various types of compensation and the corresponding IPERS coverage treatment:

6.3(1) *Vacation pay or annual leave pay.* Vacation pay or annual leave pay means the amount paid to an employee during a period of vacation.

6.3(2) *Sick pay.* Sick pay means the amount paid to an employee during a period of sick leave.

6.3(3) *Workers’ compensation payments and other third-party payments.* Workers’ compensation payments, unemployment payments, or short-term and long-term disability payments made by an insurance company or third-party payer, such as a trust, are not included as wages. Payments for sick leave which are a continuation of salary payments if paid from the employer’s general assets, regardless of whether the employer labels the payments as sick leave, short-term disability, or long-term disability, are covered wages.

6.3(4) *Compensatory time.* Wages include amounts paid for compensatory time taken in lieu of regular work hours or when paid as a lump sum. However, compensatory time paid in a lump sum shall not exceed 240 hours per employee per year or any lesser number of hours set by the employer. Each employer shall determine whether to use the calendar year or a fiscal year other than the calendar year when setting its compensatory time policy. The wages reported to IPERS must reflect the employer’s policy.

6.3(5) *Banked holiday pay.* If an employer codes banked holiday time as holiday or additional accrued vacation time, the banked holiday pay will be vacation pay under subrule 6.3(1). If an employer codes banked holiday time as compensatory time, the banked holiday pay will be combined with compensatory pay and subject to the limits set forth in subrule 6.3(4).

6.3(6) *Special lump sum payments.* Wages do not include special lump sum payments made during or at the end of service as a payoff of unused accrued sick leave or of unused accrued vacation. Wages do not include special lump sum payments made during or at the end of service as an incentive to retire early or as payments made upon dismissal, severance, or a special bonus payment intended as an early retirement incentive. Wages do not include: catastrophic leave paid in a lump sum, bonuses, tips, honoraria, or student loan repayment compensation. Exclusion of payments as described in this subrule applies whether the payment is in a lump sum or in installments.

6.3(7) *Covered wage treatment for supplemental payments.*

a. Payments excluded from covered wages as bonuses include the following:

- (1) Recruitment payments.
- (2) Retention payments.
- (3) Payments to members who achieve improvements in their employer’s financial status or performance ratings.
- (4) Employee performance incentive payments.
- (5) Extraordinary job performance payments.

(6) Payments for the possession, attainment, or maintenance of special skills or professional certifications (does not apply to advancements in a member's placement in wage or salary schedule, or placement in a higher tier wage or salary schedule).

(7) Payments to members made in lieu of merit increases because the members' wage or salary scales are capped.

(8) Payments similar in substance to those enumerated above without regard to the payments' titles, tag lines, labels or classifications by employers.

b. Payments included in covered wages that are not to be treated as bonuses include the following:

(1) Payments authorized by statute and used to increase the general level of teacher pay, except as otherwise provided in this subrule (for example, when such moneys are used to pay retention bonuses).

(2) Payments for which additional, or new and different, job duties are required in order to receive the payment.

(3) Payments for employment longevity.

c. Payments that are otherwise to be treated as covered wages under paragraph "b" shall not be covered if IPERS determines that the payments are made for paragraph "a," subparagraphs (1) to (8), of this subrule or other subrules, including, but not limited to, recruitment or retention bonuses, retirement incentive and severance payments, reimbursements of business expenses, and payment of allowances.

d. IPERS shall have the final authority to determine if supplemental payments not described in paragraphs "a," "b" and "c" of this subrule should be treated as excluded bonus payments or covered wages. In making its determination, IPERS may consider, but is not limited to, such factors as the supplemental payments' similarity to payments described in paragraphs "a," "b" and "c" of this subrule, whether such payments are discretionary with the employer, and whether, on the one hand, the payments are regular and periodic over the working careers of a broad group of individuals or, on the other hand, are short-term, irregular, or ad hoc payments whose primary effect is to spike certain members' final average salaries.

6.3(8) *Other special payment arrangements.* Wages do not include amounts paid pursuant to special arrangements between an employer and employee whereby the employer pays increased wages and the employee reimburses the employer or a third-party obligor for all or part of the wage increase. This limitation includes, but is not limited to, the practice of increasing an employee's wages by the employer's share of health care costs and having the employee reimburse the employer or a third-party provider for such health care costs. Wages do not include amounts paid pursuant to a special arrangement between an employer and employee whereby wages in excess of the covered wage ceiling for a particular year are deferred to one or more subsequent years. Wages do not include employer contributions to a plan, program, or arrangement that are not included in the employee's federal taxable income. However, certain employer contributions under IRC Section 125 plans are permitted to be treated as covered wages under rule 495—6.5(97B) subject to the terms of that rule.

Employers and employees that knowingly and willfully enter into the types of arrangements described in this subrule, causing an impermissible increase in the payments authorized under Iowa Code chapter 97B, may be prosecuted under Iowa Code section 97B.40 for engaging in a fraudulent practice. If IPERS determines that its calculation of a member's monthly benefit includes amounts paid under an arrangement described in this subrule, IPERS shall recalculate the member's monthly benefit, after making the appropriate wage adjustments. IPERS may recover the amount of overpayments caused by the inclusion of the payments described in this subrule from the monthly amounts plus interest payable to the member or amounts payable to the member's successor(s) in interest, regardless of whether or not IPERS chooses to prosecute the employers and employees under Iowa Code section 97B.40.

6.3(9) *Wage equivalents.* Items such as food, lodging and transportation are includable as employee income, if they are paid as compensation for employment. The basic test is whether or not such wage equivalent was given for the convenience of the employee or employing unit. Wage equivalents are not reportable under IPERS if given for the convenience of the employing unit or are not reasonably quantifiable. Wage equivalents that are not included in the member's federal taxable income shall be deemed to be for the convenience of the employer. A wage equivalent is not reportable if the employer

certifies that there was a substantial business reason for providing the wage equivalent, even if the wage equivalent is included in the employee's federal taxable income. Wages paid in any other form than money are measured by the fair market value of the meals, lodging, travel or other wage equivalents.

6.3(10) *Members of the general assembly.* Wages for a member of the general assembly means the total compensation received by a member of the general assembly, whether paid in the form of per diem or annual salary. Wages include per diem payments paid to members of the general assembly during interim periods between sessions of the general assembly. Wages do not include expense payments except that, effective July 1, 1990, wages include daily allowances to members of the general assembly for nontravel expenses of office during a session of the general assembly. Such nontravel expenses of office during a session of the general assembly shall not exceed the maximum established by law for members from Polk County. A member of the general assembly who has elected to participate in IPERS shall receive four quarters of service credit for each calendar year during the member's term of office, even if no wages are reported in one or more quarters during a calendar year.

6.3(11) *Wages restored following an employer-mandated reduction in hours.* Rescinded IAB 3/15/17, effective 4/19/17.

6.3(12) *Wages paid as a back pay settlement.* IPERS contributions must be calculated on the gross amount of a back pay settlement before the settlement is reduced for taxes, interim wages, unemployment compensation, and similar mitigation of damages adjustments. IPERS contributions must be calculated by reducing the gross amount of a back pay settlement by any amounts not considered covered wages such as, but not limited to, lump sum payments for medical expenses.

Notwithstanding the foregoing, a back pay settlement that does not require the reinstatement of a terminated employee and payment of the amount of wages that would have been paid during the period of severance (before adjustments) shall be treated by IPERS as a "special lump sum payment" under subrule 6.3(6) and shall not be covered.

6.3(13) *Limitations on benefits and contributions.*

a. Section 415(b) limitations on benefits. A member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Internal Revenue Code Sections 415(b) and 415(d). For purposes of applying the limits under Internal Revenue Code Section 415(b) (Limit), the following will apply:

(1) With respect to a member who does not receive a portion of the member's annual benefit in a lump sum:

1. The member's Limit will be applied to the member's annual benefit in the first limitation year without regard to any automatic cost-of-living increases;

2. To the extent the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases under the IPERS trust fund until such time as the benefit plus the accumulated increases are less than the applicable Limit; and

3. Thereafter, in any subsequent limitation year, the member's annual benefit including any automatic cost-of-living increase shall be tested under the then applicable benefit Limit, including any adjustment to the Internal Revenue Code Section 415(b)(1)(A) dollar limit under Internal Revenue Code Section 415(d) (cost-of-living adjustments) and the regulations thereunder; and

(2) With respect to a member who receives a portion of the member's annual benefit in a lump sum:

1. The member's applicable Limit shall be applied taking into consideration automatic cost of living increases as required by Internal Revenue Code Section 415(b) and applicable Treasury Regulations; and

2. In no event shall a member's annual benefit payable under the system in any limitation year be greater than the Limit applicable at the annuity starting date, as increased in subsequent years pursuant to Internal Revenue Code Section 415(d) and the regulations thereunder. If the form of benefit without regard to the automatic benefit increase feature is not a straight life or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent straight life annuity benefit determined using the assumptions required by Treasury Regulations, including the mortality table specified in Revenue Ruling 2001-62 or Revenue Ruling 2007-67, as applicable.

b. Section 415(c) limitations on contributions and other member additions. Member contributions and other additions paid to the system may not exceed the annual limits on contributions and other additions allowed by Internal Revenue Code Section 415(c). For purposes of applying these limits, the definition of “compensation,” where applicable, will be compensation as defined in Treasury Regulation Section 1.415(c)-2(d)(3), or successor regulation. The foregoing definition of compensation will exclude member contributions picked up under Internal Revenue Code Section 414(h)(2) and, for plan years beginning after December 31, 1997, compensation will include the amount of any elective deferrals, as defined in Internal Revenue Code Section 402(g)(3), and any amount contributed or deferred by the employer at the election of the member and which is not includible in the gross income of the member by reason of Internal Revenue Code Section 125 or 457 and, for plan years beginning on and after January 1, 2001, pursuant to Internal Revenue Code Section 132(f)(4).

c. Limitation year. The limitation year is the calendar year.

6.3(14) *Employer payments treated as remuneration counted against the reemployment earnings limit.* All taxable or nontaxable compensation, regardless of the title, tag line, label, or classification attributed to that compensation paid by IPERS-covered employers to retired reemployed IPERS members, shall be considered remuneration when determining reemployment earnings limits and reductions as set forth under Iowa Code section 97B.48A and rule 495—12.8(97B). This rule shall apply whether the compensation is paid pursuant to individual contracts or otherwise, and regardless of whether it is considered covered or noncovered compensation under Iowa Code section 97B.1A(26) and the administrative rules thereunder, except for:

- a.* Contributions to health insurance plans and programs, and
- b.* Reimbursements of actual work-related expenses required by the retired reemployed members’ jobs.

6.3(15) *Employer contributions as remuneration counted against the reemployment earnings limit.* Employer contributions made on behalf of retired reemployed members to tax qualified and nonqualified retirement and deferred compensation plans and to other fringe benefit arrangements, excluding health insurance plans and programs, shall constitute remuneration from employment which shall be applied to the reemployment earnings limits and reductions set forth under rule 495—12.8(97B). Such contributions, even if counted as remuneration hereunder, shall not be counted as covered wages, unless the facts in the particular case indicate that, under the circumstances, the arrangement should be treated as covered wages under rules 495—6.1(97B) through 495—6.5(97B). Nonelective employer contributions to the following shall constitute remuneration when determining reemployment earnings limits: tax qualified retirement and deferred compensation plans; all nonqualified retirement plans and deferred compensation arrangements; IRAs; rabbi, secular, and other trust arrangements; split dollar and other life insurance arrangements; and long-term care insurance. Bonuses and allowances will also be counted as reemployment earnings.

[ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 6949C, IAB 3/8/23, effective 4/12/23]

495—6.4(97B) Month for which wages are to be reported. Wages are reportable for the month in which they are actually paid to the employee, except when employees are awarded lump sum payments of back wages, whether as a result of litigation or otherwise, receive lump sum payments of extra duty pay, and similar situations involving regular and periodic lump sum payments which IPERS in its sole discretion determines should be treated as covered wages. The employer shall file with IPERS wage adjustments allocating the wages to the periods of service for which such payments are awarded. Employers shall forward the required employer and employee contributions and interest to IPERS.

6.4(1) *Actual and constructive receipt.* An employer cannot report wages as having been paid to employees as of a monthly reporting date if the employee has not actually or constructively received the payments in question. For example, wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on June 30 would be reported as June wages, but wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on July 3 would be reported as July wages.

6.4(2) One quarter of service will be credited for each quarter in which a member is paid IPERS-covered wages.

a. “Covered wages” means wages of a member during periods of service that do not exceed the annual covered wage maximum as permitted for a given year under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code, which are incorporated herein by this reference.

b. If a member is employed by more than one employer during the calendar year, the total amount of wages paid by all covered employers shall be included in determining the annual covered wage limit established under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code. If the amount of wages paid to a member by several employers during any given month exceeds the covered wage limit as determined for that calendar year, the amount of the excess shall not be subject to contributions required by Iowa Code section 97B.11. IPERS shall not accept excess wages and applicable contributions from employers and shall return excess contributions as provided in 495—subrule 4.3(8).

[ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 4337C, IAB 3/13/19, effective 4/17/19]

495—6.5(97B) Covered wage treatment for employer contributions to IRC Section 125 plans. If certain conditions are met, employer contributions to fringe benefit programs that qualify under IRC Section 125 may be treated as covered wages. The following subrules set forth IPERS’ regulations for determining covered wage treatment and for making wage adjustments when employer-paid contributions have been covered or excluded in violation of the standards set forth below.

6.5(1) Section 125 plans. For purposes of this rule, a Section 125 plan means an employer-sponsored fringe benefit plan that is subject to Section 125 of the federal Internal Revenue Code (IRC). Some of the common names for this type of plan are cafeteria plan, flexible benefits plan, flex plan, and flexible spending arrangement.

a. Effective January 1, 2017, employers must annually certify to IPERS, on a form approved by the system, that their Section 125 plans meet all IRC requirements.

b. If an employer does not certify its Section 125 plan’s compliance with the IRC, all employer contributions to fringe benefit plans will be excluded from IPERS coverage.

6.5(2) Elective employer contributions. For purposes of this rule, “elective employer contributions” means employer contributions made to a Section 125 plan that can be received in cash or used to purchase benefits under the Section 125 plan. Generally, elective employer contributions that are not subject to special eligibility requirements qualify as covered wages.

6.5(3) Mandatory minimum coverage requirements. The term “elective employer contributions” does not include employer contributions that must be used to purchase benefits under a Section 125 plan. For example, if an employer provides \$2,500 to its employees to purchase benefits in a Section 125 plan, but requires that all employees must use \$1,000 of that amount to purchase single health coverage, the cost of the single coverage is deducted. In this example, \$1,000 would be subtracted from the \$2,500 provided, resulting in \$1,500 of covered wages.

6.5(4) Uniformity determined coverage group by coverage group. Iowa Code section 97B.1A(26) “a”(1) “b” states that elective employer contributions shall be treated as covered wages only if made uniformly available and not limited to highly compensated employees. The application of the uniformity concept may be illustrated as follows: Employer Z has two major groupings of employees covered under its cafeteria plan: teaching staff and support staff. Every member of the teaching staff is provided \$3,000 to purchase benefits under the Section 125 plan. Every member of the teaching staff must take single coverage costing \$1,500. Every member of the support staff is provided \$2,500 and must also take the single coverage costing \$1,500. Each member of the teaching staff would have \$1,500 treated as covered wages, and each member of the support staff would have \$1,000 treated as covered wages. This would be considered uniform treatment.

Uniformity is not destroyed by the fact that the amount available to members of a coverage group varies because the actual cost of mandatory minimum coverage varies depending on actuarial factors that apply to each individual. For example, assume Employer Z above also requires each employee to have long-term disability coverage. In Employer Z’s case, the actual cost of disability coverage will vary

from individual to individual. In that case, Employer Z would also deduct the actual cost of the required disability coverage, individual by individual, when determining IPERS-covered wages.

Uniformity is not destroyed if an employer has two groups of employees who, as a result of collective bargaining, have differing entitlements to employer contributions. For example, Employer Y has a contract that provides \$3,500 to each employee to purchase benefits under the Section 125 plan. Every employee may take all the cash by waiving participation in the plan, or may use all or part of the employer contributions to the Section 125 plan. In the collective bargaining process, a new contract is adopted which states that the employer will still provide \$3,500 to each employee to purchase benefits under the Section 125 plan. However, under the new contract, persons who waived participation before April 15 may still waive participation in the plan and take all the cash, but persons who did not waive participation and those hired after April 15 must have single coverage costing \$1,700. Employer Y would be treated as having two groups of employees with different elective employer contribution amounts. The grandfathered group (employees who waived participation before April 15) would have covered wages of \$3,500, and the group consisting of those who did not waive participation before April 15 and new employees would have covered wages of \$1,800.

6.5(5) *Highly compensated employee test.* Iowa Code chapter 97B provides that, in addition to being uniformly available, employer contributions must not discriminate in favor of highly compensated employees (HCEs). For purposes of this subrule, an HCE is an employee who has reported wages and tips subject to Medicare tax in excess of the IRC Section 414(q) limit then in effect. IPERS shall apply the HCE limitation as follows. If elective employer contributions are made available to HCEs, the total elective employer contributions made available to the HCE group must not exceed 25 percent of the total elective employer contributions made available under the Section 125 plan to all employees, including the HCEs. If the elective employer contributions available to the HCE group exceed the 25 percent limit (or if it is determined that the Section 125 plan discriminates in favor of HCEs under other IRS rules), elective employer contributions for HCEs shall not exceed the highest amount available to a nonexecutive coverage group of employees covered under such plan. The general application of these principles is illustrated below, using the 2002 IRC Section 414(q) dollar limit of \$90,000.

Employer W has a Section 125 plan that provides elective employer contributions totaling \$7,000 to executive staff, \$4,500 to teaching staff, and \$3,500 to support staff. There are no other limits or exclusions that apply. These amounts are treated as covered wages for each member of each group, provided that the total amount of contributions made available to HCEs does not exceed 25 percent of the total elective employer contributions for all employees covered under the plan. If elective employer contributions for the executive staff totaled \$70,000, and total elective employer contributions for the remainder of the staff totaled \$500,000, the HCE percentage of total elective employer contributions would be 12 percent (\$70,000 divided by \$570,000), and all elective employer contributions would be treated as covered wages for all groups. However, if elective employer contributions for the executive staff totaled \$70,000, and elective employer contributions for the remainder of the staff totaled \$200,000, the HCE percentage would be 26 percent (\$70,000 divided by \$270,000), and HCEs' elective employer contributions would be limited to \$4,500 per HCE for covered wage purposes.

6.5(6) *Elective employer contributions limited to dual coverage employees.* In some cases, a Section 125 plan provides for what appear to be mandatory employer contributions for health plan coverage, but the terms of the Section 125 plan permit dual coverage employees to waive coverage and receive the employer contributions in cash, if the employee can prove coverage under another health care plan. IPERS shall continue to treat the full amount of employer contributions in such cases as not being IPERS-covered wages, even though individual employees with the described dual coverage may actually receive the employer contribution in cash.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 4337C, IAB 3/13/19, effective 4/17/19]

495—6.6(97B) Corrections of overpayments and underpayments of contributions and benefits caused by misreporting of covered wages. IPERS shall use the following guidelines in requiring corrections of overpayments and underpayments of contributions caused by misreported wages or

IPERS-covered service. Corrections must be made for all current employees omitted in error, active, retired, and inactive members, subject to the following limitations:

6.6(1) If employer and employee contributions were underreported, wage adjustments shall be filed and employers shall be billed for all shortages of employer and employee contributions plus interest. Employers shall be entitled to collect reimbursement for the employee share of contributions as provided in Iowa Code section 97B.9. If retirement benefits have been underpaid as a result of the error, IPERS shall, upon receipt of the contribution shortage, make the appropriate adjustments and pay all back benefits.

6.6(2) If employer and employee contributions were overreported, wage adjustments shall be filed and the appropriate contribution amounts shall be credited to employers for distribution to the respective employee and employer contributors. If the reporting error caused an overpayment of retirement benefits, IPERS may offset excess contributions received against overpayments and shall request a repayment of the remainder of the overpayment, if any, from the recipient.

Wage adjustments, overpayments and underpayments, and unintentional reporting errors shall be determined as of the onset of the error. Notwithstanding the foregoing adjustment and collection standards, IPERS reserves the right to negotiate adjustments with individual employers in special situations, and no negotiated settlement with an employer shall be deemed to constitute a waiver of this rule or a binding precedent for other employers.

[ARC 4337C, IAB 3/13/19, effective 4/17/19]

These rules are intended to implement Iowa Code sections 97B.1A(26), 97B.9, 97B.11, 97B.14 and 97B.14A.

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CHAPTER 11
APPLICATION FOR, MODIFICATION OF, AND TERMINATION OF BENEFITS

[Prior to 11/24/04, see 581—Ch 21]

495—11.1(97B) Application for benefits.

11.1(1) Form used. It is the responsibility of the member to notify IPERS of the intention to retire. This should be done 60 days before the expected retirement date. The application for monthly retirement benefits is obtainable from IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. The printed application form shall be completed by each member applying for benefits and shall be mailed, sent by fax or brought in person to IPERS. An application that is incomplete or incorrectly completed will be returned to the member. To be considered complete, an application must include the following:

- a. Proof of date of birth for the member.
- b. Option selected, and
 - (1) If Option 1 is selected, the death benefit amount.
 - (2) If Option 4 or 6 is selected, the contingent annuitant's name, social security number, proof of date of birth, and relationship to member. The member must designate the survivor benefit percentage, which shall be limited to one of the following:
 1. One hundred percent of the member's benefit amount.
 2. Seventy-five percent of the member's benefit amount.
 3. Fifty percent of the member's benefit amount.
 4. Twenty-five percent of the member's benefit amount.
 - (3) If Option 1, 2, or 5 is selected, a list of beneficiaries.
- c. If the member has been terminated less than one year, or is applying for disability benefits, the employer certification page must be completed by the employer unless the employer has provided the termination date and date of the last paycheck on the monthly wage reports.
- d. Signature of member and spouse.
- e. If the member has no spouse, "NONE" must be designated.
- f. If the member is applying for regular disability benefits, a copy of the award letter from the Social Security Administration or railroad retirement.
- g. An indication whether the member is a U.S. citizen, resident alien, or non-U.S. citizen.

A retirement application is deemed to be valid and binding on the date the first payment is paid. Members shall not cancel their applications, change their option choice, or change an IPERS option containing contingent annuitant benefits after that date.

11.1(2) Proof required in connection with application. Proof of date of birth to be submitted with an application for benefits shall be in the form of a birth certificate, a U.S. passport, an infant baptismal certificate, an identification card or driver's license issued by the state of Iowa, a state identification card that is issued in compliance with the REAL ID Act of 2005, or a driver's license that is issued in compliance with the REAL ID Act of 2005. If these records do not exist, the applicant shall submit two other documents or records which will verify the day, month and year of birth. A photographic identification record may be accepted even if now expired unless the passage of time has made it impossible to determine if the photographic identification record is that of the applicant. The following records or documents are among those deemed acceptable to IPERS as proof of date of birth:

- a. United States census record;
- b. Military record or identification card;
- c. Naturalization record;
- d. A marriage license showing age of applicant in years, months and days on date of issuance;
- e. A life insurance policy;
- f. Records in a school's administrative office;
- g. An official document from the U.S. Citizenship and Immigration Services, such as a "green card," containing such information;
- h. Driver's license or Iowa nondriver identification card;

- i.* Adoption papers; or
- j.* Any other document or record ten or more years old, or certification from the custodian of such records which verifies the day, month, and year of birth.

If the member, the member's representative, or the member's beneficiary is unable or unwilling to provide proof of birth, or in the case of death, proof of death, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, Iowa division of records and statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

IPERS is required to begin making payments to a member or beneficiary who has reached the required beginning date specified by Internal Revenue Code Section 401(a)(9). In order to begin making such payments and to protect IPERS' status as a plan qualified under Internal Revenue Code Section 401(a), IPERS may rely on its internal records with regard to date of birth, if the member or beneficiary is unable or unwilling to provide the proofs required by this subrule within 30 days after written notification of IPERS' intent to begin mandatory payments.

11.1(3) *Benefits estimates.* Prior to submitting an application for benefits, a member may request IPERS to prepare estimates of projected benefits under the various options as described under Iowa Code section 97B.51. A benefit estimate shall not bind IPERS to payment of the projected benefits under the various options specified in Iowa Code chapter 97B. A member cannot rely on the benefit estimate in making any retirement-related decision or taking any action with respect to the member's account, nor shall IPERS assume any liability for such actions. An estimate will not include deductions for a QDRO or any other legal assignments or orders on a member's account, unless specifically requested by the member. A member's actual benefit can only be known and officially calculated when an eligible member applies for benefits.

11.1(4) *Revocation of application.* If IPERS determines an application for benefits is invalid for any reason, IPERS shall revoke, in whole or in pertinent part, the application for benefits and the recipient shall repay all payments made under the revoked application or all payments made pursuant to the revoked part of the application. The terms of repayment shall be subject to the provisions of 495—11.7(97B).

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—11.2(97B) Retirement benefits and the age reduction factor.

11.2(1) *Normal retirement.*

a. A member shall be eligible for monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 65, if otherwise eligible.

b. Effective July 1, 1998, a member shall be eligible for full monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 62, if the member has 20 full years of service and is otherwise eligible.

c. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55 and is otherwise eligible.

11.2(2) *Early retirement.* A member shall be eligible to receive benefits for early retirement effective with the first of the month in which the member attains the age of 55 or the first of any month after attaining the age of 55 before the member's normal retirement date, provided the date is after the last day of service and the member is otherwise eligible.

11.2(3) *Aged 70 and older retirees.* A member shall be eligible to receive monthly retirement benefits with no age reduction effective with the first day of the month in which the member attains the age of 70, even if the member continues to be employed.

11.2(4) *Required beginning date.*

a. Notwithstanding the foregoing, IPERS shall commence payment of a member's retirement benefit under Iowa Code sections 97B.49A to 97B.49I (under Option 2) no later than the "required

beginning date” specified under Internal Revenue Code Section 401(a)(9), even if the member has not submitted the application for benefits. If the lump sum actuarial equivalent could have been elected by the member, payments shall be made in such a lump sum rather than as a monthly allowance. The “required beginning date” is defined as the later of: (1) April 1 of the year following the year that the member attains the age of 72 (or the age of 70 ½ for that member who attains the age of 70 ½ on or before December 31, 2019), or (2) April 1 of the year following the year that the member actually terminates all employment with employers covered under Iowa Code chapter 97B.

b. If IPERS distributes a member’s benefits without the member’s consent in order to begin benefits on or before the required beginning date, the member may elect to receive benefits under an option other than the default option described above, or as a refund, if the member contacts IPERS in writing within 60 days of the first mandatory distribution. IPERS shall inform the member which adjustments or repayments are required in order to make the change.

c. If a member cannot be located to commence payment on or before the required beginning date described above, the member’s benefit shall be forfeited. However, if a member later contacts IPERS and wishes to file an application for retirement benefits, the member’s benefits shall be reinstated.

d. For purposes of determining benefits, the life expectancy of a member, a member’s spouse, or a member’s beneficiary shall not be recalculated after benefits commence.

e. If an IPERS member has a qualified domestic relations order (QDRO) on file when a mandatory distribution is required, and the QDRO requires the member to choose a specific retirement option, IPERS shall pay benefits under the option required by the order.

11.2(5) *Mandatory distribution of small inactive accounts.* As soon as practicable after July 1, 2004, IPERS shall distribute small inactive accounts to members and beneficiaries as authorized in Iowa Code section 97B.48(5).

11.2(6) *Federal tax code limitation for selection of survivor percentages for same gender spouses.* Rescinded IAB 2/19/14, effective 3/26/14.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—11.3(97B) First month of entitlement (FME).

11.3(1) *General.* A member shall submit a written application to IPERS setting forth the retirement date, provided the member has attained at least age 55 by the retirement date and the retirement date is after the member’s last day of service. A member’s first month of entitlement shall be no earlier than the first day of the first month after the member’s date of termination from employment or, if later, the month provided for under subrule 11.3(2). No payment shall be made for any month prior to the month the completed application for benefits is received by IPERS.

If a member files a retirement application but fails to select a valid first month of entitlement, IPERS will select by default the earliest month possible. A member may appeal this default selection by sending written notice of the appeal postmarked on or before 30 days after a notice of the default selection was mailed to the member. Notice of the default selection is deemed sufficient if sent to the member at the member’s address.

11.3(2) *Additional FME provisions.* Effective January 1, 2001, employees of a school corporation who are permitted by the terms of their employment contracts to receive their annual salaries in monthly installments over periods ranging from 9 to 12 months may retire at the end of a school year and receive trailing wages through the end of the contract year if they have completely fulfilled their contract obligations at the time of retirement. For purposes of this paragraph, “school corporation” means body politic described in Iowa Code sections 260C.16 (community colleges), 273.2 (area education agencies) and 273.1 (K-12 public schools). For purposes of this paragraph, “trailing wages” means previously earned wage payments made to such employees of a school corporation after the first month of entitlement. This exception does not apply to hourly employees, including those who make arrangements with their employers to hold back hourly wages for payment at a later date, to employees who are placed on sick or disability leave or leave of absence, or to employees who receive lump sum leave, vacation leave, early retirement incentive pay or any other lump sum payments in installments.

For all employees of all IPERS-covered employers who terminate employment in January 2003, or later, if the final paycheck is paid within the same quarter or within one quarter after termination and wages are reported under the normal pay schedule, the first month of entitlement shall be the month following termination. However, if the last paycheck is paid more than one quarter after the termination, the first month of entitlement shall be the first month after the employee is paid the last paycheck. Under no circumstances shall such trailing wages result in more than one quarter of service credit being added to retiring members' earning records.

11.3(3) *Survival into designated FME.* To be eligible for a monthly retirement benefit, the member must survive into the designated first month of entitlement. If the member dies prior to the first month of entitlement, the member's application for monthly benefits is canceled and the distribution of the member's account is made pursuant to Iowa Code section 97B.52. Cancellation of the application shall not invalidate a beneficiary designation. If the application is dated later in time than any other designations, IPERS will accept the designation in a canceled application as binding until a subsequent designation is filed.

11.3(4) *Members retiring under the rule of 88.* The first month of entitlement of a member qualifying under the rule of 88 shall be the first of the month when the member's age as of the last birthday and years of service equal 88. The fact that a member's birthday allowing a member to qualify for the rule of 88 is the same month as the first month of entitlement does not affect the retirement date.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—11.4(97B) Termination of monthly retirement allowance. A member's retirement benefit shall terminate after payment is made to the member for the entire month during which the member's death occurs. Death benefits shall begin with the month following the month in which the member's death occurs.

Upon the death of the retired member, IPERS will reconcile the decedent's account to determine if an overpayment was made to the retired member and if further payment(s) is due to the retired member's named beneficiary, contingent annuitant, heirs at law or estate. If an overpayment has been made to the retired member, IPERS will determine if steps should be taken to seek collection of the overpayment from the named beneficiary, contingent annuitant, estate, heirs at law, or other interested parties.

495—11.5(97B) Bona fide retirement and bona fide refund.

11.5(1) *Bona fide retirement—general.* To receive retirement benefits, a member under the age of 70 must officially leave employment with all IPERS-covered employers, give up all rights as an employee, and complete a period of bona fide retirement. A period of bona fide retirement means four or more consecutive calendar months for which the member qualifies for monthly retirement benefit payments. The qualification period begins with the member's first month of entitlement for retirement benefits as approved by IPERS. A member may not return to covered employment before filing a completed application for benefits. Notwithstanding the foregoing, the continuation of group insurance coverage at employee rates for the remainder of the school year for a school employee who retires following completion of services by that individual shall not cause that person to be in violation of IPERS' bona fide retirement requirements.

A member will not be considered to have a bona fide retirement if the member is a school or university employee and returns to work with the employer after the normal summer vacation. In other positions, temporary or seasonal interruption of service which does not terminate the period of employment does not constitute a bona fide retirement. A member also will not be considered to have a bona fide retirement if the member has, prior to or during the member's first month of entitlement, entered into verbal or written arrangements with the member's former employer(s) to return to employment after the expiration of the four-month bona fide retirement period.

Effective July 1, 1990, a school employee will not be considered terminated if, while performing the normal duties, the employee performs for the same employer additional duties which take the employee beyond the expected termination date for the normal duties. Only when all the employee's compensated duties cease for that employer will that employee be considered terminated.

The bona fide retirement period shall be waived for an elected official covered under Iowa Code section 97B.1A(8)“a”(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8)“a”(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS-covered employment prior to the issuance of the retirement benefit. Such an elected official or legislator may remain in the elective office and receive an IPERS retirement without violating IPERS’ bona fide retirement rules. If such elected official or legislator terminates coverage for the elective office and also terminates all other IPERS-covered employment but is then reemployed in covered employment, and has not received a retirement as of the date of hire, the retirement shall not be made. Furthermore, if such elected official or legislator is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the elected official or legislator shall not be eligible for new IPERS coverage for such elected position. The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official or legislator is reelected to the same position without an intervening term out of office.

The bona fide retirement period will be waived if the member has been elected to public office as a part-time elected official or a member of the general assembly and the member’s term begins during the normal four-month bona fide retirement period. This includes elected officials who shall be covered under this chapter as defined in Iowa Code section 97B.1A. This waiver does not apply if the member was an elected official who was reelected to the same position for another term.

Effective July 1, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered under this chapter, is terminated for at least one month, and the member does not return to covered employment for an additional three months. In order to receive retirement benefits, the member must file a completed application for benefits before returning to any employment with a covered employer.

Effective July 1, 2023, a member will not have a bona fide retirement if the member enters into a verbal or written arrangement to perform duties for the member’s former employer(s) as an independent contractor prior to or during the member’s first month of entitlement, and the member shall not perform any duties for the member’s former employer(s) as an independent contractor prior to receiving one month of retirement benefits.

11.5(2) *Bona fide refund.* For a member to be eligible for a lump sum refund, the member must terminate the member’s covered employment and incur a bona fide separation from service and remain out of employment for at least 30 days with all covered employers. The 30-day bona fide refund period shall be waived for an elected official covered under Iowa Code section 97B.1A(8)“a”(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8)“a”(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS-covered employment prior to the issuance of the refund. Such an official may remain in the elective office and receive an IPERS refund without violating IPERS’ bona fide refund rules. If such elected official terminates coverage for the elective office and also terminates all other IPERS-covered employment but is then reemployed in covered employment, and has not received a refund as of the date of hire, the refund shall not be made. Furthermore, if such elected official is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the public official shall not be eligible for new IPERS coverage for such elected position.

The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official is reelected to the same position without an intervening term out of office. The waiver granted in this subrule shall be applicable to such elected officials who were in violation of the prior bona fide refund rules on and after November 1, 2002, when such individuals have not repaid the previously invalid refund.

If a member takes a refund in violation of the bona fide refund requirements of Iowa Code section 97B.53(4), the member may return the refund during the bona fide retirement period and restore the member’s account. If the repayment is not made, the member shall receive no credit for the period

covered by the refund. At retirement, the member may purchase, at actuarial cost, the service credit covered by the refund.

11.5(3) *Part-time appointed members of boards or commissions receiving minimal noncovered wages.* Solely for purposes of determining whether a member has severed all employment with all covered employers and has remained out of employment as required under Iowa Code section 97B.52A, persons who have been appointed as part-time members of boards or commissions prior to or during their first month of entitlement and who receive only per diem and reimbursements for reasonable business expenses for such positions will be deemed not to be in employment prohibited under Iowa Code section 97B.52A.

For purposes of this subrule, per diem shall not exceed the amount authorized under Iowa Code section 7E.6(1) “a” for members of boards, committees, commissions, and councils within the executive branch of state government. This limit shall apply regardless of whether or not the position in question is within the executive branch of state government.

Members of boards and commissions not exempted under this subrule include: (a) those who are entitled to the payment of per diem regardless of attendance at board or commission meetings, and (b) those who would have received per diem in excess of the amount authorized under Iowa Code section 7E.6(1) “a” were it not for an agreement by the member to waive such compensation.

Persons appointed as part-time board or commission members who receive only per diem as set forth above and reimbursements of reasonable business expenses may continue in or accept appointments to such positions without violating the bona fide retirement rules under Iowa Code section 97B.52A.

11.5(4) *Members of the national guard who are called into state active duty.* Effective May 25, 2008, members of the national guard who are called into state active duty as defined in Iowa Code section 29A.1 in noncovered positions during the required period of complete severance will not be in violation of the bona fide retirement requirements of Iowa Code section 97B.52A.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 4100C, IAB 10/24/18, effective 11/28/18; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 6949C, IAB 3/8/23, effective 4/12/23]

495—11.6(97B) Payment processing and administration.

11.6(1) *Monthly paper warrants processing fee.* Effective July 1, 2005, IPERS shall charge a per-warrant processing fee to members who choose to receive paper warrants in lieu of electronic deposits of their monthly retirement allowance. The fee may be waived if the person establishes that it would be an undue hardship for the person to do what is necessary to receive payment of the person’s IPERS monthly retirement allowance by electronic deposit. The processing fee will be deducted from the member’s retirement allowance on a posttax basis.

For purposes of this subrule, a member claiming undue hardship must establish that the cost normally assessed for the processing of paper warrants would be unduly burdensome because of the member’s limited income, or is otherwise financially burdensome or physically impracticable.

11.6(2) *Repeated requests for replacement warrants.* Effective July 1, 2002, for a member or beneficiary who, due to the member’s or beneficiary’s own actions or inactions, has benefits warrants replaced twice in a six-month period, except when the need for a replacement warrant is caused by IPERS’ failure to mail to the address specified by the recipient, payment shall be suspended until such time as the recipient establishes a direct deposit account in a bank, credit union or similar financial institution and provides IPERS with the information necessary to make electronic transfer of said monthly payments. Persons subject to said cases may be required to provide a face-to-face interview and additional documentation to prove that such a suspension would result in an undue hardship.

11.6(3) *Forgery claims.* When a forgery of a warrant issued in payment of an IPERS refund or benefit is alleged, the claimant must complete and sign an affidavit before a notary public that the endorsement is a forgery. A supplementary statement must be attached to the affidavit setting forth the details and circumstances of the alleged forgery.

11.6(4) *Rollover fees.* Effective January 1, 2007, if the recipient of a lump-sum distribution which qualifies to be rolled over requests that a rollover be made to more than one IRA or other qualified plan,

IPERS may assess a \$5 administrative fee for each additional rollover beyond the first one. The fee will be deducted from the gross amount of each distribution, less federal and state income tax.

11.6(5) Offsets against amounts payable. IPERS may, with or without consent and upon reasonable proof thereof, offset amounts currently payable to a member or the member's designated beneficiaries, heirs, assigns or other successors in interest by the amount of IPERS benefits paid in error to or on behalf of such member or the member's designated beneficiaries, heirs, assigns or other successors in interest.

11.6(6) Lump sum paper warrants processing fee. Effective April 1, 2012, and thereafter, IPERS shall charge \$1 for paper warrants issued in payment of all nonrecurring lump sum distributions. If a nonrecurring lump sum distribution is followed by a supplemental lump sum distribution due to the reporting of additional covered wages, the \$1 processing fee shall also be charged. This \$1 processing fee shall not apply to a direct rollover described under Iowa Code section 97B.53B (however, processing fees may be charged for multiple rollover requests), lump sum mandatory account distributions required under Iowa Code section 97B.48(5), mandatory lump sum distributions required under Internal Revenue Code Section 401(9), or warrants reissued in forged endorsement or other fraudulent payment situations. [ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—11.7(97B) Overpayment of IPERS benefits.

11.7(1) Overpayments—general.

a. An “overpayment” means a payment of money by IPERS that results in a recipient receiving a higher payment than the recipient is entitled to under the provisions of Iowa Code chapter 97B.

b. A “recipient” is a person or beneficiary, heir, assign, or other successor in interest who receives an overpayment from an IPERS benefit and is liable to repay the amount(s) upon receipt of a written explanation and request for the amounts to be repaid.

c. If IPERS determines that the cost of recovering the amount of an overpayment is estimated to exceed the overpayment, the repayment may be deemed to be unrecoverable.

d. If the overpayment is equal to or less than \$50 and cannot be recovered from other IPERS payments, IPERS may limit its recovery efforts to written requests for repayment and other nonjudicial remedies.

11.7(2) Overpayment made to a retired member. A retired member shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and a limited opportunity to repay the overpayment in full without interest. If a retired member repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. A retired member may repay an overpayment out of pocket or direct IPERS to recover the overpayment from future retirement benefit payments, or a combination of both. If the retired member cannot repay an overpayment in full, either out of pocket or from the next monthly installment of retirement benefits, or both, interest shall be charged. A retired member who cannot repay the full amount of the overpayment within 30 days after the date of the notice must enter into an agreement with IPERS to make monthly installment payments, or to have the overpayment offset against future monthly benefit payments or death benefits, if any, and authorize any unpaid balance as a first priority claim in the recipient's estate.

11.7(3) Overpayment made to a person other than a retired member. A recipient other than a retired member, except a recipient listed in subrule 11.5(2), shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. If such a recipient repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. If such a recipient cannot repay an overpayment in full within 30 days after the date of the notice, interest shall be charged. If repayment in full cannot be made within 30 days, such a recipient shall make repayment arrangements subject to IPERS' approval within 30 days of the written notice and request for repayment.

If the overpayment recipient cannot be located to receive notice of the overpayment at the recipient's last-known address, IPERS shall, after trying to locate the person, consider the recipient to have waived entitlement to the quarters covered by the refund.

11.7(4) Interest charges.

a. Overpayment not fraudulent. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.5(2), was not the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 5 percent, or the rate IPERS determines, on the outstanding balance, beginning 30 days after the date of notice of the overpayment(s) is provided by IPERS.

b. Overpayments in violation of Iowa Code section 97B.40 or 715A.8. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.5(2), was the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 7 percent on the outstanding balance, beginning on the date of the overpayment(s).

c. Overpayments that result in a judgment. In addition to other remedies, IPERS may file a civil action to recover overpayments, and the interest rate may be set by the court.

11.7(5) Recovery of overpayment from a deceased recipient. If a recipient dies prior to the full repayment of an erroneous overpayment of benefits, IPERS shall be entitled to apply to the estate of the deceased to recover the remaining balance.

11.7(6) Offsets against amounts payable. IPERS may, in addition to other remedies and after notice to the recipient, request an offset against amounts owing to the recipient by the state according to the offset procedures pursuant to Iowa Code sections 8A.504 and 421.17, or section 421.65 as enacted by 2020 Iowa Acts, House File 2565, section 16, as applicable.

11.7(7) Rights of appeal. A recipient who is notified of an overpayment and required to make repayments under this rule may appeal IPERS' determination in writing to the CEO or CEO's designee. The written request must explain the basis of the appeal and must be received by IPERS' office within 30 days of overpayment notice pursuant to 495—Chapter 26.

11.7(8) Release of overpayment. IPERS may release a recipient from liability to repay an overpayment, in whole or in part, if IPERS determines that the receipt of overpayment is not the fault of the recipient, and that it would be contrary to equity and good conscience to collect the overpayment. No release of an individual recipient's obligation to repay an overpayment shall stand as precedent for release of another recipient's obligation to repay an overpayment.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 6949C, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9A, 97B.15, 97B.25, 97B.38, 97B.40, 97B.45, 97B.47, 97B.48, 97B.48A, 97B.49A to 97B.49I, 97B.50, 97B.51, 97B.52, 97B.52A, 97B.53, and 97B.53B.

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[Filed ARC 6949C (Notice ARC 6823C, IAB 1/11/23), IAB 3/8/23, effective 4/12/23]

CHAPTER 12
CALCULATION OF MONTHLY RETIREMENT BENEFITS

[Prior to 11/24/04, see 581—Ch 21]

495—12.1(97B) General.

12.1(1) *Formula benefit versus money purchase benefit.* If a member is vested by years of service credit in IPERS, a monthly payment allowance will be paid in accordance with the formulas set forth in Iowa Code sections 97B.49A through 97B.49I, the applicable paragraphs of this chapter, and the option the member elects pursuant to Iowa Code section 97B.51(1). IPERS shall determine on the applicable forms which designated fractions of a member's monthly retirement allowance payable to contingent annuitants shall be provided as options under Iowa Code section 97B.51(1). Any option elected by a member under Iowa Code section 97B.51(1) must comply with the requirements of the Internal Revenue Code that apply to governmental pension plans, including but not limited to Internal Revenue Code Section 401(a)(9). If a member is not vested by years of service credit in IPERS, the benefit receivable will be computed on a money purchase basis, with reference to annuity tables used by IPERS in accordance with the member's age and option choice.

12.1(2) *Reduction for early retirement for regular class members.*

a. Effective July 1, 1988, through December 31, 2000, a member's benefit formula will be reduced by .25 percent for each month the member's retirement precedes the normal retirement date, as defined in Iowa Code section 97B.45 excluding section 97B.45(4). The following are situations in which a member is considered to be taking early retirement:

(1) If a member has not attained the age of 65 in the member's first month of entitlement and has less than 20 years of service; or

(2) If a member has not attained the age of 62 in the month of the member's retirement and has 20 years of service.

b. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55.

c. Effective July 1, 1991, a member qualifying for early retirement due to disability under Iowa Code section 97B.50 shall not be subject to a reduction in benefits due to age.

d. If a member retires with at least 20 years of service but has not attained the age of 62, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 62. If a member retires with less than 20 years of service, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 65.

e. Effective January 1, 2001, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the earliest possible normal retirement date for that member based on the age and years of service at the member's actual retirement.

f. For the portion of the member's retirement allowance based on service through June 30, 2012, the early retirement reduction shall be calculated as provided in paragraphs 12.1(2)"a" through "e." For the portion of the retirement allowance based on years of service beginning July 1, 2012, and later, the member's early retirement reduction shall be one-half of one percent for each month that the early retirement precedes the date the member attains age 65.

12.1(3) *Early retirement date for regular class members.* A member's early retirement date shall be the first day of the month of the fifty-fifth birthday or any following month before the normal retirement date, provided that date is after the member's termination date.

12.1(4) *Benefit formulas for members retiring on or after July 1, 2012.*

a. For each member retiring on or after July 1, 2012, who is vested by service, the monthly benefit will be equal to one-twelfth of an amount equal to 60 percent of the final average covered wage multiplied by a fraction of years of service.

b. For all active and inactive vested members, the monthly retirement allowance shall be determined on the basis of the formula in effect on the date of the member's retirement. If the member takes early retirement, the benefit shall be adjusted as provided in subrule 12.1(2).

c. In addition to the 60 percent multiplier identified above, regular class members who retire with years of service in excess of 30 years shall have the percentage multiplier increased by .25 percent for each quarter of a year in excess of 30, not to exceed an increase of 5 percent.

d. In addition to the 60 percent multiplier identified above, protection occupation members, sheriffs, and deputy sheriffs who retire with years of service in excess of 22 years shall have the percentage multiplier increased by .375 percent for each quarter of a year in excess of 22, not to exceed an increase of 12 percent.

e. Regular service does not count as "eligible service" in determining a special service member's applicable percentage.

12.1(5) *Average covered wages for special service members and for wages of regular class members prior to July 2012.*

a. "Three-year average covered wage" means a member's covered calendar year wages averaged for the highest three years of the member's service. However, for the member's final year of wages, IPERS may determine the wages for the third year by computing the final quarter or quarters of wages to complete the year. The computed year will be created when the final quarter or quarters reported are combined with a computed average quarter to complete the last year. The value of this average quarter will be computed by selecting the highest covered wage year not used in the computation of the three high years and dividing the covered salary by four quarters. This value will be combined with the final quarter or quarters to complete a full calendar year. If the member's final quarter of wages will reduce the three-year average covered wage, it can be dropped from the computation. However, if the covered wages for that quarter are dropped, the service credit for that quarter will be forfeited as well. If the final quarter is the first quarter of a calendar year, those wages must be used in order to give the member a computed year. The computed year wages shall not exceed the Internal Revenue Service maximum covered wage in effect for that calendar year. Furthermore, the computed year shall not exceed the member's highest actual calendar year of covered wages by more than 3 percent. Effective July 1, 2007, a member's high three-year average wage shall be the greater of (1) the member's high three-year average covered wage based on covered wages reported through June 30, 2007; or (2) the member's high three-year average covered wage after application of the antispiking control as described in paragraph 12.1(5) "b" below.

b. Antispiking limit on the growth of a member's high three-year average.

(1) Selection of the control year shall give highest priority to calendar years of wages in which there are four quarters of service credit for wages on file not used in the high three-year average wage calculation. For example, if the member receives \$20,000 of wages for a calendar year with four quarters of service credit for wages, and the member also has received \$30,000 of wages for a calendar year with three quarters of service credit for wages, the control year selection process shall give preference to the calendar year with \$20,000 of reported wages.

(2) If there is a calendar year of covered wages outside the high three-year average wage calculation that has four quarters, but the covered wages for that year are less than the covered wages for the fourth highest calendar year of covered wages, and that fourth highest calendar year of covered wages does not have four quarters of service credit for wages, the control year will be the lowest of the high three calendar years of wages with service credits for wages in all four quarters being used in the high three-year average wage calculation.

(3) "Service credit for wages" means service credit recorded for:

1. Quarters in which the member receives covered wages from covered employment.
2. Quarters in which the member is credited with covered wages due to a military leave.
3. Quarters in which the member would have had covered wages but for the application of the IRS covered wage limitations.
4. Quarters in which an employee of a nine-month institution receives service credit for a qualifying leave of absence under 495—subrule 7.1(2).

5. Quarters in which a legislator, legislative employee, or elected official receives service credit for employment.

(4) If none of the calendar years of wages that fall outside of the high three-year average wage calculation have service credit for wages reported in all four quarters, the control year will then be the lowest of the high three calendar years of wages with service credit for wages in all four quarters being used in the high three-year average wage calculation.

(5) If none of the wage years used in the high three-year average wage calculation have service credits for wages reported in all four quarters, the control year will then revert to the highest calendar year of wages not included in the high three-year average wage calculation, regardless of whether there are fewer than four quarters with service credits for wages on file.

(6) For high three-year average wage calculations that utilize the computed year, the control year may be the calendar year from which the “average quarters” used in the computed year are drawn. However, the control year cannot be the computed year, as the computed year will never be a calendar year with service credit for wages in all four quarters.

c. Effective July 1, 2012, a nonvested regular class member’s average covered wage shall be the member’s five-year average covered wage calculated as provided in Iowa Code section 97B.1A(10A) “a.”

d. Effective July 1, 2012, for regular class members vested as of June 30, 2012, the member’s average covered wage shall be the greater of the member’s three-year average covered wage calculated as provided under paragraphs 12.1(5) “a” and “b,” or the member’s five-year average covered wage calculated as provided in Iowa Code section 97B.1A(10A) “a.” The “five-year average covered wage” means a member’s covered calendar year wages averaged for the highest five years of the member’s service. However, in the member’s final year of wages, IPERS may determine the wages for the fifth year by computing the final quarter or quarters of wages to complete the year. The computed year wages shall not exceed the Internal Revenue Service maximum covered wage in effect for that calendar year. Furthermore, the computed year shall not exceed the member’s highest actual calendar year of covered wages by more than 3 percent. A full fifth year will be created when the final quarter or quarters reported are combined with a computed average quarter to complete the last year. The value of this average quarter will be computed by selecting the highest covered wage year not used in the computation of the five high years and dividing the covered salary by four quarters. This value will be combined with the final quarter or quarters of wages to complete a full calendar year. If the member’s final quarter of wages will reduce the five-year average covered wage, it can be dropped from the computation. However, if the covered wages for that quarter are dropped, the service credit for that quarter will be forfeited as well. If the final quarter is the first quarter of a calendar year, those wages must be used in order to give the member a computed year. The five-year average covered wage cannot exceed the highest Internal Revenue Service maximum covered wages in effect during the member’s service. In addition, the average five-year salary is restricted to an antispiking limit of 134 percent of the highest sixth year of wages.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.2(97B) Initial benefit determination.

12.2(1) The initial monthly benefit for the retired member will be calculated utilizing the wages that have been reported as of the member’s retirement and subject to the requirements of subrule 12.1(5). When the final quarter(s) of wages is reported for the retired member, a recalculation of benefits will be performed by IPERS to redetermine the member’s benefit amount. In cases where the recalculation determines that the benefit will be changed, the adjustment in benefits will be made retroactive to the first month of entitlement. The wages for the “computed year” shall not exceed the highest covered wage ceiling in effect during the member’s period of employment.

12.2(2) In cases where the member’s final quarter’s wages have been reported to IPERS prior to retirement, the original benefit will be calculated utilizing all available wages.

12.2(3) The Option 1 death benefit amount cannot exceed the member’s investment and cannot lower the member’s benefit below the minimum distribution required by federal law.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.3(97B) Hybrid formula for members with more than one type of service credit.

12.3(1) Eligibility. Effective July 1, 1996, members having both regular and special service (as defined in Iowa Code section 97B.1A(22)) shall receive the greater of the benefit amount calculated under this subrule or the benefit amount calculated under the applicable nonhybrid benefit formula.

a. Members who are vested by service as defined in Iowa Code section 97B.1A(25) “*d*” may utilize the hybrid formula.

b. The following classes of members are not eligible for the hybrid formula:

- (1) Members who have only regular service credit.
- (2) Members who have 22 years of special service credit.
- (3) Members who have 30 years of regular service.
- (4) Members who are not vested by service as defined in Iowa Code section 97B.1A(25) “*d*.”

12.3(2) Assumptions. IPERS shall utilize the following assumptions in calculating benefits under this rule.

a. The member’s average covered wage shall be determined in the same manner as it is determined for the nonhybrid formula.

b. Increases in the benefit formula under this rule shall be determined as provided under Iowa Code section 97B.49D. The percentage multiplier shall only be increased for total years of service over 30.

c. Years of service shall be utilized as follows:

(1) Quarters which have two or more occupation class codes shall be credited as the class that has the highest reported wage for said quarter. A member shall not receive more than one quarter of credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

(2) Quarters shall not be treated as special service quarters unless the applicable employer and employee contributions have been made.

12.3(3) Years of service fraction not to exceed one.

a. In no event shall a member’s years of service fraction under the hybrid formula exceed, in the aggregate, one.

b. If the years of service fraction does, in the aggregate, exceed one, the member’s quarters of service credit shall be reduced until the member’s years of service fraction equals, in the aggregate, one.

c. Service credit shall first be subtracted from the member’s regular service credit and, if necessary, shall next be subtracted from the member’s special service credit.

12.3(4) Age reduction. The portion of the member’s benefit calculated under this rule that is based on the member’s regular service shall be subject to a reduction for early retirement. In calculating the age reduction to be applied to the portion of the member’s benefit based on the member’s regular service, the system shall use all quarters of service credit, including both regular and special service quarters.

12.3(5) Calculations. A member’s benefit under the hybrid formula shall be the sum of the following:

a. The applicable percentage multiplier divided by 22 times the years of special service credit times the member’s high three-year average covered wage, plus

b. The applicable percentage multiplier divided by 30 times the years of regular service credit (if any) times the member’s high three-year average prior to July 1, 2012, or the member’s high five-year average after June 30, 2012, covered wage minus the applicable wage reduction (if any).

c. If the sum of the percentages obtained exceeds the applicable percentage multiplier for that member, the percentage obtained above for each class of service shall be subject to reduction so that the total shall not exceed the member’s applicable percentage multiplier in the order specified in paragraph 12.3(3) “*c*.”

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.4(97B) Money purchase benefits.

12.4(1) For each member not vested by service as defined in Iowa Code section 97B.1A(25) “*d*,” a monthly annuity shall be determined by applying the total member and employer’s accumulated

contributions as of the effective retirement date to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable).

12.4(2) For each vested member for whom the present value of future benefits under Option 2 is less than the member reserve as of the effective retirement date, a monthly annuity shall be determined by applying the member reserve to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable).

12.4(3) For calculations under subrule 12.4(1), Options 2, 3, 4, 5 and 6 shall be calculated by dividing the member's total reserve by the applicable Option 2, 3, 4, 5 or 6 annuity factor taken from the system's tables to determine the monthly amount. For calculations under subrule 12.4(2), Options 2, 3, 4, 5 and 6 shall be calculated by dividing the member reserve by the applicable Option 2, 3, 4, 5 or 6 annuity factor taken from the system's tables to determine the monthly amount.

12.4(4) For Option 1, the cost per \$1,000 of death benefit shall be determined according to the system's tables. That cost shall be subtracted from the Option 3 monthly amount to determine the Option 1 monthly benefit amount. The Option 1 death benefit amount shall be reduced as necessary so that the Option 1 monthly benefit amount is not less than one-half of the Option 2 monthly benefit amount.

12.4(5) For members retiring after June 30, 2012, the money purchase benefit calculated pursuant to this rule shall be provided to members who are not vested by service as defined in Iowa Code section 97B.1A(25) "d."

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.5(97B) Recalculation for a member aged 70. A member remaining in covered employment after attaining the age of 70 years may receive a retirement allowance without terminating the covered employment. A member who is in covered employment, attains the age of 70 and begins receiving a retirement allowance must terminate all covered employment before the member's retirement allowance can be recalculated to take into account service after the member's original FME. The termination of employment must be a true severance lasting at least 30 days. The formula to be used in recalculating such a member's retirement allowance depends on the date of the member's FME and the member's termination date, as follows:

If the member is receiving a retirement allowance with an FME prior to July 1, 2000, and terminates covered employment on or after January 1, 2000, the member's retirement formula for recalculation purposes shall be the formula in effect at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation.

In all other cases, the recalculation for a member aged 70 who retires while actively employed shall use the retirement formula in effect at the time of the member's FME.

Payments under this rule shall begin no earlier than the month following the month of termination, upon IPERS' receipt of a member's application for recalculation. It is the member's responsibility to apply for the recalculation by completing and submitting the form specified by IPERS.

A member receiving a recalculation under this rule after June 30, 2012, will have the member's average covered wage calculated as follows. IPERS will calculate the average high three covered wage as of June 30, 2012. IPERS will next calculate the average high five covered wage at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation. IPERS will determine the benefit amount based on the calculation that produces the greatest benefit to the member.

[ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.6(97B) Level payment choice for special service members. A level payment choice is created effective July 1, 2002. IPERS shall implement the level payment choice by preparing factors to convert nonhybrid IPERS Options 1, 2, 3, 4, and 5 to the level payment choice. The new benefit feature applies solely to special service members, and any reference to members in this rule shall only apply to special service members.

12.6(1) Member's social security retirement amount. Calculations of a member's level payment choice shall be based on the member's social security retirement amount at age 62 as verified by

Social Security Administration statements provided by the member. No adjustments shall be made if subsequent social security statements indicate an increase in the age 62 social security retirement amount. Verification of the social security benefits shall not precede the member's first month of entitlement by more than 12 months.

12.6(2) *Death benefit assumptions.* In preparing level payment choice factors, IPERS shall assume:

a. For IPERS Options 1 and 2, death benefits under those options shall not be reduced as a result of a member's attaining the age of 62 and having the member's monthly allowance reduced under this rule.

b. For IPERS Options 4 and 5, IPERS shall assume that the contingent annuitant's or beneficiary's monthly payments and death benefits, if any, prior to the date the member attains, or would have attained, age 62 shall be based on the amount that was payable to the member for periods before the member attains, or would have attained, age 62. Beginning with the month after the month that the member attains, or would have attained, age 62, a contingent annuitant's or beneficiary's monthly payments and death benefits, except death benefits under IPERS Options 1 and 2, shall be based on the reduced amount that would have been payable to the member in the month after the month that the member attained age 62.

12.6(3) *Favorable experience dividends.* An eligible member's or beneficiary's favorable experience dividend, if any, shall be based on the member's or beneficiary's level payment choice monthly amount as of the preceding December 31.

12.6(4) *Prohibitions.* The following special service members shall be prohibited from receiving benefits under this rule:

a. Those who retire under Iowa Code section 97B.49D, 97B.50(2), or 97B.50A.

b. Those who retire under Option 6.

c. Those who request a level payment amount that reflects less than a full offset for the social security retirement amount at age 62.

d. Those reemployed in covered employment and subsequently retiring, for the period of reemployment. A member who has elected the level payment choice shall have retirement benefits calculated solely for the period of reemployment, except for vesting credit.

12.6(5) *Limit on reductions.* The level payment choice factors shall not reduce the monthly amount payable to a member at age 62 to less than 50 percent of the monthly amount that would have been payable under IPERS Option 2. Accordingly, payments before age 62 to such members shall be reduced in the same manner, with the corresponding adjustments made to death benefits.

12.6(6) *Commencement of level payment option reduction.* The monthly benefit of a member who selects the level payment option shall be reduced beginning with the month after the member reaches age 62.

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.7(97B) Reemployment of retired members.

12.7(1) Effective July 1, 1998, the monthly benefit payments for a member under the age of 65 who has a bona fide retirement and is then reemployed in covered employment shall be reduced by 50 cents for each dollar the member earns in excess of the annual limit. Effective March 23, 2022, this reduction is not required until the member earns the amount of remuneration permitted for a calendar year as defined in Iowa Code section 97B.48A. The foregoing reduction shall apply only to IPERS benefits payable for the applicable year that the member has reemployment earnings and after the earnings limit has been reached. Said reductions shall be applied as provided in subrule 12.7(2).

Effective January 1, 1991, this earnings limitation does not apply to covered employment as an elected official. A member aged 65 or older who has completed at least four full calendar months of bona fide retirement and is later reemployed in covered employment shall not be subject to any wage-earning disqualification.

12.7(2) Beginning on or after July 1, 1996, the retirement allowance of a member subject to reduction pursuant to subrule 12.7(1) shall be reduced as follows:

a. A member's monthly retirement allowance in the following calendar year shall be reduced by the excess benefit paid in the preceding year after the excess benefit payment amount has been determined.

b. Employers shall be required to complete IPERS wage reporting forms for reemployed individuals which shall reflect the prior year's wage payments on a month-to-month basis. These reports shall be used by IPERS to determine the amount which must be recovered to offset overpayments in the prior calendar year due to reemployment wages.

c. The member's overpayment shall be collected as follows:

(1) IPERS will reduce the member's gross monthly benefit by 50 percent until the overpayment is repaid. If the 50 percent reduction will not recover the overpayment by the end of the current calendar year, IPERS will calculate the monthly reduction amount so that the overpayment will be recovered within the current calendar year. Other monthly reduction amounts may be made by an agreement in writing between the member and IPERS; or

(2) A member may elect to make repayments of the overpayment amounts out of pocket in lieu of having the member's monthly benefit reduced. An out-of-pocket repayment may be made in one check or in installments. However, an election to make repayment in installments must be agreed to in writing between the member and IPERS.

(3) If a member dies and the full amount of overpayment determined under this subrule has not been repaid, the remaining amounts shall be deducted from the payments to be made, if any, to the member's designated beneficiary or contingent annuitant. If the member has selected an option under which there are no remaining amounts to be paid, or the remaining amounts are insufficient, the unrecovered amounts shall be a charge on the member's estate.

(4) A member may elect in writing to have the member's monthly retirement allowance suspended in the month in which the member's remuneration exceeds the amount of remuneration permitted under this subrule in lieu of receiving a reduced retirement allowance under subparagraph (1). In order to become effective, the member's written election must be delivered to IPERS in person, by regular mail, email, facsimile or by private carrier. Oral elections shall not be accepted. The member's election to suspend benefit payments in the month when the member's remuneration exceeds the amount of reimbursement permitted under this subrule shall remain in effect for all subsequent calendar years until revoked by the member in writing. If the member's written election is not received in time to avoid overpayment, the overpayment must be recovered, to the extent possible, from monthly amounts beginning in January of the next calendar year or under one of the alternate arrangements permitted under this rule. Effective July 1, 2007, remuneration shall include those amounts as described in 495—subrule 6.3(13).

12.7(3) A member who is reemployed in covered employment after retirement may, after again retiring from employment, request a recomputation of benefits. The member's retirement benefit shall be increased, if possible, by the addition of a second annuity, which is based on years of reemployment service, reemployment covered wages and the benefit formula in place at the time of the recomputation. A maximum of 30 years of service is creditable to an individual retired member. If a member's combined years of service exceed 30, a member's initial annuity may be reduced by a fraction of the years in excess of 30, divided by 30. The second retirement benefit will be treated as a separate annuity by IPERS.

Effective July 1, 1998, a member who is reemployed in covered employment after retirement may, after again terminating employment for at least 30 days, elect to receive a refund of the employee and employer contributions made during the period of reemployment in lieu of a second annuity. If a member requests a refund in lieu of a second annuity, the related service credit shall be forfeited.

Effective July 1, 2007, employer contributions described in 495—subrule 6.3(13) shall constitute "remuneration" for purposes of applying the reemployment earnings limit and determining reductions in the member's monthly benefits but shall not be considered covered wages for IPERS benefits calculations.

It is the member's responsibility to apply for the recomputation or lump sum by completing and submitting the form specified by IPERS.

12.7(4) In recomputing a retired member's monthly benefit, IPERS shall use the following assumptions.

a. The member cannot change the option or beneficiary with respect to the reemployment period.

b. If the member would only qualify for a money purchase benefit under rule 495—12.4(97B) based solely on the period of reemployment, then the money purchase formula shall be used to compute the additional benefit amount due to the reemployment.

c. If the member would qualify for a non-money purchase retirement allowance based solely on the period of reemployment, the benefit formula in effect as of the first month of entitlement (FME) for the reemployment period shall be used. If the FME is July 1998 or later, and the member has more than 30 years of service, including both original and reemployment service, the percentage multiplier for the reemployment period only will be at the applicable percentage (up to 65 percent) for the total years of service.

d. If a period of reemployment would increase the monthly benefit a member is entitled to receive, the member may elect between the increase and a refund of the employee and employer contributions without regard to reemployment FME.

e. If a member previously elected IPERS Option 1, is eligible for an increase in the Option 1 monthly benefits, and elects to receive the increase in the member's monthly benefits, the member's Option 1 death benefit shall also be increased if the investment is at least \$1,000. The amount of the increase shall be at least the same percentage of the maximum death benefit permitted with respect to the reemployment as the percentage of the maximum death benefit elected at the member's original retirement. In determining the increase in Option 1 death benefits, IPERS shall round up to the nearest \$1,000. For example, if a member's investment for a period of reemployment is \$1,900 and the member elected at the member's original retirement to receive 50 percent of the Option 1 maximum death benefit, the death benefit attributable to the reemployment shall be \$1,000 (50 percent times \$1,900, rounded up to the nearest \$1,000). Notwithstanding the foregoing, if the member's investment for the period of reemployment is less than \$1,000, the benefit formula for a member who originally elected new IPERS Option 1 shall be calculated under IPERS Option 3.

f. A retired reemployed member who requests a return of the employee and employer contributions made during a period of reemployment cannot repay the distribution and have the service credit for the period of reemployment restored.

g. If a retired reemployed member selected IPERS Option 5 at retirement, and after the period of reemployment requests an increase in the member's monthly allowance, at death all remaining guaranteed payments with respect to both periods of employment shall be paid in a commuted lump sum.

h. If a retired reemployed member selected IPERS Option 2 at retirement, and after the period of reemployment requests an increase in the member's monthly allowance, at death the member's monthly payments following the increase shall be prorated between the member's two annuities to determine the amount of the member's remaining accumulated contributions that may be paid as a death benefit.

i. A retired reemployed member who has attained the age of 70 may take an actuarial equivalent (AE) payment. However, such a member must terminate covered employment for at least 30 days before taking an additional AE payment.

12.7(5) Mandatory distribution of active wages. If a retired reemployed member whose annual benefit would be increased by less than \$600 does not request a second annuity or a lump sum payment of reemployment accruals by the end of the fourth quarter after the last quarter in which the member had covered wages, IPERS shall proceed to pay the member the applicable lump sum amount. The member shall have 60 days after the postmark date of the mandatory payment to return the payment and request a benefit increase.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21; ARC 6949C, IAB 3/8/23, effective 4/12/23]

495—12.8(97B) Actuarial equivalent (AE) payments.

12.8(1) If a member aged 55 or older requests an estimate of benefits which results in a monthly benefit amount under Option 2 of less than \$50, the member shall receive, under Iowa Code section 97B.48(1), a lump sum actuarial equivalent (AE) payment in lieu of a monthly benefit. Once the AE payment has been paid to the member, the member shall not be entitled to any further benefits based on the contributions included in the AE payment and the employment period represented thereby. If the member later returns to covered employment, any future benefits the member accrues shall be based solely on the new employment period. If an estimate of benefits based on the new employment period again results in any one of the options having a monthly benefit amount of less than \$50, the member may again elect to receive an AE payment.

12.8(2) If a member, upon attaining the age of 70 or later, requests a retirement allowance without terminating employment and the member's monthly benefit amount under Option 2 is less than \$50, the member shall receive an AE payment based on the member's employment up to, but not including, the quarter in which the application is filed. When the member subsequently terminates covered employment, any benefits due to the member will be based only on the period of employment not used in computing the AE paid when the member first applied for a retirement allowance. If an estimate of benefits based on the later period of employment again results in a monthly benefit amount under Option 2 of less than \$50, the member shall receive another AE payment. However, a member who elects to receive an AE payment upon or after attaining age 70 without terminating employment may not elect to receive additional AE payments unless the member terminates all covered employment for at least one full calendar month.

12.8(3) An AE payment under this rule shall be equal to the sum of the member's and employer's accumulated contributions.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.9(97B) Conforming rules for lump sum payments. Effective January 1, 2007, IPERS may, notwithstanding certain provisions of Iowa Code section 97B.53B enacted in order to comply with prior rollover provisions of the Internal Revenue Code, utilize forms and procedures affording payees of lump sum distributions with broader rollover rights as permitted under the applicable rollover provisions of the Internal Revenue Code as amended subsequent to the enactment of Iowa Code section 97B.53B.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

These rules are intended to implement Iowa Code sections 97B.1A, 97B.1A(24), 97B.15, 97B.25, 97B.45, 97B.47 to 97B.48A, 97B.49A to 97B.49I, 97B.51, and 97B.53B.

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CHAPTER 16
DOMESTIC RELATIONS ORDERS AND OTHER ASSIGNMENTS

[Prior to 11/24/04, see 581—Ch 21]

495—16.1(97B) Garnishments and income withholding orders.

16.1(1) For the limited purposes of this rule, the term “member” includes IPERS members, beneficiaries, contingent annuitants and any other third-party payees to whom IPERS is paying a monthly benefit or a lump sum distribution.

16.1(2) A member’s right to any payment from IPERS is not transferable or assignable and is not subject to execution, levy, attachment, garnishment, or other legal process, including bankruptcy or insolvency law, except for the purpose of enforcing child, spousal, or medical support.

16.1(3) Only members receiving payment from IPERS, including monthly benefits and lump sum distributions, may be subject to garnishment, attachment, or execution against funds that are payable. Such garnishment, attachment, or execution is not valid and enforceable for members who have not applied for and have not been approved to receive funds from IPERS.

16.1(4) Upon receipt of an income withholding order issued by the Iowa department of human services or a court, IPERS shall send a copy of the withholding order to the member. If a garnishment has been issued by a court, the party pursuing the garnishment shall send a notice pursuant to Iowa law to the member against whom the garnishment is issued.

16.1(5) IPERS shall continue to withhold a portion of the member’s monthly benefit as specified in the initial withholding order until instructed by the court or the Iowa department of human services issuing the order to amend or cease payment. IPERS shall continue to withhold a portion of the member’s monthly benefit as specified in the garnishment until the garnishment expires or is released.

16.1(6) Funds withheld or garnished are taxable to the member. IPERS may assess a fee of \$2 per payment in accordance with Iowa Code section 252D.18A(2). The fee will be deducted from the gross amount, less federal and state income tax, before a distribution is divided.

16.1(7) A garnishment, attachment or execution may not be levied upon funds which are already the subject of a levy, including a levy placed upon funds by the United States Internal Revenue Service, unless the requirements of IRC Section 6334(a)(8) are met. Multiple garnishments, attachments and executions are allowed as long as the amount levied upon does not exceed the limitations prescribed in 15 U.S.C. Section 1673(b).

16.1(8) IPERS may release information relating to entitlement to funds to a court or to the Iowa department of human services prior to receipt of a valid garnishment, attachment, execution, or income withholding order when presented with a written request stating the information requested and reasons for the request. This request must be signed by a magistrate, judge, or child support recovery unit director or the director’s designee, including an attorney representing the Iowa department of human services. In addition, IPERS may release information to the Iowa department of human services through automated matches.

495—16.2(97B) Domestic relations orders. This rule shall apply only to marital property orders. All support orders shall continue to be administered under rule 495—16.1(97B).

16.2(1) Definitions.

“*Alternate payee*” means a spouse or former spouse, regardless of gender, of a member who is recognized by a domestic relations order as having a right to receive all or a portion of the benefits payable by IPERS with respect to such member.

“*Benefits*” means, for purposes of this rule and depending on the context, a refund, monthly allowance (including monthly allowance paid as an actuarial equivalent (AE)), or death benefit payable with respect to a member covered under IPERS. “Benefits” does not include dividends payable under Iowa Code section 97B.49 or other cost-of-living increases unless specifically provided for in a QDRO.

“*Domestic relations order*” means any judgment, decree, or order which relates to the provision of marital property rights to a spouse or former spouse, regardless of gender, of a member and is made pursuant to the domestic relations laws of a state.

“*Member*” means, for purposes of this rule, IPERS members, beneficiaries, and contingent annuitants.

“*Qualified domestic relations order*” or “*QDRO*” means a domestic relations order that divides the marital property of former spouses and assigns to a former spouse alternate payee the right to receive all or a portion of the benefits payable with respect to a member under IPERS and meets the requirements of this rule.

“*Successor alternate payee*” means a person or persons named in a domestic relations order prior to July 1, 2019, to receive the amounts payable to the former spouse alternate payee under the QDRO if the alternate payee dies before the member. Successor alternate payees must be named individuals, not a class of individuals, a trust or an estate.

“*Trigger event*” means a distribution or series of distributions of benefits made with respect to a member.

16.2(2) Requirements.

a. Mandatory provisions. A domestic relations order is a QDRO if such order:

(1) Clearly specifies the member’s name and last-known mailing address, member identification number or social security number, and the names and last-known mailing addresses and social security numbers of alternate payees. This information shall be provided to IPERS on IPERS’ Confidential Information form;

(2) Clearly specifies a fixed dollar amount or a percentage, but not both, of the member’s benefits to be paid by IPERS to the alternate payee or the manner in which the fixed dollar amount or percentage is to be determined, provided that no such method shall require IPERS to perform present value calculations of the member’s accrued benefit;

(3) Clearly specifies the period to which such order applies;

(4) Clearly specifies that the order applies to IPERS;

(5) Clearly specifies that the order is for purposes of making a property division;

(6) Conforms IPERS with IRS reporting requirements for distributions to successor alternate payees. Prior to July 1, 2019, the taxable portion and basis will be prorated to each respective recipient if the payee is the alternate payee. If the payee is a successor alternate payee, the taxable portion and basis will be borne by the member, pursuant to IRC Pub. L. 99-514, 100 Stat. 2085, enacted October 22, 1986. Effective July 1, 2019, a domestic relations order must conform IPERS with IRS reporting requirements for distributions to alternate payees. The taxable portion and basis will be prorated to each respective recipient; and

(7) Is clearly signed by the judge and filed with the clerk of court. IPERS will consider an order duly signed if it carries an original signature, a stamp bearing the judge’s signature, an electronic clerk-of-court stamp and judge’s signature page via the electronic data management system (EDMS) or is conformed in accordance with local court rules.

b. Prohibited provisions. A domestic relations order is not a QDRO if such order:

(1) Requires IPERS to provide any type or form of benefit or any option not otherwise provided under Iowa Code chapter 97B;

(2) Requires IPERS to provide increased benefits determined on the basis of actuarial value;

(3) Requires the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined by IPERS to be a QDRO;

(4) Requires any action by IPERS that is contrary to its governing statutes or plan provisions;

(5) Awards any future benefit increases that are provided by the legislature, except as provided in subparagraph 16.2(2)“c”(2);

(6) Requires the payment of benefits to an alternate payee prior to a trigger event; or

(7) Appoints a successor alternate payee after June 30, 2019.

c. Permitted provisions. A QDRO may also:

(1) If a trigger event has not occurred as of the date the order is received by IPERS, name an alternate payee as a designated beneficiary or contingent annuitant or require the payment of benefits under a particular benefit option, or both;

(2) Specify that the alternate payee shall be entitled to a fixed dollar amount or percentage of dividend payments, or cost-of-living increase or any other postretirement benefit increase to the member (all known as dividend payments), as follows:

1. If the court order awards a fixed dollar amount of benefits to the alternate payee, the dollar amount of dividend payments to be added or method for determining the dollar amount shall be stated in the court order or an award of a share of dividend payments shall be given no effect; and

2. If the court order awards a specified percentage of benefits to the alternate payee, IPERS shall add dividends to the alternate payee's share of the retirement allowance as necessary to keep the alternate payee's share of payments at the percentage specified in the court order;

(3) Bar a vested member from requesting a refund of the member's accumulated contributions without the alternate payee's written consent. If a member applies for a refund, a consent form will be sent to the alternate payee at the address of record at IPERS. The completed consent form must be received by IPERS within 60 days. If returned undeliverable or no response is received, the member's portion of the refund amount will be payable to the member. If returned marked "no consent," the refund will not be payable to either the member or alternate payee;

(4) Allow benefits to be paid to an alternate payee based on a period of reemployment for a retired member.

16.2(3) Administrative provisions.

a. IPERS uses the shared payment method for payments under a domestic relations order. IPERS will not create a separate account for the alternate payee or any successor alternate payee(s). Payment to the alternate payee (or successor alternate payee(s)) shall be in a lump sum if the member's benefits are paid in a lump sum distribution or as monthly payments if the member's benefits are paid under a retirement option. A member shall not be able to receive an actuarial equivalent (AE) under Iowa Code section 97B.48(1) unless the total benefit payable with respect to that member meets the applicable requirements. All divisions of benefits shall be based on the gross amount of monthly or lump sum benefits payable. Federal and state income taxes shall be deducted from the member's and former spouse alternate payee's respective shares and reported under their respective federal tax identification numbers. Unrecovered basis shall be allocated on a pro rata basis to the member and alternate payee. Federal and state income taxes shall be deducted from the member's gross payment when a successor alternate payee(s) receives a payment. Federal and state income taxes shall be reported under the member's federal tax identification number. Unrecovered basis shall be allocated to the member.

b. The alternate payee shall not be entitled to any share of the member's death benefits except to the extent such entitlement is so provided in a QDRO or in a beneficiary designation filed subsequent to the dissolution.

c. Upon acceptable proof from a member that a preretirement divorce is final, a member may submit a new enrollment/beneficiary designation form to IPERS. IPERS will place the new designation in the member's record. However, if a domestic relations order is later received and qualified by IPERS, the provisions of the QDRO shall be deemed, except as revoked or modified in a subsequent QDRO, to operate as a beneficiary designation, and shall be given first priority by IPERS in the determination and payment of such member's death benefits. Death benefits remaining after payments are made as required by the QDRO, to the extent possible, shall then be made according to the terms of the member's most recent beneficiary designation. If a QDRO does not contain a form of benefit paragraph requiring the member to select a specific IPERS option at retirement, the member is allowed to select any option at retirement, including an option that does not provide for payment of postretirement death benefits. Once a divorce is final postretirement, a member may submit a new enrollment/beneficiary designation form to IPERS if the member has retired under Option 1, 2 or 5, unless otherwise specified in a QDRO.

d. If an alternate payee has been awarded a share of the member's benefits and dies before the member, the alternate payee's entire share shall be restored to the member unless otherwise specified in the order and in the manner required under this rule. In order for the alternate payee's entire share to be restored to the member, IPERS requires proof of death of the alternate payee in the form of a death certificate. If a death certificate cannot be obtained, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, bureau of health statistics,

IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

e. A named successor alternate payee may waive current or future rights to payments to which the successor alternate payee would have otherwise been entitled. The funds waived by a successor alternate payee shall revert to the member. The waiver of rights shall occur prior to the receipt of any payment from IPERS to the successor alternate payee and shall be in the form of a filed and signed court order. The waiver of rights by a successor alternate payee is binding and shall serve to indemnify IPERS from all liability to beneficiaries, heirs, or other claimants for any waiver executed by a successor alternate payee. The waiver must be received by IPERS no later than nine months after the date of death of the alternate payee or the date on which the successor alternate payee reaches age 21, whichever occurs later.

f. An alternate payee shall not receive a share of dividends or other cost-of-living increases, unless so provided in a QDRO.

g. The CEO, or CEO's designee, shall have exclusive authority to determine whether a domestic relations order is a QDRO. A final determination by the CEO, or CEO's designee, may be appealed in the same manner as any other final agency determination under Iowa Code chapter 97B.

h. A person who attempts to make IPERS a party or requires IPERS to appear as a witness to a domestic relations action in order to determine an alternate payee's right to receive a portion of the benefits payable to a member shall be liable to IPERS for its costs and attorney's fees.

i. A domestic relations order shall not become effective until IPERS qualification. If a member is receiving a retirement allowance at the time a domestic relations order is deemed qualified by the system, the order shall be effective only with respect to payments made after the appropriate appeal period has elapsed or been waived by the signature of both parties or their respective counsel. Payment to the alternate payee will be withheld from the member's next monthly payment after the date the alternate payee's application is mailed by IPERS. If the member is not receiving a retirement allowance at the time a domestic relations order is qualified by IPERS and subsequently applies for a refund or monthly allowance, or dies, no distributions shall be made until the respective rights of the parties under the domestic relations order are determined by IPERS. If IPERS has placed a hold on the member's account following written or verbal notification from the member, member's spouse, or either party's respective legal representative, and no further contacts are received from either party or their representatives within the following one-year period, or IPERS has not received and qualified a domestic relations order within that time period, IPERS shall release the hold.

j. IPERS and its staff shall have no liability for making or withholding payments in accordance with the provisions of this rule.

k. IPERS has no duty or responsibility to search for alternate payees. Alternate payees must notify IPERS of any change in their mailing addresses. IPERS shall mail the alternate payee an application once an application for a distribution has been received from the member and considered a complete application by IPERS. For monthly benefit applications, the alternate payee is eligible for monthly payments as of the member's first month of entitlement.

l. If a QDRO requires the member to select an option with joint and survivor provisions (Option 4 or 6) and name the alternate payee as contingent annuitant, the order must state the percentage in Option 4 or 6 to be payable to the alternate payee as contingent annuitant (the currently available percentages under Option 4 or 6 are 25, 50, 75 and 100 percent). Acceptable birth proof for the alternate payee as the named contingent annuitant, pursuant to 495—subrule 11.1(2), must also be provided to IPERS prior to approval of the order by IPERS.

m. For both lump sum and monthly payments, the alternate payee's tax withholding and rollover elections, if eligible, must be received before the first or current month's benefit is certified for payment or IPERS will use the applicable default tax withholding elections.

n. If an order that is determined to be a QDRO divides a member's account using a service factor formula and the member's IPERS benefits are based on a number of quarters less than the member's total covered quarters, notwithstanding any terms of the order to the contrary, IPERS shall limit the number of quarters used in the numerator and the denominator of the service fraction to the number of quarters actually used in the calculation of IPERS benefits, not to exceed 120 quarters for special service members

and 140 quarters for regular and hybrid members. IPERS will not accept or administer a service factor formula fraction in excess of 1.

o. Service credit that is purchased during the period when the member is married to the alternate payee shall be added to the numerator and the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Service credit that is purchased during a period when the member is not married to the alternate payee shall only be added to the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Under no circumstances shall the number of quarters in the denominator be more than the number of quarters used to calculate the member's benefit. Service purchase after retirement shall not increase or decrease the alternate payee's payment amount that was deducted and was payable at the time of retirement.

p. The parties or their attorneys in a dissolution action involving an IPERS member shall decide between themselves which attorney will submit a proposed domestic relations order to IPERS for review. With the initial submission of an order for review, drafters must also submit a completed, signed, and dated Confidential Information (CI) form; in addition, every draft order submitted for review must be accompanied by a freshly signed and dated Administrative Rule Compliance for QDROs (ARC) form. Both the member and alternate payee, or their respective counsel, must sign and date the ARC form. Both forms must be wet signed; however, attorneys or pro se filers may sign with their electronic (eFile or EDMS) signatures. A rejection under this paragraph shall not preclude IPERS from placing a hold on a member's account until the status of a proposed order as a QDRO is resolved or the hold is released pursuant to the terms of paragraph 16.2(3) "i."

q. If a member has filed for and is receiving monthly pension benefits, or wishes to file an application for retirement or a refund and has a qualified domestic relations order pending on the member's account, the parties (the member and the alternate payee or their counsel of record) may execute a waiver of the 30-day appeal period following review and qualification of the member's domestic relations order, using a form approved by the system.

r. If a member with an IPERS-approved QDRO is receiving a distribution according to a qualified benefits arrangement (QBA), the alternate payee shall share in the distribution to the member unless the order specifically states otherwise.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 6215C, IAB 2/23/22, effective 3/30/22; ARC 6949C, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code sections 97B.4, 97B.15, 97B.25, 97B.38 and 97B.39.

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CHAPTER 15
GENERAL LICENSE REGULATIONS

[Prior to 12/31/86, see Conservation Commission[290] Chs 17, 66, 67, and 75]

571—15.1(483A) Scope. The purposes of this chapter are to provide rules for license fees, sales, refunds and administration; implement the wildlife violator compact and penalties for multiple offenses; administer special licenses available for hunting and fishing; and describe and implement certification and education programs of the department of natural resources.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 4072C, IAB 10/10/18, effective 12/15/18]

DIVISION I
LICENSE SALES, REFUNDS AND ADMINISTRATION

571—15.2(483A) Definitions. For the purposes of this division, the following definitions shall apply:

“Administration fee” means the fee collected by the department to pay a portion of the cost of administering the sale of licenses through electronic means.

“Department” means the department of natural resources.

“Director” means the director of the department of natural resources.

“Immediate family member” means the spouse, a domestic partner, and all minor children of the licensee or person seeking a license.

“License” means any license or privilege issued by the department to an individual for hunting or fishing in the state of Iowa. Multiple types of licenses are described in these rules.

“License agent” means an individual, business, or governmental agency authorized to sell a license.

“Licensee” means the person who applies for and receives a license under these rules from the department.

“Nonresident” means a person who is not a resident as that term is defined in this rule.

“Principal and primary residence or domicile” means the one and only place where a person has a true, fixed, and permanent home, and to where, whenever the person is briefly and temporarily absent, the person intends to return. Relevant factors used to determine a person’s principal and primary residence or domicile include the following:

1. Proof of place of employment, which must include the address of the person’s place of employment or business, including the area or region where a majority of the person’s work is performed.

2. Physical address, which shall be the person’s 911 address(es) or the address of an immediate family member. A post office box or a forwarded address shall not be accepted by the department to verify the person’s principal and primary residence or domicile.

3. Utility records, which must include the person’s name and be associated with the physical address provided for as the person’s principal and primary residence or domicile. The types of records that may be submitted include rental and lease documents and telephone, cellular phone, electricity, water, sewer, cable or satellite television, and any other utility records.

4. Real estate records, which include legal documents showing ownership or leasehold interests of any and all real estate related to the physical address used by the department to verify the person’s principal and primary residence or domicile. These records should also provide the time period of such ownership or rental.

5. Vehicle registration(s) for any vehicles owned or leased by the person and immediate family members.

6. Portion of federal, state or local income tax returns filed during the relevant time period showing the address provided on those forms by the person.

7. Documentation of homestead tax exemption allowed to the person or immediate family member(s) for all states in which such exemption is allowed.

8. Documentation of any coinhabitants, other than the person’s immediate family members, who use the same principal and primary residence or domicile.

“*Resident*” means a natural person who meets any of the following criteria during each year in which the person claims status as a resident:

1. Has physically resided in this state at the person’s principal and primary residence or domicile for a period of not less than 90 consecutive days immediately before applying for or purchasing a resident license, tag, or permit under this chapter and has been issued an Iowa driver’s license or an Iowa nonoperator’s identification card. A person is not considered a resident under this rule if the person is residing in the state only for a special or temporary purpose including but not limited to engaging in hunting, fishing, or trapping.

2. Is a full-time student at either of the following:

- An accredited educational institution located in this state if the person resides in this state while attending the educational institution.

- An accredited educational institution located outside of this state, if the person is under the age of 25 and normally resides with at least one parent or legal guardian who maintains a principal and primary residence or domicile in this state.

3. Is a student who qualifies as a resident pursuant to paragraph “2,” second bulleted paragraph, only for the purpose of purchasing any resident license specified in Iowa Code section 483A.1 or 484A.2.

4. Is a resident under 18 years of age whose parent is a resident of this state.

5. Is a member of the armed forces of the United States who is serving on active duty, claims residency in this state, and has filed a state individual income tax return as a resident pursuant to Iowa Code chapter 422, division II, for the preceding tax year, or is stationed in this state.

“*Retail*” means the sale of goods or commodities to the ultimate consumer, as opposed to the sale of goods or commodities for further distribution or processing.

“*Wholesale*” means the sale of goods or commodities for resale by a retailer, as opposed to the sale of goods or commodities to the ultimate consumer.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.3(483A) Form of licenses. Every license shall contain a general description of the licensee. At the time of application, the applicant for a license must provide the applicant’s date of birth and either a social security number or a valid Iowa driver’s license number. The license shall be signed by the applicant and shall clearly indicate the privilege granted.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.4(483A) Administration fee. An administration fee of \$1.50 per privilege purchased shall be collected from the purchaser at the time of purchase, except upon the issuance of free landowner deer and turkey hunting licenses, free annual hunting and fishing licenses, free annual fishing licenses, free group home fishing licenses, and boat registrations, renewals, transfers, and duplicates. An administrative fee of \$3.65 will be collected from the purchaser at the time of boat registration, renewal, transfer, and duplicate purchases.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8104B, IAB 9/9/09, effective 10/14/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.5(483A) Electronic license sales.

15.5(1) Designation as license agent. The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as an agent of electronically issued licenses in accordance with the provisions of this rule. The provisions of 571—15.6(483A) shall not apply to a license agent engaging in, or applying to engage in, the electronic sale and issuance of licenses.

15.5(2) Application. Application forms to sell electronically issued licenses may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The following information must be provided on the application form:

- a. The legal name, address, and telephone number of the entity applying for designation;
- b. The hours open for business and general service to the public;
- c. A brief statement of the nature of the business or service provided by the applicant;

d. Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system; and

e. A signature by an owner, partner, authorized corporate official, or public official of the entity applying for designation.

15.5(3) Application review.

a. The director shall approve or deny the application to sell electronically issued licenses based upon the following criteria:

- (1) The need for a license agent in the area;
- (2) The hours open for business or general service to the public;
- (3) The potential volume of license sales;
- (4) The apparent financial stability and longevity of the applicant;
- (5) The number of point-of-sale (POS) terminals available to the department; and
- (6) Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system.

b. If necessary, the department may utilize a waiting list for license agent designation. The order of priority for the waiting list will be determined by the time of submittal of a complete and correct application and receipt of the required security deposit, as outlined in the application.

15.5(4) Issuance of electronic licensing equipment. Upon the director's approval of an application under this rule and designation of a license agent for electronic license sales, the equipment necessary to conduct such sales will be issued to the license agent by the department subject to the following terms and conditions:

a. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department an equipment security deposit in an amount to be determined by the department.

b. Prior to the issuance of the electronic licensing equipment, the approved license agent shall enter into an electronic license sales agreement with the department which sets forth the terms and conditions of such sales, including the authorized amounts to be retained by the license agent.

c. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department a signed authorization agreement for electronic funds transfer pursuant to subrule 15.5(5).

d. Electronic licensing equipment and supplies must be stored in a manner to provide protection from damage, theft, and unauthorized access. Any damage to or loss of equipment or loss of moneys derived from license sales is the responsibility of the license agent.

e. Upon termination of the agreement by either party, all equipment and supplies, as outlined in the agreement, must be returned to the department. Failure to return equipment and supplies in a usable condition, excluding normal wear and tear, will result in the forfeiture of deposit in addition to any other remedies available to the department by law.

15.5(5) License fees. All moneys received from the sale of licenses, less and except the agreed-upon service fee, must be immediately deposited and held in trust for the department.

a. All license agents must furnish to the department a signed authorization agreement for electronic funds transfer authorizing access by the department to a bank account for electronic transfer of license fees received by the license agent.

b. The amount of money due for accumulated sales will be drawn electronically by the department on a weekly basis. The license agent shall be given notice of the amount to be withdrawn at least two business days before the actual transfer of funds occurs. The license agent is responsible for ensuring that enough money is in the account to cover the amount due.

c. License agents may accept or decline payment in any manner other than cash, such as personal checks or credit cards, at their discretion. Checks or credit payments must be made payable to the license agent, not to the department. The license agent shall be responsible for ensuring that the license fee is deposited in the electronic transfer account, regardless of the payment or nonpayment status of any check accepted by the license agent.

15.5(6) Upon the termination of the electronic license sales agreement pursuant to subrule 15.5(7) or 15.5(8), the department may disconnect or otherwise block the license agent's access to the electronic licensing system.

15.5(7) Equipment shut down and termination. The department reserves the right to disconnect the license agent's access to the electronic licensing system or terminate the license agent's electronic license sales agreement for cause. Cause shall include, but is not limited to, the following:

- a. Failing to deposit license fees into the electronic transfer account in a sum sufficient to cover the amount due for accumulated sales;
- b. Charging or collecting any fees in excess of those authorized by law;
- c. Discriminating in the sale of a license in violation of state or federal law;
- d. Knowingly making a false entry concerning any license sold or knowingly issuing a license to a person who is not eligible for the license issued;
- e. Using license sale proceeds, other than the service fee, for personal or business purposes;
- f. Disconnecting or blocking access to the electronic licensing system for a period of 30 days or more; or
- g. Violating any of these rules or the terms of the electronic license sales agreement. Repeated violations of these rules may result in termination of the license agent's electronic license sales agreement.

15.5(8) Voluntary termination. A license agent may terminate its designation and the electronic license sales agreement at its discretion by providing written notice to the department. Voluntary termination shall become effective 30 days after the department's receipt of notice.
[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.6(483A) Paper license sales. Paper licenses shall be sold only in the event that the electronic licensing system is no longer available.

15.6(1) *Depository designation.* The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as a depository for the sale of hunting and fishing licenses in accordance with the provisions of this rule.

15.6(2) *Application.*

a. An application form to act as a depository may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. Requests for an application form may be made through department field staff or field officers. The applicant must provide the following information on the form:

- (1) The name of the retail business establishment, governmental entity, or nonprofit corporation, and location(s) and telephone numbers.
- (2) A general description of the type of retail business establishment, governmental entity, or nonprofit corporation.
- (3) The form of ownership if a retail business establishment. If a partnership, the full names and addresses of all partners must be provided. If a corporation, the date and state of incorporation must be provided.
- (4) If a governmental entity, the name and title of the responsible official.
- (5) If a nonprofit corporation, the date and state of incorporation.
- (6) The hours and days open to the public.
- (7) The contact information of the person signing the application.
- (8) The name, address, and telephone number of three credit references, including the bank used by the retail business establishment, governmental entity, or nonprofit corporation.

b. The application form contains a statement by which the applicant agrees to the terms and conditions as set forth in this rule. The application form must be signed by the owner if a sole proprietorship; by a partner if a partnership; by an authorized corporate official if a corporation; or by

the elected or appointed official administratively in charge of the governmental entity. The signature must be attested to by a notary public.

15.6(3) Security. The applicant under this rule must provide security, either a surety bond from an association or corporation whose business is assuring the fidelity of others and which has the authority by law to do business in this state, a collateral assignment of a certificate of deposit, or a letter of credit.

a. Condition of security. A surety bond required by this rule shall generally provide that the applicant render a true account of and turn over all moneys, license blanks, and duplicates when requested to do so by the director or an authorized representative and that the applicant comply with all applicable provisions of the application, the Iowa Administrative Code, and the Iowa Code.

b. Amount of security. All forms of security required by this rule shall be in the amount of \$5,000 each or a larger amount as jointly agreed to by the department and the depository.

c. Term of bond. The bond required by this rule shall run continuously from the date the application is approved.

d. Termination of bond. The surety or principal may terminate the bond at any time by sending written notice by certified mail, return receipt requested, to the Director, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The termination shall become effective 30 days after the receipt of the notice by the director.

e. Collateral assignment of a certificate of deposit and letters of credit. Collateral assignments of certificates of deposit and letters of credit shall be subject to the following terms and conditions:

(1) Certificates of deposit shall be assigned, in writing, to the department, and the assignment shall be recorded on the books of the bank issuing the certificate.

(2) Banks issuing these certificates shall waive all rights of setoff or liens which they have or might have against these certificates.

(3) Certificates of deposit shall be automatically renewed unless the director approves, in writing, release of the funds. Letters of credit shall be without reservation and shall remain in effect continuously, or as otherwise agreed to by the director.

(4) The director will release the certificates of deposit or approve the cancellation of a letter of credit upon termination of a license agent agreement if all licenses and moneys have been accounted for satisfactorily or if the depository provides a satisfactory surety bond in lieu thereof.

15.6(4) Multiple establishment locations. An application and security may be submitted for retail business establishments with multiple locations. For purposes of reporting and for determining the amount of the security, each application will be considered on a case-by-case basis and as mutually agreed upon by the depository and the director.

15.6(5) Approval of application and security. The director will approve the application upon the receipt of a satisfactory bond, collateral assignment of deposit, or letter of credit and a determination that the credit references are satisfactory. However, the director reserves the right not to approve any application received from a party whose depository agreement has previously been terminated by the department for cause. Upon approval by the director, the department will provide the depository with license blanks, reporting forms, and instructions.

15.6(6) Depository reporting standards. All depositories shall comply with the following reporting standards:

a. Monthly reports. A full and complete monthly sales report, including duplicate copies of the licenses sold and a check or other monetary instrument in the amount due, shall be remitted to the department the following month on a prescheduled due date. A depository that does not provide the monthly report to the department within 10 days after the due date shall be considered seriously delinquent. However, if the depository's office or business is operated on a seasonal basis, a monthly report is not required for any month that the office or business is not open to the public.

b. Annual report. An annual report for all sales for the calendar year and all unused license blanks for the year shall be remitted to the department by January 31 of each year. A depository will be considered seriously delinquent if the annual report is not received by February 15. An annual report shall also be submitted at the time a depository agreement is terminated for any reason during the

calendar year. This report must be received within 15 days after the director issues or, in the case of a voluntary termination, receives the notice of termination.

15.6(7) *Accountability.* The depositary shall be fully accountable to the state for all proceeds collected from the sale of licenses. This accountability shall not be diminished by reason of bankruptcy, fire loss, theft loss, or other similar reason.

15.6(8) *Probation.*

a. A depositary shall be placed on probation under any of the following circumstances:

(1) The depositary is seriously delinquent for the second time during any consecutive six-month period.

(2) The depositary fails to correct a serious delinquency within ten days.

(3) A check is returned by the bank due to insufficient funds.

b. Notice of probation shall be sent to the depositary by certified mail, return receipt requested.

c. The probation will be automatically canceled after six months of satisfactory performance by the depositary.

15.6(9) *Termination of depositary agreement.* A depositary may terminate the agreement at any time by notifying the director by certified mail, return receipt requested. The termination shall be effective 30 days after the receipt of the notice by the director and after the depositary has fully accounted for all moneys and unused license blanks. The director may terminate the depositary agreement and require an immediate and full accounting of all moneys and unused license blanks under any of the following circumstances:

a. The occurrence of a third serious delinquency during any consecutive six-month period.

b. When an insufficient funds check is received by the department, not correcting the deficiency within 10 days after proper notice by the director.

c. Failing to correct a serious delinquency within 15 calendar days.

d. Knowingly placing a date, other than the correct date, on any license.

e. Knowingly selling a resident license to a nonresident or selling a license to a person not qualified for such license.

f. Charging more than the statutory writing fee.

g. Refusing to sell a license to any individual by reason of creed, sexual orientation, gender identity, religion, pregnancy or public accommodation.

h. Canceling a bond, certificate of deposit, or letter of credit or allowing one to expire.

i. Failing to make a full and complete monthly sales report and monthly remittance.

j. Knowingly making a false entry on any license being sold or knowingly issuing any license to a person to whom issuance of that license is improper.

15.6(10) *Forms available from the department.* Copies of the forms required for application, bond, monthly reports, and collateral as assignment may be obtained by written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.7(483A) Lost or destroyed license blanks.

15.7(1) *Accountability for license blanks.* Whenever a depositary or county recorder requests to be relieved from accountability for license blanks that have been lost or destroyed, the depositary or county recorder (recorder) shall file a bond for the face value of such lost or destroyed license blanks and provide an explanation to the director.

15.7(2) *Explanation.*

a. The depositary or recorder shall submit a written statement in the form of an affidavit regarding the facts and circumstances surrounding the alleged loss or destruction. Pictures, drawings, or other pertinent information may be attached and referenced in the statement. The loss or destruction must relate to one or a combination of the following reasons:

(1) Loss or destruction by fire.

(2) Loss from theft.

- (3) Loss while in transit.
- (4) Loss from natural causes, including but not limited to floods, tornadoes, and severe storms.
- (5) Loss or accidental destruction during the course of normal business operations or facility maintenance and repair.

b. The statement must also include a specific description of the precautions and procedures normally utilized by the recorder or depository to prevent or to guard against the loss or destruction described, and a further statement as to why the precautions or procedures failed in this particular instance.

c. The director shall consider the written explanation as provided. The director shall also consider the past record of the depository or recorder regarding losses and destructions and the past record of the depository or recorder regarding prompt and accurate reporting. The director may direct department staff to further investigate the circumstances and facts.

(1) If the director determines that the depository or recorder exercised reasonable and prudent care, the director shall relieve the depository or recorder of accountability upon the filing of a bond.

(2) If the director determines that there was gross negligence by the depository or recorder and holds the depository or recorder accountable, the depository or recorder may file a request for a contested case proceeding as provided in 571—Chapter 7 of the Iowa Administrative Code.

15.7(3) Bond. The depository or recorder shall provide a bond in the amount of the face value of the lost or destroyed licenses. The bond shall be on a bond form provided by the department. The bond shall be conditioned to the effect that the depository or recorder agrees to surrender the subject licenses to the department in the event that they are located at any future time; or in the event of proof showing that any or all of the subject licenses have been issued, the depository, recorder, or sureties jointly and severally agree to pay the state the face value of all licenses covered by the bond.

a. For a face amount of \$500 or less, the personal bond of the depository or recorder is sufficient. One additional personal surety is required for a face amount up to \$1,000; and two personal sureties, in addition to the depository or recorder, are required if the face amount is more than \$1,000.

b. A corporate surety authorized to do business in Iowa may be provided in lieu of the personal sureties required, in addition to the depository or recorder.

c. The value assigned to a lost or destroyed blank license form shall be \$25. This amount will be paid by the depository to the department, except as relief from such payment is provided according to this rule.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.8(483A) Refund or change requests for special deer and turkey hunting licenses and general licenses.

15.8(1) Invalid applications. Deer and turkey hunting license applications that are received after the closing date for acceptance of applications and applications that are invalid on their face will be returned unopened to the applicant. Any license fee related to an application determined invalid by a computer analysis or other analysis after the application has been processed will be refunded to the applicant, less a \$10 invalid application fee to compensate for the additional processing cost related to an invalid application.

15.8(2) Death of licensee. The fee for a deer or turkey hunting license will be refunded to the licensee's estate when the licensee's death predates the season for which the license was issued and a written request from the licensee's spouse, executor or estate administrator is received by the department within 90 days of the last date of the season for which the license was issued.

15.8(3) National or state emergency. The fee for a deer or turkey hunting license will be refunded if the licensee is a member of the National Guard or a reserve unit and is activated for a national or state emergency which occurs during the season for which the license was issued. A written refund request must be received by the department within 90 days of the last date of the season for which the license was issued.

15.8(4) License changes. The department will attempt to change an applicant's choice of season or type of license if a written or telephonic request is received by the licensing section in sufficient time

(usually 20 days) before the license is printed and if the requested change does not result in disadvantage to another applicant. A change request made by telephone must be verified in writing by the requester before the change request will be honored. The department's ability to accommodate requests to change the season or license type is dependent on workload and processing considerations. If the department cannot accommodate a request to change a season or license type, the license will be issued as originally requested by the applicant. No refund will be allowed. The department will not change the name on the license from that submitted on the application.

15.8(5) Duplicate purchases of general hunting and fishing licenses. Upon a showing of sufficient documentation (usually a photocopy of the licenses) that more than one hunting or fishing license was purchased by or for a single person, the department will refund the amount related to the duplicate purchase. A written request for refund, with supporting documentation, must be received by the licensing section within 90 days of the date on the face of the duplicate licenses.

15.8(6) Other refund requests. Except as previously described in this rule, the department will not issue refunds for any licenses as defined in 571—15.2(483A).

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.9(483A) Proof of residency required. The department shall have the authority to require persons applying for or who have received resident licenses to provide additional information to determine the person's principal and primary residence or domicile and residency status. Whether a person was issued resident or nonresident licenses by the department in previous years shall not be a determining factor of residency. Persons required to provide additional information under this rule shall be notified in writing by the department and shall have 60 days to submit all required information to the department.

[ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.10(483A) Residency status determination. Upon receipt of information requested from the person, the department may determine whether the person is a resident or a nonresident for purposes of these rules and Iowa Code chapter 483A. The department shall provide the person with written notice of the finding.

[ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.11(483A) Suspension or revocation of licenses when nonresidents obtain resident licenses.

15.11(1) Suspension or revocation of license. If the department finds that a nonresident has obtained a resident license, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7. If the department finds that a nonresident has obtained a resident license fraudulently or through intentional misrepresentation, the person shall be guilty of a simple misdemeanor, punishable as a scheduled violation under Iowa Code section 805.8B.

15.11(2) Dates of suspension or revocation. The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in rule 571—15.10(483A) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.11(3) Magistrate authority. Nothing in this chapter shall limit the magistrate's authority as described in Iowa Code section 483A.21 to suspend or revoke licenses.

[ARC 9004B, IAB 8/11/10, effective 9/15/10]

571—15.12(483A) Licenses—fees. Except as otherwise provided by law, a person shall not fish, trap, hunt, harvest, pursue, catch, kill, take in any manner, use, have possession of, sell, or transport all or a part of any wild animal, bird, game, turtle, or fish, the protection and regulation of which is desirable for the conservation of resources of the state, without first obtaining a license for that purpose and paying a fee as follows:

15.12(1) Residents.

- a. Fishing license, annual — \$20.
 - b. Fishing license, three-year — \$60.
 - c. Fishing license, seven-day — \$13.50.
 - d. Fishing license, one-day — \$8.50.
 - e. Third-line fishing permit, annual — \$12.
 - f. Fishing license, lifetime, 65 years of age or older — \$59.50.
 - g. Fishing license, lifetime, disabled veteran or POW — \$5.
 - h. Paddlefish fishing license, annual — \$23.50.
 - i. Trout fishing fee — \$12.50.
 - j. Boundary waters sport trotline license, annual — \$24.
 - k. Hunting license, annual — \$20.
 - l. Hunting license, annual, including the wildlife habitat fee — \$33.
 - m. Hunting license, three-year, including the wildlife habitat fee — \$99.
 - n. Hunting license, lifetime, 65 years of age or older — \$59.50.
 - o. Combination hunting and fishing license, annual, including the wildlife habitat fee — \$53.
 - p. Combination hunting and fishing license, lifetime, disabled veteran or POW — \$5.
 - q. Deer hunting license — \$30.
 - r. First antlerless deer license — \$25.50.
 - s. Additional antlerless deer license — \$12.
 - t. Wildlife habitat fee — \$13.
 - u. Migratory game bird fee — \$10.
 - v. Wild turkey hunting license — \$26.50.
 - w. Fur harvester license, annual — \$24.
 - x. Fur harvester license, annual, including the wildlife habitat fee — \$37.
 - y. Fur harvester license, annual, under 16 years of age — \$5.50.
 - z. Fur harvester license, lifetime, 65 years of age or older — \$59.50.
 - aa. Fur dealer license, annual — \$264.
 - bb. Aquaculture unit license, annual — \$30.
 - cc. Retail bait dealer license, annual — \$36.
 - dd. Wholesale bait dealer license, annual — \$146.50.
 - ee. Game breeder license, annual — \$18.
 - ff. Taxidermy license, annual — \$18.
 - gg. Trout fishing license, lifetime, 65 years of age or older — \$63.
 - hh. Trout fishing license, lifetime, disabled veteran — \$63.
 - ii. Fishing license, annual, veteran — \$5.
 - jj. Combination hunting and fishing license, annual, veteran — \$5.
- 15.12(2) Nonresidents.**
- a. Fishing license, annual — \$46.
 - b. Fishing license, seven-day — \$35.50.
 - c. Fishing license, three-day — \$18.50.
 - d. Fishing license, one-day — \$10.
 - e. Third-line fishing permit, annual — \$12.
 - f. Paddlefish fishing license, annual — \$47.
 - g. Trout fishing fee — \$15.50.
 - h. Boundary waters sport trotline license, annual — \$47.50.
 - i. Hunting license, annual — \$129.
 - j. Hunting license, annual, including the wildlife habitat fee — \$142.
 - k. Hunting license, annual, under 18 years of age — \$30.
 - l. Hunting license, annual, under 18 years of age, including the wildlife habitat fee — \$43.
 - m. Hunting license, five-day (not applicable to deer or wild turkey seasons) — \$75.
 - n. Hunting license, five-day, including the wildlife habitat fee (not applicable to deer or wild turkey seasons) — \$88.

- o.* Deer hunting license, antlered or any-sex deer — \$345.50.
- p.* Deer hunting license, antlerless-deer-only, required with the purchase of an antlered or any-sex deer hunting license — \$146.50.
- q.* Deer hunting license, antlerless-deer-only — \$263.50.
- r.* Preference point issued under Iowa Code section 483A.7(3)“*b*” or 483A.8(3)“*e*” — \$58.50.
- s.* Holiday deer hunting license issued under Iowa Code section 483A.8(6), antlerless-deer-only — \$88.
- t.* Wildlife habitat fee — \$13.
- u.* Migratory game bird fee — \$10.
- v.* Wild turkey hunting license, annual — \$117.
- w.* Fur harvester license, annual — \$232.
- x.* Fur harvester license, annual, including the wildlife habitat fee — \$245.
- y.* Fur dealer license, annual — \$586.50.
- z.* Fur dealer license, one day, one location — \$292.50.
- aa.* Location permit for fur dealer — \$66.
- bb.* Aquaculture unit license, annual — \$66.
- cc.* Retail bait dealer license, annual — \$146.50.
- dd.* Wholesale bait dealer license, annual — \$292.50.
- ee.* Game breeder license, annual — \$30.50.
- ff.* Taxidermy license, annual — \$30.50.

[ARC 4072C, IAB 10/10/18, effective 12/15/18; ARC 6064C, IAB 12/1/21, effective 1/5/22; ARC 6929C, IAB 3/8/23, effective 4/12/23]

571—15.13 to 15.15 Reserved.

DIVISION II
MULTIPLE OFFENDER AND WILDLIFE VIOLATOR COMPACT

571—15.16(481A,481B,482,483A,484A,484B) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders.

15.16(1) Definitions. For the purpose of this rule, the following definitions shall apply:

“*Department*” means the Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

“*License*” means any paid or free license, permit, or certificate to hunt, fish, or trap listed in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716, including the authorization to hunt, fish, or trap pursuant to any reciprocity agreements with neighboring states.

“*Licensee*” means the holder of any license.

“*Multiple offender*” means any person who has equaled or exceeded five points for convictions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716 during a consecutive three-year period as provided in 15.16(3).

“*Revocation*” means the taking or cancellation of an existing license.

“*Suspension*” means to bar or exclude one from applying for or acquiring licenses for future seasons.

15.16(2) Record-keeping procedures. For the purpose of administering this rule, it shall be the responsibility of the clerk of district court for each county to deliver, on a weekly basis, disposition reports of each charge filed under Iowa Code chapters 456A, 481A, 481B, 482, 483A, 484A, 484B, and 716 to the department. Dispositions and orders of the court of all cases filed on the chapters listed in this subrule shall be sent to the department regardless of the jurisdiction or the department of the initiating officer.

a. License suspensions. In the event of a license suspension pursuant to Iowa Code section 481A.133, the clerk of court shall immediately notify the department.

b. Entering information. Upon receipt of the disposition information from the clerks of court, the department will, on a monthly basis, enter this information into a computerized system that is directly

accessible by the department of public safety communications system for use by the department's licensing section, and all state and local law enforcement officers. Direct access through the department of public safety communications system will be available as soon as practical and is dependent on the development of appropriate computer linkage by the department of public safety.

c. Disposition report information. Information from the disposition report that will be entered into a computerized system which includes but may not be limited to the following:

County of violation, name of defendant, address of defendant, social security or driver's license number, date of birth, race, sex, height, weight, date and time of violation, charge and Iowa Code section, officer name/C-number who filed charge, and date of conviction.

15.16(3) Point values assigned to convictions. Point values for convictions shall be assessed as stated in this subrule. Multiple citations and convictions of the same offense will be added as separate convictions:

- a.* Convictions of the following offenses shall have a point value of three:
- (1) Illegal sale of birds, game, fish, or bait.
 - (2) More than the possession or bag limit for any species of game or fish.
 - (3) Hunting, trapping, or fishing during the closed season.
 - (4) Hunting by artificial light.
 - (5) Hunting from aircraft, snowmobiles, all-terrain vehicles or motor vehicle.
 - (6) Any violation involving threatened or endangered species.
 - (7) Any violations of Iowa Code chapter 482, except sections 482.6 and 482.14.
 - (8) Any violation of nonresident license requirements.
 - (9) No fur dealer license (resident or nonresident).
 - (10) Illegal taking or possession of protected nongame species.
 - (11) The unlawful taking of any fish, game, or fur-bearing animal.
 - (12) Illegal taking, possession, or transporting of a raptor.
 - (13) Hunting, fishing, or trapping while under license suspension or revocation.
 - (14) Illegal removal of fish, minnows, frogs, or other aquatic wildlife from a state fish hatchery.
 - (15) Any fur dealer violations except failure to submit a timely annual report.
 - (16) Any resident or nonresident making false claims to obtain a license.
 - (17) Illegal taking or possession of hen pheasant.
 - (18) Applying for or acquiring a license while under suspension or revocation.
 - (19) For a repeat offense of acquiring a hunting license without hunter safety certification.
 - (20) Taking game from the wild—see Iowa Code section 481A.61.
 - (21) Violation of Iowa Code sections 483A.27(7) and 483A.27A.
 - (22) Any violation of Iowa Code section 716.8 while hunting deer.
- b.* Convictions of the following offenses shall have a point value of two:
- (1) Hunting, fishing, or trapping on a refuge.
 - (2) Illegal possession of fur, fish, or game.
 - (3) Chasing wildlife from or disturbing dens.
 - (4) Trapping within 200 yards of an occupied building or private drive.
 - (5) Possession of undersized or oversized fish.
 - (6) Snagging of game fish.
 - (7) Shooting within 200 yards of occupied building or feedlot.
 - (8) No valid resident license relating to deer, turkey, or paddlefish.
 - (9) Illegal importation of fur, fish, or game.
 - (10) Failure to exhibit catch to an officer.
 - (11) Trapping or poisoning game birds, or poisoning game animals.
 - (12) Violations pertaining to private fish hatcheries and aquaculture.
 - (13) Violations of the fur dealers reporting requirements.
 - (14) Violation of Iowa Code section 481A.126 pertaining to taxidermy.
 - (15) Loaded gun in a vehicle.
 - (16) Attempting to unlawfully take any fish, game, or fur-bearing animals.

- (17) Attempting to take game before or after legal shooting hours.
- (18) Wanton waste of fish, game or fur-bearing animals.
- (19) Illegal discharge of a firearm pursuant to Iowa Code section 481A.54.
- (20) Any violation of Iowa Code section 482.14 pertaining to commercial fishing.
- (21) Failure to tag deer, turkey, or paddlefish.
- (22) Applying for or obtaining more than the legal number of licenses allowed for deer or turkey.
- (23) Illegal transportation of game, fish or furbearers.
- (24) Violation of Iowa Code section 483A.27, except subsection (7).

c. All other convictions of provisions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B shall have a point value of one.

15.16(4) *Length of suspension or revocation.*

a. The term of license suspension or revocation shall be determined by the total points accumulated during any consecutive three-year period, according to the following: 5 points through 8 points is one year, 9 points through 12 points is two years, and 13 points or over is three years.

b. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(2) shall have an additional suspension of one year. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(3) shall have an additional suspension of two years. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(4) shall have an additional suspension of three years. The foregoing provisions apply whether or not a person has been found guilty of a simple misdemeanor, serious misdemeanor or aggravated misdemeanor pursuant to Iowa Code subsections 481A.135(2), 481A.135(3) and 481A.135(4). If a magistrate suspends the privilege of a defendant to procure another license and the conviction contributes to the accumulation of a point total that requires the department to initiate a suspension, the term of suspension shall run consecutively up to a maximum of five years. After a five-year suspension, remaining time will be calculated at a concurrent rate.

15.16(5) *Points applicable toward suspension or revocation.* If a person pleads guilty or is found guilty of an offense for which points have been established by this rule but is given a suspended sentence or deferred sentence by the court as defined in Iowa Code section 907.1, the assigned points will become part of that person's violation record and apply toward a department suspension or revocation.

15.16(6) *Notification of intent to suspend and revoke license.* If a person reaches a total of five or more points, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7.

15.16(7) *Dates of suspension or revocation.* The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in 15.16(6) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.16(8) *Magistrate authority.* This chapter does not limit the magistrate authority as described in Iowa Code section 483A.21.

15.16(9) *Suspension for failure to comply with a child support order.* The department is required to suspend or deny all licenses of an individual upon receipt of a certificate of noncompliance with child support obligation from the Iowa child support recovery unit pursuant to Iowa Code section 252J.8(4).

a. The receipt by the department of the certificate of noncompliance shall be conclusive evidence. Pursuant to Iowa Code section 252J.8(4), the person does not have a right to a hearing before the department to contest the denial or suspension action taken due to the department's receipt of a certificate of noncompliance with a child support obligation but may seek a hearing in district court in accordance with Iowa Code section 252J.9.

b. Suspensions for noncompliance with a child support obligation shall continue until the department receives a withdrawal of the certificate of noncompliance from the Iowa child support recovery unit.

c. After the department receives a withdrawal of the certificate of noncompliance, an individual may obtain a new license upon application and the payment of all applicable fees.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.17(456A) Wildlife violator compact. The department has entered into the wildlife violator compact (the compact) with other states for the uniform enforcement of license suspensions. The compact, a copy of which may be obtained by contacting the department's law enforcement bureau, is adopted herein by reference. The procedures set forth in this rule shall apply to license suspensions pursuant to the wildlife violator compact.

15.17(1) Definitions. For purposes of this rule, the following definitions shall apply:

"Compliance" with respect to a citation means the act of answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

"Department" means the Iowa department of natural resources.

"Home state" means the state of primary residence of a person.

"Issuing state" means a participating state that issues a fish or wildlife citation to a person.

"License" means any license, permit, or other public document which conveys to the person to whom it was issued the privilege of pursuing, possessing, or taking any fish or wildlife regulated by statute, law, regulation, ordinance, or administrative rule of a participating state.

"Participating state" means any state which enacts legislation to become a member of the wildlife violator compact. Iowa is a participating state pursuant to Iowa Code section 456A.24(14).

15.17(2) Suspension of licenses for noncompliance. Upon the receipt of a valid notice of failure to comply, as defined in the compact, the department shall issue a notice of suspension to the Iowa resident. The notice of suspension shall:

a. Indicate that all department-issued hunting (including furbearer) or fishing licenses shall be suspended, effective 30 days from the receipt of the notice, unless the department receives proof of compliance.

b. Inform the violator of the facts behind the suspension with special emphasis on the procedures to be followed in resolving the matter with the court in the issuing state. Accurate information in regard to the court (name, address, telephone number) must be provided in the notice of suspension.

c. Notify the license holder of the right to appeal the notice of suspension within 30 days of receipt. Said appeal shall be conducted pursuant to 571—Chapter 7 but shall be limited to the issues of whether the person so notified has a pending charge in the issuing state, whether the person has previously received notice of the violation from the issuing state, and whether the pending charge is subject to a license suspension for failure to comply pursuant to the terms of the compact.

d. Notify the license holder that, prior to the effective date of suspension, a person may avoid suspension through an appearance in the court with jurisdiction over the underlying violations or through the payment of all fines, costs, and surcharges associated with the violations.

e. Indicate that, once a suspension has become effective, the suspension may only be lifted upon the final resolution of the underlying violations.

15.17(3) Reinstatement of licenses. Any license suspended pursuant to this rule may be reinstated upon the receipt of an acknowledgement of compliance from the issuing state, a copy of a court judgment, or a certificate from the court with jurisdiction over the underlying violations and the payment of applicable Iowa license fees.

15.17(4) Issuance of notice of failure to comply. When a nonresident is issued a citation by the state of Iowa for violations of any provisions under the jurisdiction of the natural resource commission which is covered by the suspension procedures of the compact and fails to timely resolve said citation by payment of applicable fines or by properly contesting the citation through the courts, the department shall issue a notice of failure to comply.

a. The notice of failure to comply shall be delivered to the violator by certified mail, return receipt requested, or by personal service.

b. The notice of failure to comply shall provide the violator with 14 days to comply with the terms of the citation. The violator may avoid the imposition of the suspension by answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

c. If the violator fails to achieve compliance, as defined in this rule, within 14 days of receipt of the notice of failure to comply, the department shall forward a copy of the notice of failure to comply to the home state of the violator.

15.17(5) Issuance of acknowledgement of compliance. When a person who has previously been issued a notice of failure to comply achieves compliance, as defined in this rule, the department shall issue an acknowledgement of compliance to the person who was issued the notice of failure to comply.

15.17(6) Reciprocal recognition of suspensions. Upon receipt of notification from a state that is a member of the wildlife violator compact that the state has suspended or revoked any person's hunting or fishing license privileges, the department shall:

a. Enter the person's identifying information into the records of the department.

b. Deny all applications for licenses to the person for the term of the suspension or until the department is notified by the suspending state that the suspension has been lifted.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.18 to 15.20 Reserved.

DIVISION III
SPECIAL LICENSES

571—15.21(483A) Fishing license exemption for patients of substance abuse facilities.

15.21(1) Definition. For the purpose of this rule, the definition of "substance abuse facility" is identical to the definition of "facility" in Iowa Code subsection 125.2(9).

15.21(2) Procedure. Each substance abuse facility may apply to the department of natural resources for a license exempting patients from the fishing license requirement while fishing as a supervised group as follows:

a. Application shall be made on a form provided by the department and shall include the name, address and telephone number of the substance abuse facility including the name of the contact person. A general description of the type of services or care offered by the facility must be included as well as the expected number of participants in the fishing program and the water bodies to be fished.

b. A license will be issued to qualifying substance abuse facilities and will be valid for all patients under the care of that facility.

c. Patients of the substance abuse facility must be supervised by an employee of the facility while fishing without a license pursuant to this rule. An employee of the substance abuse facility must have the license in possession while supervising the fishing activity of patients.

d. Notwithstanding the provisions of this rule, each employee of the substance abuse facility must possess a valid fishing license while participating in fishing.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.22(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals.

15.22(1) Definitions. For the purpose of this rule:

"Bow and arrow" means a compound, recurve, or longbow.

"Crossbow" means a weapon consisting of a bow mounted transversely on a stock or frame and designed to fire a bolt, arrow, or quarrel by the release of the bow string, which is controlled by a mechanical or electric trigger and a working safety.

"Handicapped" means a person possessing a physical impairment of the upper extremities that makes a person physically incapable of shooting a bow and arrow. This includes difficulty in lifting and reaching with arms as well as difficulty in handling and fingering.

15.22(2) Application for authorization card. An individual requesting use of a crossbow for hunting deer or turkey must submit an application for an authorization card on forms provided by the department. The application must include a statement signed by the applicant's physician declaring that the individual is not physically capable of shooting a bow and arrow. A first-time applicant must submit the authorization card application no later than ten days before the last day of the license application period for the season the person intends to hunt.

15.22(3) Authorization card—issuance and use. Approved applicants will be issued a card authorizing the individual to hunt deer and turkey with a crossbow. The authorization card must be carried with the license and on the person while hunting deer and turkey and must be exhibited to a conservation officer upon request.

15.22(4) Validity and forfeiture of authorization card. A card authorizing the use of a crossbow for hunting deer and turkey will be valid for as long as the person is incapable of shooting a bow and arrow. If a conservation officer has probable cause to believe the person's handicapped status has improved, making it possible for the person to shoot a bow and arrow, the department may, upon the officer's request, require the person to obtain in writing a current physician's statement.

If the person is unable to obtain a current physician's statement confirming that the person is incapable of shooting a bow and arrow, the department may initiate action to revoke the authorization card pursuant to 571—Chapter 7.

15.22(5) Restrictions. Crossbows equipped with pistol grips and designed to be fired with one hand are illegal for taking or attempting to take deer or turkey. All projectiles used in conjunction with a crossbow for deer hunting must be equipped with a broadhead.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.23(483A) Free hunting and fishing license for low-income persons 65 years of age and older or low-income persons who are permanently disabled.

15.23(1) Purpose. Pursuant to Iowa Code subsection 483A.24(15), the department of natural resources will issue a free annual combination hunting and fishing license to low-income persons who meet the age status or permanently disabled status as defined.

15.23(2) Definitions.

“Age status” means a person who has achieved the sixty-fifth birthday.

“Low-income person” means a person who is a recipient of a program administered by the state department of human services for persons who meet low-income guidelines.

“Permanently disabled” means a person who meets the definition in Iowa Code section 483A.4.

15.23(3) Procedure. Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, address, height, weight, color of eyes and hair, date of birth, and gender of the applicant. In addition, applicants shall include a copy of an official document such as a birth certificate if claiming age status, or a copy of an award letter from the Social Security Administration or private pension plan if claiming permanent disabled status. The application shall include an authorization allowing the department of human services to verify the applicant's household income if proof of income is provided through the department of human services.

b. The free annual hunting and fishing combination license will be issued by the department upon verification of program eligibility. The license issued under this rule will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain a free license.

c. A person whose income falls below the federal poverty guidelines may apply for this license by providing either of the following:

(1) A current Notice of Decision letter. For purposes of this rule, a “current Notice of Decision letter” shall mean a letter from the department of human services dated in the month the application is received or dated in the five months immediately preceding the month the application is received that describes the applicant's monthly or annual household income.

(2) If a person does not have a Notice of Decision letter as described in subparagraph (1), a document shall be provided that states that the applicant's annual income does not exceed the federal poverty limit for the current year and lists income from all sources, including but not limited to any wages or compensation, social security, retirement income, dividends and interest, cash gifts, rents and royalties, or other cash income. In addition, the applicant shall provide documentation of such income by submitting a copy of the applicant's most recently filed state or federal income tax return to the department. In the event an applicant does not have a tax return that was filed within the last year because the applicant's income level does not require the filing of a tax return, the applicant shall so notify the department, shall provide to the department bank statements, social security statements or other relevant income documentation identified by the department, and shall meet with the department to verify income eligibility under this rule.

Federal poverty guidelines are published in February of each year and will be the income standard for applicants from that time until the guidelines are available in the subsequent year. The guidelines will be shown on the application and will be available upon request from the department.

15.23(4) Revocation. Any license issued pursuant to rule 571—15.23(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.24(483A) Free annual fishing license for persons who have severe physical or mental disabilities.

15.24(1) Purpose. Pursuant to Iowa Code subsection 483A.24(9), the department of natural resources will issue a free annual fishing license to Iowa residents 16 or more years of age who have severe mental or physical disabilities who meet the definition of “severe mental disability” or “severe physical disability” in 15.24(2).

15.24(2) Definitions. For the purposes of this rule, the following definitions apply:

“*Severe mental disability*” means a person who has severe, chronic conditions in all of the following areas which:

1. Are attributable to a mental impairment or combination of mental and physical impairments;
2. Result in substantial functional limitations in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency;
3. Reflect the person's need for a combination and sequence of services that are individually planned and coordinated; and
4. Requires the full-time assistance of another person to maintain a safe presence in the outdoors.

“*Severe physical disability*” means a disability that limits or impairs the person's mobility or use of a hand or arm and that requires the full-time assistance of another person or that makes the person dependant on a wheelchair for the person's normal life routine.

15.24(3) Procedure. Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, home address, home telephone number, height, weight, eye and hair color, date of birth, and gender of the applicant and other information as required. The license issued under this rule will be issued by the department upon verification of program eligibility and will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain the license.

b. The application shall be certified by the applicant's attending physician with an original signature and, based upon the definition of severe mental disability or severe physical disability as

provided for in this rule, declare that the applicant has a severe mental or physical disability. A medical statement from the applicant's attending physician specifying the applicant's type of disability shall be on 8½" x 11" stationery of the attending physician or on paper inscribed with the attending physician's letterhead. For purposes of this rule, the attending physician must be a currently practicing doctor of medicine, doctor of osteopathy, physician's assistant or nurse practitioner.

15.24(4) Revocation. Any license issued pursuant to 571—15.24(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.25(483A) Transportation tags for military personnel on leave from active duty.

15.25(1) Military transportation tags for deer and turkey. The military transportation tag shall include the following information: name, birth date, current address of military person; species and sex of animal taken; date of kill; and weapon used. Only conservation officers of the department shall be authorized to issue military transportation tags.

15.25(2) Annual limit for military transportation tags. A person receiving a military transportation tag shall be limited to one military deer tag and one military turkey tag annually.

15.25(3) Regulations apply to military personnel. With the exception of the license requirement exemption set forth in Iowa Code section 483A.24(6), all hunting and fishing regulations shall apply to active duty military personnel.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.26(483A) Special nonresident deer and turkey licenses. The commission hereby authorizes the director to issue special nonresident deer and turkey licenses pursuant to the provisions of 561—Chapter 12.

[ARC 2398C, IAB 2/17/16, effective 3/23/16]

571—15.27(483A) Apprentice hunter designation.

15.27(1) A person who is 16 years of age or older and meets all the requirements of Iowa Code section 483A.27A may purchase, up to two times, a hunting license with an apprentice hunter designation on the license without first completing a hunter education course.

15.27(2) A hunting license with an apprentice hunter designation issued pursuant to Iowa Code section 483A.27A is valid from the date issued to January 10 of the succeeding calendar year.

[ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.28 to 15.40 Reserved.

DIVISION IV
EDUCATION AND CERTIFICATION PROGRAMS

571—15.41(483A) Hunter education program. This division clarifies the term “hunting license” as used in Iowa Code section 483A.27 in relation to the hunter education course requirement, clarifies the need for exhibiting a hunter education course certificate when applying for a deer or wild turkey license, and explains the requirements for individuals who wish to demonstrate their knowledge of hunter education so as to be eligible to purchase an Iowa hunting license. For the purpose of this division, a hunting license, pursuant to Iowa Code sections 483A.1 and 483A.24, includes:

1. Hunting licenses for legal residents except as otherwise provided. (Iowa Code section 483A.1(1))

2. Hunting licenses for nonresidents. (Iowa Code section 483A.1(2))

3. Hunting preserve license.
4. Free annual hunting and fishing licenses for persons who are disabled or are 65 years of age or older and qualify for low-income status as defined in Iowa Code section 483A.24.
5. Veteran's lifetime hunting and fishing license as defined in Iowa Code section 483A.24.
[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.42(483A) Testing procedures.

15.42(1) General testing procedures.

a. Upon completion of the required curriculum, each person shall score a minimum of 75 percent on the written or oral test provided by the department and demonstrate safe handling of a firearm. Based on the results of the written or oral test and demonstrated firearm safe handling techniques as prescribed by the department, the volunteer instructor shall determine the persons who shall be issued a certificate of completion.

b. Notwithstanding paragraph 15.42(1)“a” above, a resident who is 18 years of age or older may obtain a certificate of completion without demonstrating the safe handling of a firearm.

15.42(2) Exemptions. The following groups of individuals do not need hunting licenses and therefore do not need to satisfactorily complete a hunter education course:

a. *Landowners and tenants.* Owners or tenants of land and their children when hunting on the land which they own or on which they are tenants.

b. *Residents under 16.* Residents of the state under 16 years of age accompanied by their parent or guardian or in the company of any other competent adult if the adult accompanying said minor possesses a valid hunting license, providing, however, there is one licensed adult accompanying each person under 16 years of age.

15.42(3) Deer and wild turkey license applications. Individuals are not required to exhibit a certificate showing satisfactory completion of a hunter education course only when applying for a deer or wild turkey license.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 2561C, IAB 6/8/16, effective 7/13/16]

571—15.43(321G,462A,483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors. Rescinded ARC 2561C, IAB 6/8/16, effective 7/13/16.

571—15.44 to 15.50 Reserved.

DIVISION V

LICENSE REVOCATION, SUSPENSION, AND MODIFICATION DUE TO LIABILITIES OWED TO THE STATE

571—15.51(272D) Purpose and use. This rule is intended to help collect liabilities of the state or a state agency. This rule shall apply to all licenses issued, renewed or otherwise authorized by the department.
[ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.52(272D) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Certificate of noncompliance*” means a document provided by the unit certifying the named person has outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

“*Department*” means the department of natural resources.

“*Liability*” means a debt or obligation placed with the unit for collection that is greater than \$1,000. For purposes of this chapter, “liability” does not include child support payments collected pursuant to Iowa Code chapter 252J.

“*License*” means a license, certification, registration, permit, approval, renewal or other similar authorization issued to a person by the department which evidences the admission to, or granting of authority to engage in, a profession, occupation, business, industry, or recreation, including those authorizations set out in Iowa Code chapters 321G, 321I, 455B, 455C, 455D, 456A, 459, 459A, 461A, 462A, 481A, 481B, 481C, 482, 483A, 484B and 484C.

“*Licensee*” means a person to whom a license has been issued by the department or who is seeking the issuance of a license from the department.

“*Notice of intent*” means a notice sent to a licensee indicating the department’s intent to suspend, revoke, or deny renewal or issuance of a license.

“*Obligor*” means a person with a liability placed with the unit.

“*Unit*” means the centralized collection unit of the department of revenue or the college student aid commission.

“*Withdrawal of a certificate of noncompliance*” means a document provided by the unit certifying that the certificate of noncompliance is withdrawn and that the department may proceed with issuance, reinstatement, or renewal of a person’s license.

[ARC 8465B, IAB 1/13/10, effective 2/17/10; ARC 9005B, IAB 8/11/10, effective 9/15/10]

571—15.53(272D) Requirements of the department.

15.53(1) *Records.* The department shall collect and maintain records of its licensees that must include, at a minimum, the following:

- a. The licensee’s first and last names.
- b. The licensee’s current known address.
- c. The licensee’s social security number.

The records shall be made available to the unit so that the unit may match to the records the names of persons with any liabilities placed with the unit for collections. The records must be submitted in an electronic format and updated on a quarterly basis.

15.53(2) *Certificate of noncompliance.* Upon receipt of a certificate of noncompliance from the unit, the department shall initiate its existing rules and procedures for the suspension, revocation, or denial of issuance or renewal of a person’s license.

15.53(3) *Notice of intent.* The department shall provide a notice of intent to a person of its intent to suspend, revoke or deny issuance or renewal of a license in accordance with Iowa Code chapter 272D or section 261.126, whichever is appropriate. The suspension, revocation, or denial shall be effective no sooner than 30 days following the issuance of the notice of intent to the person. The notice shall include all of the following:

- a. That the department has received a certificate of noncompliance from the unit and intends to suspend, revoke or deny issuance or renewal of a person’s license;
- b. That the person must contact the unit to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;
- c. That the department will revoke, suspend or deny the person’s license unless a withdrawal of a certificate of noncompliance is received from the unit within 30 days from the date of the notice;
- d. That, in the event the department’s rules and procedures conflict with the additional rules and procedures under this action, the rules and procedures of this action shall apply;
- e. That mistakes of fact in the amount of the liability owed and the person’s identity may not be contested to the department; and
- f. That the person may request a district court hearing as outlined in rule 701—153.14(272D).

15.53(4) *Withdrawal.* Upon receipt of a withdrawal of a certificate of noncompliance from the unit, the department shall immediately reinstate, renew, or issue a license if the person is otherwise in compliance with the department’s requirements.

[ARC 8465B, IAB 1/13/10, effective 2/17/10; ARC 9005B, IAB 8/11/10, effective 9/15/10]

571—15.54(272D) No administrative appeal of the department’s action. Pursuant to Iowa Code sections 261.126 and 272D.8, a person does not have a right to a hearing before the department to contest the department’s action under this rule, but may request a court hearing pursuant to rule 571—15.55(272D).

[ARC 8465B, IAB 1/13/10, effective 2/17/10; ARC 9005B, IAB 8/11/10, effective 9/15/10]

571—15.55(272D) District court hearing. A person may seek review of the actions listed in rule 701—153.14(272D) and request a hearing before the district court by filing an application with the

district court in the county in which the majority of the liability was incurred. The person must send a copy of the application to the unit by regular mail. The application must be filed no later than 30 days after the department issues its notice of intent.

15.55(1) Scheduling. The clerk of the district court shall schedule a hearing and mail a copy of the scheduling order to the person, the unit, and the department.

15.55(2) Certification. The unit shall certify a copy of its written decision and certificate of noncompliance, indicating the date of issuance, and the department shall certify a copy of the notice issued pursuant to subrule 15.53(3) to the court prior to the hearing.

15.55(3) Stay. Upon receipt from the clerk of court of a copy of a scheduling order and prior to the hearing, the department shall stay any action contemplated on the person's license pursuant to the notice of intent.

15.55(4) Hearing. The hearing on the person's application shall be scheduled and held within 30 days of the application being filed. However, if the person fails to appear at the scheduled hearing, the stay shall be lifted and the department shall continue its procedures pursuant to the notice of intent.

15.55(5) Scope of review. The district court's review shall be limited to demonstration of the amount of the liability owed or the identity of the person.

15.55(6) Findings. If the court finds the unit was in error either in issuing a certificate of noncompliance or in its failure to issue a withdrawal of a certificate of noncompliance, the unit shall issue a withdrawal of a certificate of noncompliance to the department. If the court finds the unit was justified in issuing a certificate of noncompliance or in not issuing a withdrawal of a certificate of noncompliance, a stay imposed under subrule 15.55(3) shall be lifted and the department shall proceed with the action as outlined in its notice of intent.

[ARC 8465B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement Iowa Code chapters 272D, 321G, 456A, 462A, 481A, 481B, 482, 483A, 484A, and 484B and Iowa Code section 261.126.

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CHAPTER 28
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSURE FEES

641—28.1(105) Fees. All fees are nonrefundable.

28.1(1) Fees for three-year initial licenses are as follows:

- a.* An apprentice license as defined in 641—subrule 29.2(1) is \$50.
- b.* A journey license as defined in 641—subrule 29.2(2) is \$180.
- c.* A master license as defined in 641—subrule 29.2(3) is \$240.
- d.* A medical gas pipe certificate as defined in 641—29.3(105) is \$75.
- e.* An inactive license as defined in 641—subrules 29.2(5) and 29.2(6) is \$50.
- f.* A contractor license as defined in 641—subrule 29.2(4) is \$250.
- g.* A special restricted license as defined in 641—subrules 29.2(8), 29.2(9), and 29.2(10) is \$50.
- h.* Fees for all initial licenses issued for a period of less than three years shall be prorated using a one-sixth deduction for each six-month period.

28.1(2) Fees for three-year reciprocal licenses or three-year licenses obtained by verification in accordance with 641—Chapter 35 are as follows:

- a.* An apprentice license as defined in 641—subrule 29.2(1) is \$50.
- b.* A journey license as defined in 641—subrule 29.2(2) is \$180.
- c.* A master license as defined in 641—subrule 29.2(3) is \$240.
- d.* Fees for all reciprocal licenses or three-year licenses obtained by verification in accordance with 641—Chapter 35 issued for a period of less than three years shall be prorated using a one-sixth deduction for each six-month period.

28.1(3) Fees for renewal of licenses are as follows:

- a.* An apprentice license as defined in 641—subrule 29.2(1) is \$50.
- b.* A journey license as defined in 641—subrule 29.2(2) is \$180.
- c.* A master license as defined in 641—subrule 29.2(3) is \$240.
- d.* A medical gas pipe certificate as defined in 641—29.3(105) is \$75.
- e.* An inactive license as defined in 641—subrules 29.2(5) and 29.2(6) is \$50. However, no fee is required for an inactive specialty license as defined in 641—subrule 23.8(3) so long as the person possessing the inactive specialty license remains actively licensed as an apprentice.
- f.* A contractor license as defined in 641—subrule 29.2(4) is \$250.
- g.* A special restricted license as defined in 641—subrules 29.2(8), 29.2(9), and 29.2(10) is \$50. However, no fee is required for an inactive specialty license as defined in 641—subrule 23.8(3) so long as the person possessing the inactive specialty license remains actively licensed as an apprentice.

28.1(4) The examination application fee is \$35.

28.1(5) A late fee for failure to renew before expiration is determined as follows:

- a.* Prior to July 1, 2017, a licensee who allows a license to lapse for 30 days or less may reinstate and renew the license with payment of the appropriate renewal fee and without payment of a late fee. Beginning July 1, 2017, a licensee who does not timely renew but renews a license on or before the following July 31 may reinstate and renew the license upon payment of the appropriate renewal fee and without payment of a late fee.
- b.* Prior to July 1, 2017, a licensee who allows a license to lapse for more than 30 days but less than 60 days may reinstate and renew the license without examination upon payment of a \$60 late fee and the appropriate renewal of license fee. Beginning July 1, 2017, a licensee who does not timely renew but renews a license between the following August 1 and August 31 may reinstate and renew the license without examination upon payment of a \$60 late fee and the appropriate renewal of license fee.
- c.* Prior to July 1, 2017, a licensee who allows a license to lapse for more than 60 days but not more than 365 days may reinstate and renew the license without examination upon payment of a \$100 late fee and the appropriate renewal of license fee. Beginning July 1, 2017, a licensee who does not timely renew but renews a license after the following August 31 and on or before the following June 30 may reinstate and renew the license without examination upon payment of a \$100 late fee and the appropriate renewal of license fee.

28.1(6) The duplicate or reissued license certificate or wallet card fee is \$20.

28.1(7) The fee for written verification of licensee status is \$20.

28.1(8) The returned check fee is \$25.

28.1(9) The disciplinary hearing fee is a maximum of \$75.

28.1(10) The paper application fee is \$25 plus the appropriate license fee.

28.1(11) Combined license.

a. For purposes of this subrule, “combined license” shall mean more than one active master, contractor, or journeyman license in one or multiple disciplines held by the same individual.

b. A license fee for a combined license shall be the sum total of each of the separate license fees as set forth in subrules 28.1(1) through 28.1(3) reduced by 30 percent.

c. In order to be eligible for the combined license fee reduction, all individual licenses must be purchased in a single transaction.

28.1(12) The fee for converting an HVAC-refrigeration or hydronics license to a mechanical license is \$50. This fee shall not apply at the time of reissue.

28.1(13) The fee for submitting a petition for eligibility determination as defined in 641—subrule 29.13(2) is \$25.

[Editorial change: IAC Supplement 2/25/09; **ARC 8529B**, IAB 2/24/10, effective 1/26/10; **ARC 9603B**, IAB 7/13/11, effective 6/21/11; **ARC 9847B**, IAB 11/16/11, effective 12/21/11; **ARC 0341C**, IAB 10/3/12, effective 11/7/12; **ARC 1299C**, IAB 2/5/14, effective 3/12/14; **ARC 3061C**, IAB 5/10/17, effective 6/14/17; **ARC 5762C**, IAB 7/14/21, effective 8/18/21]

641—28.2(105) Annual review of fee schedule. Within 60 days following the end of each fiscal year, the board shall submit a report to the general assembly that includes a balance sheet projection extending no less than three years. If the revenue projection exceeds the expense projections by more than 10 percent, the board shall adjust the fee schedules so that projected revenues are no more than 10 percent higher than projected expenses. Revised fees shall be implemented no later than January 1, 2013, and January 1 of each subsequent year.

[**ARC 9603B**, IAB 7/13/11, effective 6/21/11; **ARC 9847B**, IAB 11/16/11, effective 12/21/11; **ARC 5762C**, IAB 7/14/21, effective 8/18/21]

641—28.3(105) Waiver of fees. Fee waivers are available under the following circumstances:

a. The board shall waive any fee charged to an applicant for a license if the applicant’s household income does not exceed 200 percent of the federal poverty income guidelines and the applicant is applying for the license for the first time in this state.

b. For an applicant who has been honorably or generally discharged from federal active duty or national guard duty, the board shall waive an initial application fee and one renewal fee if those fees would otherwise be charged within five years of the discharge.

[**ARC 5762C**, IAB 7/14/21, effective 8/18/21; **ARC 6939C**, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code sections 105.9 and 272C.15.

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CHAPTER 35
PLUMBING AND MECHANICAL SYSTEMS BOARD—ALTERNATIVE LICENSURE
PATHWAYS

641—35.1(105) Definitions. For purposes of this chapter, the following definitions apply:

“*Board*” means the plumbing and mechanical systems board as established pursuant to Iowa Code section 105.3.

“*Full time*” means a minimum of 1,700 hours of work in a one-year period.

“*Issuing jurisdiction*” means the duly constituted authority in another state that has issued a professional license, certificate, or registration to a person.

“*Transferring jurisdiction*” means the specific issuing jurisdiction on which an applicant relies to seek licensure in Iowa by verification under this chapter.

[ARC 8533B, IAB 2/24/10, effective 1/26/10; ARC 5762C, IAB 7/14/21, effective 8/18/21]

641—35.2(105) Reciprocity agreements.

35.2(1) The board may enter into reciprocity agreements with other states that have plumbing, mechanical, HVAC-refrigeration, sheet metal, and hydronic licensing requirements similar to those set forth under Iowa law.

35.2(2) The board shall not enter into a reciprocity agreement with another state unless the other state grants the same reciprocity licensing privileges to residents of Iowa who have obtained Iowa plumbing, mechanical, HVAC-refrigeration, sheet metal, or hydronic licenses under Iowa Code chapter 105.

[ARC 8533B, IAB 2/24/10, effective 1/26/10; ARC 1224C, IAB 12/11/13, effective 1/15/14; ARC 5762C, IAB 7/14/21, effective 8/18/21]

641—35.3(105) Licensure by reciprocity. A nonresident of Iowa seeking a reciprocal license under Iowa Code chapter 105 shall apply on forms provided by the board.

35.3(1) *Reciprocity requirements.* The board may issue a reciprocal license if all of the following criteria are met:

- a. The applicant is a nonresident of Iowa;
 - b. The applicant possesses a valid plumbing, mechanical, HVAC-refrigeration, sheet metal, or hydronic license from an issuing jurisdiction with which the board has entered into a reciprocity agreement;
 - c. The applicant has paid the appropriate fee or fees required in 641—Chapter 28;
 - d. The applicant meets the minimum qualifications for licensure set forth in rule 641—29.4(105);
- and
- e. The applicant agrees to comply with all provisions of Iowa law and applicable administrative rules.

35.3(2) *Denial of reciprocal license.* The board may refuse to issue a reciprocal license to an applicant otherwise qualified based upon a suspension, revocation, or other disciplinary action taken against the applicant by a licensing authority in this or another jurisdiction. For purposes of this subrule, a “disciplinary action” includes the voluntary surrender of a license to resolve a pending disciplinary investigation or proceeding.

[ARC 8533B, IAB 2/24/10, effective 1/26/10; ARC 1224C, IAB 12/11/13, effective 1/15/14; ARC 5762C, IAB 7/14/21, effective 8/18/21]

641—35.4(105) Licensure by verification. Licensure by verification is available under the following circumstances.

35.4(1) *Eligibility.* A person may seek licensure by verification if all of the following criteria are satisfied:

- a. The person is licensed, certified, or registered in at least one other issuing jurisdiction;
- b. The scope of practice in the transferring jurisdiction is substantially similar to the scope of practice in Iowa;
- c. The person’s license, certification, or registration is in good standing in all issuing jurisdictions in which the person holds a license, certificate, or registration; and

- d.* The person either:
- (1) Establishes residency in the state of Iowa; or
 - (2) Is married to an active duty member of the military forces of the United States and is accompanying the member on an official permanent change of station.

35.4(2) Board application. The applicant must submit all of the following:

- a.* A completed application for licensure by verification.
- b.* Payment of the appropriate fee or fees required by 641—Chapter 28.
- c.* A verification form completed by the transferring jurisdiction, verifying that the applicant's license, certificate, or registration in that jurisdiction complies with the requirements of Iowa Code section 272C.12. The completed verification form must be sent directly from the transferring jurisdiction to the board.

d. Proof of residency in the state of Iowa or proof of military member's official permanent change of station. Proof of residency may include:

- (1) A residential mortgage, lease, or rental agreement;
- (2) A utility bill;
- (3) A bank statement;
- (4) A paycheck or pay stub;
- (5) A property tax statement;
- (6) A document issued by the federal or state government; or
- (7) Any other board-approved document that reliably confirms Iowa residency.

e. Proof of passing the applicable Iowa licensing examination.

f. Documentation of the applicant's complete criminal record in accordance with 641—paragraph 29.5(4) "c," including the applicant's personal statement regarding whether each offense directly relates to the practice of the profession.

g. Copies of any relevant disciplinary documents, if another issuing jurisdiction has taken disciplinary action against the applicant.

35.4(3) Applicants with prior discipline. If another issuing jurisdiction has taken disciplinary action against an applicant, the board will determine whether the cause for the disciplinary action has been corrected and the matter has been resolved. If the board determines the disciplinary matter has not been resolved, the board will neither issue a license nor deny the application for licensure until the matter is resolved. A person whose license was revoked, or a person who voluntarily surrendered a license, in another issuing jurisdiction is ineligible for licensure by verification.

35.4(4) Applicants with pending licensing complaints or investigations. If an Iowa applicant is concurrently subject to a complaint, allegation, or investigation relating to unprofessional conduct pending before any regulating entity in another issuing jurisdiction, the board will neither issue a license nor deny the application for licensure until the complaint, allegation, or investigation is resolved.

35.4(5) Temporary licenses. Applicants who satisfy all requirements for a license by verification under this rule, except for passing the applicable Iowa licensing examination, may be issued a temporary license that is valid for a period of three months and may be renewed once for an additional period of three months. The applicant must submit proof of passing the applicable Iowa licensing examination before the temporary license expires.

[ARC 5762C, IAB 7/14/21, effective 8/18/21; ARC 6939C, IAB 3/8/23, effective 4/12/23]

641—35.5(105) Licensure by work experience in jurisdictions without licensure requirements.

35.5(1) Work experience.

a. An applicant for initial licensure who has relocated to Iowa from another jurisdiction that did not require a license to practice the profession may be considered to have met the applicable educational and training requirements if the person has at least three years of full time work experience within the four years preceding the date of application for initial licensure. For each application submitted under this rule, the board will determine whether the applicant's prior work experience was substantially similar to the applicable apprenticeship training that is required for individuals licensed under 641—Chapter 29.

b. If the board determines an applicant's prior work experience was not substantially similar to the scope of practice in Iowa, the applicant may submit a subsequent application for licensure by work experience if all of the following criteria are satisfied:

(1) The applicant enrolls in an apprenticeship program approved by the United States Department of Labor;

(2) The applicant obtains a board-issued apprentice license; and

(3) The applicant successfully completes one year in the apprenticeship program.

c. The applicant must satisfy all other license requirements, including passing any required examinations, to receive a license.

35.5(2) Required documentation. An applicant seeking to substitute work experience in lieu of satisfying applicable education or training requirements bears the burden of providing all of the following by submitting relevant documents as part of a completed license application:

a. Proof of Iowa residency, which may include:

(1) A residential mortgage, lease, or rental agreement;

(2) A utility bill;

(3) A bank statement;

(4) A paycheck or pay stub;

(5) A property tax statement;

(6) A document issued by the federal or state government; or

(7) Any other board-approved document that reliably confirms Iowa residency.

b. Proof of three or more years of full time work experience within the four years preceding the application for Iowa licensure, which demonstrates that the work experience was substantially similar to an applicable apprenticeship program approved by the United States Department of Labor. Proof of work experience may include, but is not limited to:

(1) A letter from the applicant's prior employer or employers documenting the applicant's dates of employment and scope of practice;

(2) A paycheck or pay stub; or

(3) If the applicant was self-employed, business documents filed with the secretary of state or other applicable business registry or regulatory agency in the other jurisdiction.

c. Proof that the applicant's work experience involved a substantially similar scope of practice to the practice in Iowa, which must include:

(1) A written statement by the applicant detailing the scope of practice and stating how the work experience correlates to an applicable apprenticeship program approved by the United States Department of Labor; and

(2) Business or marketing materials detailing the services provided.

d. Proof that the other jurisdiction did not require a license to practice the profession, which may include:

(1) Copies of applicable laws;

(2) Materials from a website operated by a governmental entity in that jurisdiction; or

(3) Materials from a nationally recognized professional association applicable to the profession.

[ARC 5762C, IAB 7/14/21, effective 8/18/21]

These rules are intended to implement Iowa Code sections 105.21 and 272C.12.

[Filed Emergency After Notice ARC 8533B (Notice ARC 8365B, IAB 12/2/09), IAB 2/24/10, effective 1/26/10]

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PROFESSIONAL LICENSURE DIVISION[645]

Created within the Department of Public Health[641] by 1986 Iowa Acts, chapter 1245.
Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

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CHAPTER 5
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645—5.1(147,152D) Athletic training license fees. All fees are nonrefundable.

- 5.1(1) License fee for license to practice athletic training is \$120.
- 5.1(2) Temporary license fee for license to practice athletic training is \$120.
- 5.1(3) Biennial license renewal fee for each biennium is \$120.
- 5.1(4) Late fee for failure to renew before expiration is \$60.
- 5.1(5) Reactivation fee is \$180.
- 5.1(6) Duplicate or reissued license certificate fee is \$20.
- 5.1(7) Verification of license fee is \$20.
- 5.1(8) Returned check fee is \$25.
- 5.1(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapters 17A, 147, 152D and 272C.

[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.2(147,158) Barbering license fees. All fees are nonrefundable.

5.2(1) License fee for an initial license to practice barbering, license by endorsement, license by reciprocity or an instructor's license is \$60.

5.2(2) Biennial renewal fee for a barber license or barber instructor license is \$60.

5.2(3) Temporary permit fee is \$12.

5.2(4) Practical examination fee is \$75.

5.2(5) Demonstrator permit fee is \$45 for the first day and \$12 for each day thereafter for which the permit is valid.

5.2(6) Barber school license fee is \$600.

5.2(7) Barber school annual renewal fee is \$300.

5.2(8) Barbershop license fee is \$72.

5.2(9) Biennial renewal fee for a barbershop license is \$72.

5.2(10) Late fee for failure to renew before expiration is \$60.

5.2(11) Reactivation fee for a barber license is \$120.

5.2(12) Reactivation fee for a barbershop license is \$132.

5.2(13) Reactivation fee for a barber school license is \$360.

5.2(14) Duplicate or reissued license certificate fee is \$20.

5.2(15) Verification of license fee is \$20.

5.2(16) Returned check fee is \$25.

5.2(17) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.80 and Iowa Code chapter 158.

[ARC 8349B, IAB 12/2/09, effective 1/6/10; ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.3(147,154D) Behavioral science license fees. All fees are nonrefundable.

5.3(1) License fee for license to practice marital and family therapy or mental health counseling is \$120.

5.3(2) Temporary license fee for license to practice marital and family therapy or mental health counseling is \$120.

5.3(3) License fee for license to practice as a behavior analyst or assistant behavior analyst is \$120. Behavior analyst and assistant behavior analyst licenses issued for less than one year shall not be subject to a renewal fee for the first renewal.

5.3(4) Biennial license renewal fee for each biennium is \$120.

5.3(5) Late fee for failure to renew before expiration is \$60.

5.3(6) Reactivation fee is \$180.

5.3(7) Duplicate or reissued license certificate fee is \$20.

5.3(8) Verification of license fee is \$20.

5.3(9) Returned check fee is \$25.

5.3(10) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 154D and 272C.
[ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5751C, IAB 7/14/21, effective 8/18/21; ARC 6549C, IAB 10/5/22, effective 11/9/22]

645—5.4(151) Chiropractic license fees. All fees are nonrefundable.

- 5.4(1) License fee for license to practice chiropractic is \$270.
- 5.4(2) Fee for issuance of annual temporary certificate is \$120.
- 5.4(3) Biennial license renewal fee is \$120.
- 5.4(4) Late fee for failure to renew before the expiration date is \$60.
- 5.4(5) Reactivation fee is \$180.
- 5.4(6) Duplicate or reissued license certificate fee is \$20.
- 5.4(7) Fee for verification of license is \$20.
- 5.4(8) Returned check fee is \$25.
- 5.4(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapters 17A, 151 and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.5(147,157) Cosmetology arts and sciences license fees. All fees are nonrefundable.

- 5.5(1) License fee for license to practice cosmetology arts and sciences, license by endorsement, license by reciprocity, or an instructor's license is \$60.
- 5.5(2) Biennial license renewal fee for each license for each biennium is \$60.
- 5.5(3) Late fee for failure to renew before expiration is \$60.
- 5.5(4) Reactivation fee for applicants licensed to practice cosmetology is \$120; for salons, \$144; and for schools, \$330.
- 5.5(5) Duplicate or reissued license certificate fee is \$20.
- 5.5(6) Fee for verification of license is \$20.
- 5.5(7) Returned check fee is \$25.
- 5.5(8) Disciplinary hearing fee is a maximum of \$75.
- 5.5(9) Fee for license to conduct a school teaching cosmetology arts and sciences is \$600.
- 5.5(10) Fee for renewal of a school license is \$270 annually.
- 5.5(11) Salon license fee is \$84.
- 5.5(12) Biennial license renewal fee for each salon license for each biennium is \$84.
- 5.5(13) Demonstrator and not-for-profit temporary permit fee is \$42 for the first day and \$12 for each day thereafter that the permit is valid.
- 5.5(14) An initial fee or a reactivation fee for certification to administer microdermabrasion or utilize a certified laser product or an intense pulsed light (IPL) device is \$25 for each type of procedure or certified laser product or IPL device.
- 5.5(15) An initial fee or a reactivation fee for certification of cosmetologists to administer chemical peels is \$25.

This rule is intended to implement Iowa Code section 147.80 and chapter 157.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.6(147,152A) Dietetics license fees. All fees are nonrefundable.

- 5.6(1) License fee for license to practice dietetics, license by endorsement, or license by reciprocity is \$120.
- 5.6(2) Biennial license renewal fee for each biennium is \$120.
- 5.6(3) Late fee for failure to renew before expiration is \$60.
- 5.6(4) Reactivation fee is \$180.
- 5.6(5) Duplicate or reissued license certificate fee is \$20.
- 5.6(6) Verification of license fee is \$20.
- 5.6(7) Returned check fee is \$25.

5.6(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and Iowa Code chapters 17A, 152A and 272C.

[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.7(147,154A) Hearing aid specialists license fees. All fees are nonrefundable.

5.7(1) Application fee for a license to practice by examination, endorsement, or reciprocity is \$156.

5.7(2) Examination fee (check or money order made payable to the International Hearing Society) is \$95.

5.7(3) Renewal of license fee is \$60.

5.7(4) Temporary permit fee is \$42.

5.7(5) Late fee is \$60.

5.7(6) Reactivation fee is \$120.

5.7(7) Duplicate or reissued license certificate fee is \$20.

5.7(8) Verification of license fee is \$20.

5.7(9) Returned check fee is \$25.

5.7(10) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapter 154A.

[ARC 2151C, IAB 9/16/15, effective 10/21/15; ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.8(147) Massage therapy license fees. All fees are nonrefundable.

5.8(1) License fee for license to practice massage therapy is \$120.

5.8(2) Biennial license renewal fee for each biennium is \$60.

5.8(3) Temporary license fee for up to one year is \$120.

5.8(4) Late fee for failure to renew before expiration is \$60.

5.8(5) Reactivation fee is \$120.

5.8(6) Duplicate or reissued license certificate fee is \$20.

5.8(7) Verification of license fee is \$20.

5.8(8) Returned check fee is \$25.

5.8(9) Disciplinary hearing fee is a maximum of \$75.

5.8(10) Initial application fee for approval of massage therapy education curriculum is \$120.

This rule is intended to implement Iowa Code chapters 17A, 147 and 272C.

[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.9(147,156) Mortuary science license fees. All fees are nonrefundable.

5.9(1) License fee for license to practice funeral directing is \$120.

5.9(2) Biennial funeral director's license renewal fee for each biennium is \$120.

5.9(3) Late fee for failure to renew before expiration is \$60.

5.9(4) Reactivation fee for a funeral director is \$180 and for a funeral establishment or cremation establishment is \$150.

5.9(5) Duplicate or reissued license certificate fee is \$20.

5.9(6) Verification of license fee is \$20.

5.9(7) Returned check fee is \$25.

5.9(8) Disciplinary hearing fee is a maximum of \$75.

5.9(9) Funeral establishment or cremation establishment fee is \$90.

5.9(10) Three-year renewal fee of funeral establishment or cremation establishment is \$90.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 156 and 272C.

[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.10(147,155) Nursing home administrators license fees. All fees are nonrefundable.

5.10(1) License fee for license to practice nursing home administration is \$120.

5.10(2) Biennial license renewal fee for each license for each biennium is \$60.

5.10(3) Late fee for failure to renew before expiration is \$60.

- 5.10(4) Reactivation fee is \$120.
- 5.10(5) Duplicate or reissued license certificate fee is \$20.
- 5.10(6) Verification of license fee is \$20.
- 5.10(7) Returned check fee is \$25.
- 5.10(8) Disciplinary hearing fee is a maximum of \$75.
- 5.10(9) Provisional license fee is \$120.

This rule is intended to implement Iowa Code section 147.80 and Iowa Code chapter 155.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.11(147,148B) Occupational therapy license fees. All fees are nonrefundable.

- 5.11(1) License fee for an OT or OTA license to practice occupational therapy is \$120.
- 5.11(2) Biennial license renewal fee to practice occupational therapy is \$60.
- 5.11(3) Biennial license renewal fee for an occupational therapy assistant is \$60.
- 5.11(4) Late fee for failure to renew before expiration is \$60.
- 5.11(5) Reactivation fee is \$120.
- 5.11(6) Duplicate or reissued license certificate fee is \$20.
- 5.11(7) Verification of license fee is \$20.
- 5.11(8) Returned check fee is \$25.
- 5.11(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148B and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.12(147,154) Optometry license fees. All fees are nonrefundable.

- 5.12(1) License fee for license to practice optometry, license by endorsement, or license by reciprocity is \$300.
- 5.12(2) Biennial license renewal fee for each biennium is \$144.
- 5.12(3) Late fee for failure to renew before expiration date is \$60.
- 5.12(4) Reactivation fee is \$204.
- 5.12(5) Duplicate or reissued license certificate fee is \$20.
- 5.12(6) Verification of license fee is \$20.
- 5.12(7) Returned check fee is \$25.
- 5.12(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapters 17A, 147, 154 and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.13(147,148A) Physical therapy license fees. All fees are nonrefundable.

- 5.13(1) License fee for license to practice physical therapy or as a physical therapist assistant is \$120.
- 5.13(2) Biennial license renewal fee for a physical therapist is \$60.
- 5.13(3) Biennial license renewal fee for a physical therapist assistant is \$60.
- 5.13(4) Late fee for failure to renew before expiration is \$60.
- 5.13(5) Reactivation fee is \$120.
- 5.13(6) Duplicate or reissued license certificate fee is \$20.
- 5.13(7) Verification of license fee is \$20.
- 5.13(8) Returned check fee is \$25.
- 5.13(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148A and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.14(148C) Physician assistants license fees. All fees are nonrefundable.

- 5.14(1) Application fee for a license is \$120.
- 5.14(2) Fee for a temporary license is \$120.
- 5.14(3) Renewal of license fee is \$120.

5.14(4) Late fee for failure to renew before expiration is \$60.

5.14(5) Reactivation fee is \$180.

5.14(6) Duplicate or reissued license certificate fee is \$20.

5.14(7) Fee for verification of license is \$20.

5.14(8) Returned check fee is \$25.

5.14(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148C and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.15(147,148F,149) Podiatry license fees. All fees are nonrefundable.

5.15(1) License fee for license to practice podiatry, license by endorsement, or license by reciprocity is \$400.

5.15(2) License fee for temporary license to practice podiatry is \$200.

5.15(3) The fee for a license to practice orthotics, prosthetics, or pedorthics received on or before July 1, 2015, shall be \$600. The fee for a license to practice orthotics, prosthetics, or pedorthics received after July 1, 2015, shall be \$400.

5.15(4) Biennial license renewal fee is \$400 for each biennium.

5.15(5) Reactivation fee is \$460.

5.15(6) Temporary license renewal fee is \$200.

5.15(7) Late fee for failure to renew before expiration is \$60.

5.15(8) Duplicate or reissued license certificate fee is \$20.

5.15(9) Verification of license fee is \$20.

5.15(10) Returned check fee is \$25.

5.15(11) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and Iowa Code chapters 17A, 148F, 149 and 272C.

[ARC 1192C, IAB 11/27/13, effective 1/1/14; ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.16(147,154B) Psychology license fees. All fees are nonrefundable.

5.16(1) License fee for license to practice psychology is \$120.

5.16(2) Biennial license renewal fee is \$170.

5.16(3) Late fee for failure to renew before expiration is \$60.

5.16(4) Reactivation fee is \$230.

5.16(5) Duplicate or reissued license certificate fee is \$20.

5.16(6) Verification of license fee is \$20.

5.16(7) Returned check fee is \$25.

5.16(8) Disciplinary hearing fee is a maximum of \$75.

5.16(9) Processing fee for exemption to licensure is \$60.

5.16(10) Certification fee for a health service provider is \$60.

5.16(11) Biennial renewal fee for certification as a certified health service provider in psychology is \$60.

5.16(12) Reactivation fee for certification as a certified health service provider in psychology is \$60.

5.16(13) Provisional license fee is \$120.

5.16(14) Provisional license renewal fee is \$120.

This rule is intended to implement Iowa Code section 147.80 and chapters 17A, 154B and 272C and 2014 Iowa Acts, chapter 1043.

[ARC 1834C, IAB 1/21/15, effective 2/25/15; ARC 5751C, IAB 7/14/21, effective 8/18/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—5.17(147,152B) Respiratory care license fees. All fees are nonrefundable.

5.17(1) Initial license fee.

a. The initial license fee for a respiratory care practitioner license is \$75, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

b. The initial license fee for a polysomnographic technologist license is \$75, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

c. The initial license fee for a respiratory care and polysomnography practitioner license is \$90, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

5.17(2) Biennial license renewal fee for each biennium.

a. The biennial license renewal fee for each biennium for a respiratory care practitioner license is \$75.

b. The biennial license renewal fee for each biennium for a polysomnographic technologist license is \$75.

c. The biennial license renewal fee for each biennium for a respiratory care and polysomnography practitioner license is \$90.

5.17(3) Late fee for failure to renew before expiration is \$60.

5.17(4) Reactivation fee.

a. The reactivation fee to practice respiratory care is \$135, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) if the license has been on inactive status for two or more years.

b. The reactivation fee to practice as a polysomnographic technologist is \$135, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) if the license has been on inactive status for two or more years.

c. The reactivation fee to practice respiratory care and polysomnography is \$150, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) if the license has been on inactive status for two or more years.

5.17(5) Duplicate or reissued license certificate fee is \$20.

5.17(6) Verification of license fee is \$20.

5.17(7) Returned check fee is \$25.

5.17(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and Iowa Code chapters 17A, 152B and 272C.

[ARC 2717C, IAB 9/14/16, effective 10/19/16; ARC 5751C, IAB 7/14/21, effective 8/18/21; ARC 6464C, IAB 8/10/22, effective 9/14/22]

645—5.18(147,154E) Sign language interpreters and transliterators license fees. All fees are nonrefundable.

5.18(1) License fee for license to practice interpreting or transliterating is \$120.

5.18(2) License fee for temporary license to practice interpreting or transliterating is \$120.

5.18(3) Biennial license renewal fee for each biennium is \$120.

5.18(4) Late fee for failure to renew before expiration is \$60.

5.18(5) Duplicate or reissued license certificate fee is \$20.

5.18(6) Verification of license fee is \$20.

5.18(7) Returned check fee is \$25.

5.18(8) Disciplinary hearing fee is a maximum of \$75.

5.18(9) Reactivation fee is \$180.

This rule is intended to implement Iowa Code chapters 17A, 147, 154E and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.19(147,154C) Social work license fees. All fees are nonrefundable.

5.19(1) License fee for license to practice social work is \$120.

5.19(2) Biennial license renewal fee for a license at the bachelor's level is \$72; at the master's level, \$120; and independent level, \$144.

5.19(3) Late fee for failure to renew before expiration is \$60.

5.19(4) Reactivation fee for the bachelor's level is \$132; for the master's level, \$180; and independent level, \$204.

5.19(5) Duplicate or reissued license certificate fee is \$20.

5.19(6) Verification of license fee is \$20.

5.19(7) Returned check fee is \$25.

5.19(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.80 and chapters 17A, 154C and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

645—5.20(147) Speech pathology and audiology license fees. All fees are nonrefundable.

5.20(1) License fee for license to practice speech pathology or audiology, temporary clinical license, license by endorsement, or license by reciprocity is \$120.

5.20(2) Biennial license renewal fee for each biennium is \$96.

5.20(3) Late fee for failure to renew before expiration is \$60.

5.20(4) Reactivation fee is \$156.

5.20(5) Duplicate or reissued license certificate fee is \$20.

5.20(6) Verification of license fee is \$20.

5.20(7) Returned check fee is \$25.

5.20(8) Disciplinary hearing fee is a maximum of \$75.

5.20(9) Temporary clinical license renewal fee is \$60.

5.20(10) Temporary permit fee is \$30.

This rule is intended to implement Iowa Code chapters 17A, 147 and 272C.
[ARC 5751C, IAB 7/14/21, effective 8/18/21]

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[Filed ARC 1192C (Notice ARC 0942C, IAB 8/7/13), IAB 11/27/13, effective 1/1/14]

[Filed ARC 1834C (Notice ARC 1730C, IAB 11/12/14), IAB 1/21/15, effective 2/25/15]

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[Filed ARC 4557C (Notice ARC 4389C, IAB 4/10/19), IAB 7/17/19, effective 8/21/19]

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[Filed ARC 6464C (Notice ARC 6180C, IAB 2/9/22), IAB 8/10/22, effective 9/14/22]

[Filed ARC 6549C (Notice ARC 6401C, IAB 7/13/22), IAB 10/5/22, effective 11/9/22]

[Filed ARC 6938C (Notice ARC 6769C, IAB 12/28/22), IAB 3/8/23, effective 4/12/23]

PSYCHOLOGISTS

CHAPTER 240	LICENSURE OF PSYCHOLOGISTS
CHAPTER 241	CONTINUING EDUCATION FOR PSYCHOLOGISTS
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CHAPTER 240
LICENSURE OF PSYCHOLOGISTS

645—240.1(154B) Definitions. For purposes of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*ASPPB*” means the Association of State and Provincial Psychology Boards.

“*Board*” means the board of psychology.

“*Certified health service provider in psychology*” means a person who works in a clinical setting, who is licensed to practice psychology and who has a doctoral degree in psychology. A person certified as a health service provider in psychology shall be deemed qualified to diagnose or evaluate mental illness and nervous disorders.

“*Clinical experience*” means the provision of health services in psychology by the applicant to individuals or groups of clients/patients. Clinical experience does not include teaching or research performed in an academic setting.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as a psychologist or health service provider in psychology in the state of Iowa.

“*License expiration date*” means June 30 of even-numbered years.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice psychology to an applicant who is or has been licensed in another jurisdiction.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of psychologists who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“*National examination*” means the Examination for Professional Practice in Psychology (EPPP).

“*Provisional license*” means a license issued to a person who is completing a predoctoral internship or postdoctoral residency under supervision in order to satisfy the requirements for licensure.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 645—240.14(17A,147,272C) by which an inactive license is restored to active status.

“*Reinstatement*” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

[ARC 9937B, IAB 12/28/11, effective 2/1/12; ARC 1834C, IAB 1/21/15, effective 2/25/15; ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.2(154B) Requirements for licensure. The following criteria shall apply to licensure:

240.2(1) An applicant shall complete a board-approved application packet. Application forms may be obtained from the board’s website at idph.iowa.gov/Licensure or directly from the board office. All

applications shall be sent to Board of Psychology, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075. The applicant may complete the application online at ibplicense.iowa.gov.

240.2(2) An applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

240.2(3) Each application shall be accompanied by the appropriate fees payable to the Board of Psychology. The fees are nonrefundable.

240.2(4) Except as otherwise stated in these rules, no application will be considered by the board until:

a. Official copies of academic transcripts sent directly from the school to the board of psychology have been received by the board; and

b. Satisfactory evidence of the candidate's qualifications has been supplied in writing on the prescribed forms by the candidate's supervisors.

240.2(5) An applicant shall successfully pass the national examination.

240.2(6) The applicant shall have the national examination score sent directly from the ASPPB to the board.

240.2(7) Incomplete applications that have been on file in the board office for more than two years without additional supporting documentation shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

[ARC 1029C, IAB 9/18/13, effective 10/23/13; ARC 5225C, IAB 10/7/20, effective 11/11/20]

645—240.3(154B) Educational qualifications. An applicant for licensure to practice as a psychologist shall possess a doctoral degree in psychology.

240.3(1) At the time of an applicant's graduation:

a. The program from which the doctoral degree in psychology is granted must be:

(1) Accredited by the American Psychological Association; or

(2) Accredited by the Canadian Psychological Association; or

(3) Designated by the ASPPB/National Register; or

b. The applicant must hold current board certification from the American Board of Professional Psychology; or

c. The applicant must possess a postdoctoral respecialization certificate from a program accredited by the American Psychological Association.

240.3(2) Foreign-trained psychologists who possess a doctoral degree in psychology and who do not meet the requirements of subrule 240.3(1) shall:

a. Provide an equivalency evaluation of their educational credentials by the National Register of Health Service Psychologists, 1200 New York Avenue NW, Suite 800, Washington, D.C. 20005, telephone (202)783-7663, website www.nationalregister.org, or by an evaluation service with membership in the National Association of Credential Evaluation Services at www.naces.org. A certified translation of documents submitted in a language other than English shall be provided. The candidate shall bear the expense of the curriculum evaluation and translation of application documents. The educational credentials must be equivalent to programs stated in subrule 240.3(1).

b. Submit evidence of meeting all other requirements for licensure stated in these rules.

c. Receive a final determination from the board regarding the application for licensure.

[ARC 9937B, IAB 12/28/11, effective 2/1/12; ARC 1029C, IAB 9/18/13, effective 10/23/13; ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.4(154B) Examination requirements. An applicant must pass the national examination to be eligible for licensure in Iowa.

240.4(1) To be eligible to take the national examination, the applicant shall:

a. Meet all requirements of subrules 240.2(1) to 240.2(3); and

b. Provide official copies of academic transcripts sent directly from the school to the board of psychology verifying completion of a doctoral degree in psychology in accordance with rule 645—240.3(154B).

240.4(2) Notification of an applicant’s eligibility for the examination shall be transmitted by the board office to the online examination portal of the ASPPB.

240.4(3) The EPPP passing score shall be utilized as the Iowa passing score.

240.4(4) The board of psychology shall provide examination results to the applicant.

[ARC 1029C, IAB 9/18/13, effective 10/23/13; ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.5(154B,147) Title designations.

240.5(1) Students who are enrolled in an education program that satisfies the requirements of subrule 240.3(1) and who are completing the predoctoral internship may be designated “psychology intern” or “intern in psychology.”

240.5(2) Applicants for licensure who have met educational requirements and who are completing the postdoctoral residency to be eligible for licensure may be designated “psychology resident,” “resident in psychology,” “psychology postdoctoral fellow,” or “postdoctoral fellow in psychology.” The designation of “resident” shall not be used except during a postdoctoral residency that meets the requirements of rule 645—240.6(154B).

240.5(3) Persons who possess provisional licenses shall add the designation “provisional license in psychology” following the “resident,” “intern,” or “fellow” designation.

240.5(4) A licensed psychologist who possesses a doctoral degree may use the prefix “Dr.” or “Doctor” but shall add after the person’s name the word “psychologist.”

[ARC 9937B, IAB 12/28/11, effective 2/1/12; ARC 1834C, IAB 1/21/15, effective 2/25/15; ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.6(154B) Postdoctoral residency.

240.6(1) The postdoctoral residency may begin after all academic requirements for the doctoral degree, including completion of the predoctoral internship, have been completed. The postdoctoral residency shall consist of a minimum of 1,500 hours that are completed in no less than ten months.

240.6(2) During the postdoctoral residency, the supervisee shall competently apply the principles of psychology under the supervision of a licensed psychologist who is actively licensed in the jurisdiction where the supervision occurs in accordance with the following:

a. The supervisee and supervisor shall complete a supervision plan using the form provided by the board. The supervision plan must be submitted to the board if the supervisee is applying for or utilizing a provisional license.

b. A supervisor shall not have more than three concurrent full-time supervisees or the equivalent in part-time supervisees. Full-time is defined as 40 hours per week.

c. The supervisee and supervisor shall meet individually in person or via videoconferencing during each week in which postdoctoral residency hours are accrued, for no less than a total of 45 hours during the postdoctoral residency. Group supervision hours cannot count toward the 45 hours of individual supervision required.

d. The supervisor shall provide supervision at all times, which means the supervisor shall be readily available on site, or via electronic or telephonic means, at all times when the supervisee is providing services so that the supervisee may contact the supervisor for advice, assistance, or instruction. A supervisor shall identify one or more licensed mental health providers who can be contacted for advice, assistance, or instruction during times in which the supervisor will not be readily available.

e. The supervisee and supervisor shall have a crisis plan in place any time the supervisee is providing services and the supervisor is not on site in the same physical setting as the supervisee.

f. The supervisor shall establish and maintain a level of supervisory contact consistent with established professional standards and be fully accountable in the event that professional, ethical or legal issues are raised.

g. The supervisor shall provide training that is appropriate to the functions to be performed. The supervisee shall have the background, training, and experience that is appropriate to the functions performed. The supervisor shall not permit the supervisee to engage in any psychological practice that the supervisor cannot perform competently.

h. The supervisor and supervisee shall ensure clients are informed regarding the supervisee's status and the sharing of information between the supervisee and supervisor.

i. The supervisor must have reasonable access to the clinical records corresponding to the work being supervised. The supervisor shall countersign all written reports, clinical records and clinical communications as "Reviewed and Approved" by the supervisor.

j. All services must be offered in the name of the supervisor. The supervisee and supervisor must ensure that the supervisee uses a title in accordance with rule 645—240.5(154B,147).

k. The fee schedule and receipt of payment shall remain the sole domain of the supervisor or employing agency.

l. The supervisor shall maintain an ongoing record of supervision that details the types of activities in which the supervisee is engaged, the level of the supervisee's competence in each, and the type and outcome of all procedures.

m. The supervisor is responsible for determining the competency of the work performed by the supervisee and must honestly and accurately complete the supervision report at the conclusion of providing supervision.

This rule is intended to implement Iowa Code section 154B.6.
[ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.7(154B) Certified health service provider in psychology.

240.7(1) *Requirements for the health service provider in psychology.* The applicant shall:

a. Verify at least one year of clinical experience in an organized health service training program that meets the requirements of subrule 240.7(2) and at least one year of clinical experience in a health service setting that meets the requirements for postdoctoral residency stated in rule 645—240.6(154B). Alternatively, an applicant may submit verification of current registration at the doctoral level by the National Register of Health Service Psychologists to verify completion of the required clinical experience.

b. Complete a board-approved application and submit supporting documentation. Application forms may be obtained from the board's website at idph.iowa.gov/Licensure or directly from the board office. All applications shall be sent to the Board of Psychology, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075. The applicant may complete the application online at ibplicense.iowa.gov. An applicant shall complete the application according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board. Incomplete applications that have been on file in the board office for more than two years without additional supporting documentation shall be:

(1) Considered invalid and shall be destroyed; or
(2) Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

c. Submit with the application the health service provider fee payable to the Board of Psychology. The fee is nonrefundable.

d. Renew the certificate biennially at the same time as the psychology license.

240.7(2) *Requirements of the organized health service training program.* Internship programs in professional psychology that are accredited by the American Psychological Association (APA) or the Canadian Psychological Association (CPA) or that hold membership in the Association of Psychology Postdoctoral and Internship Centers (APPIC) are deemed approved. Applicants completing an organized health service training program that is not accredited by the APA or the CPA, or is not APPIC-designated at the time the applicant completes the training shall cause documentation to be sent from the program to establish that the program:

a. Provides the intern with a planned, programmed sequence of training experiences.

b. Has a clearly designated doctoral-level staff psychologist who is responsible for the integrity and quality of the training program and is actively licensed by the board of psychology in the jurisdiction in which the program exists.

c. Has two or more doctoral-level psychologists on the staff who serve as supervisors, at least one of whom is actively licensed by the board of psychology in the jurisdiction in which the program exists.

d. Has supervision that is provided by staff members of the organized health service training program or by an affiliate of the organized health service training program who carries clinical responsibility for the cases being supervised. At least half of the internship supervision shall be provided by one or more doctoral-level psychologists.

e. Provides training in a range of psychological assessment and treatment activities conducted directly with recipients of psychological services.

f. Ensures that trainees have a minimum of 375 hours of direct patient contact.

g. Includes a minimum of two hours per week (regardless of whether the internship is completed in one year or two years) of regularly scheduled, formal, face-to-face individual supervision with the specific intent of dealing with psychological services rendered directly by the intern. There must also be at least two additional hours per week in learning activities such as case conferences involving a case in which the intern is actively involved, seminars dealing with clinical issues, cotherapy with a staff person including discussion, group supervision, and additional individual supervision.

h. Has training that is at the postclerkship, postpracticum, and postexternship level.

i. Has a minimum of two interns at the internship level of training during any period of training.

j. Designates for internship-level trainees titles such as “intern,” “resident,” “fellow,” or other designation of trainee status.

k. Has a written statement or brochure which describes the goals and content of the internship, states clear expectations for quantity and quality of trainees’ work and is made available to prospective interns.

l. Provides a minimum of 1500 hours of training experience that shall be completed in no less than 12 months within a 24-consecutive-month period.

[ARC 9937B, IAB 12/28/11, effective 2/1/12; ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.8(154B) Exemption to licensure. Psychologists residing outside the state of Iowa and intending to practice in Iowa under the provisions of Iowa Code section 154B.3(5) shall complete and submit the application for the exemption to licensure according to the instructions contained in the application.

240.8(1) Application forms may be obtained from the board’s website at idph.iowa.gov/Licensure or directly from the board office. All applications shall be sent to Board of Psychology, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075. The applicant may complete the application online at ibplicense.iowa.gov.

240.8(2) The applicant shall provide a summary of the intent to practice and a verification of the license in the applicant’s jurisdiction of residence, sent directly from the jurisdiction to the board office. Web-based verification may be substituted for verification direct from the jurisdiction’s board office if the verification provides:

- a.* Licensee’s name;
- b.* Date of initial licensure;
- c.* Current licensure status; and
- d.* Any disciplinary action taken against the license.

240.8(3) The application and supporting documentation shall be accompanied by the processing fee for the exemption to licensure pursuant to 645—Chapter 5. The fee is nonrefundable and shall be submitted payable to the Board of Psychology.

240.8(4) The exemption must be issued prior to practice in Iowa. The exemption shall be valid for 10 consecutive business days or not to exceed 15 business days in any 90-day period.

[ARC 5225C, IAB 10/7/20, effective 11/11/20]

645—240.9(154B) Psychologists' supervision of persons other than postdoctoral residents in a practice setting.

240.9(1) This rule applies when a psychologist is supervising individuals who are not licensed or who are provisionally licensed and completing the predoctoral internship. This rule does not apply to supervision of an individual completing a postdoctoral residency in accordance with rule 645—240.6(154B), regardless of whether the individual is provisionally licensed or not.

240.9(2) The supervising psychologist shall:

a. Be vested with administrative control over the functioning of assistants in order to maintain ultimate responsibility for the welfare of every client. When the employer is a person other than the supervising psychologist, the supervising psychologist must have direct input into administrative matters.

b. Have sufficient knowledge of all clients, including face-to-face contact when necessary, in order to plan effective service delivery procedures. The progress of the work shall be monitored through such means as will ensure that full legal and professional responsibility can be accepted by the supervisor for all services rendered. Supervisors shall also be available for emergency consultation and intervention.

c. Provide work assignments that shall be commensurate with the skills of the supervisee. All procedures shall be planned in consultation with the supervisor.

d. Work in the same physical setting as the supervisee, unless the supervisee is receiving formal training pursuant to the requirements for licensure as a psychologist. For supervisees working off site while receiving formal licensure training, ensure the off-site location has a licensed mental health provider or primary care provider on site whenever the supervisee is working for purposes of providing emergency consultation.

e. Make public announcement of services and fees; contact with laypersons or the professional community shall be offered only by or in the name of the supervising psychologist. Titles of unlicensed persons must clearly indicate their supervised status.

f. Provide specific information to clients when an unlicensed person delivers services to those clients, including disclosure of the unlicensed person's status and information regarding the person's qualifications and functions.

g. Inform clients of the possibility of periodic meetings with the supervising psychologist at the client's, the supervisee's or the supervisor's request.

h. Provide for setting and receipt of payment that shall remain the sole domain of the employing agency or supervising psychologist.

i. Establish and maintain a level of supervisory contact consistent with established professional standards, and be fully accountable in the event that professional, ethical or legal issues are raised.

j. Provide a detailed job description in which functions are designated at varying levels of difficulty, requiring increasing levels of training, skill and experience. This job description shall be made available to representatives of the board and service recipients upon request.

k. Be responsible for the planning, course, and outcome of the work. The conduct of supervision shall ensure the professional, ethical, and legal protection of the client and of the unlicensed persons.

l. Maintain an ongoing record of supervision that details the types of activities in which the unlicensed person is engaged, the level of competence in each, and the type and outcome of all procedures.

m. Countersign all written reports, clinical records and clinical communications as "Reviewed and Approved" by the supervising psychologist.

[ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 5777C, IAB 7/14/21, effective 8/18/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.10(147) Licensure by endorsement. An applicant who possesses a doctoral degree in psychology and has been a licensed psychologist at the doctoral level under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may license by endorsement any applicant from the District of Columbia or another state, territory, province, or foreign country who:

240.10(1) Submits to the board a completed application.

240.10(2) Pays the licensure fee.

240.10(3) Provides verification of license from the jurisdiction in which the applicant has most recently been licensed, and additional verifications if necessary to verify at least five years of an independent license as described in subrule 240.10(4), sent directly from the jurisdiction to the board office. The applicant must also disclose any public or pending complaints against the applicant in any other jurisdiction. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- a. Licensee's name;
- b. Date of initial licensure;
- c. Current licensure status; and
- d. Any disciplinary action taken against the license.

240.10(4) Provides verification of a current Certificate of Professional Qualification (CPQ) issued by the ASPPB, or verification of a doctoral degree in psychology and an independent license to practice psychology in another jurisdiction for at least five years with no disciplinary history. Except as stated in subrule 240.3(2), applicants providing certification or verification are deemed to have met the requirements stated in paragraphs 240.10(4) "a" and "b." The board may license by endorsement any other applicant who:

a. Provides the official EPPP score sent directly to the board from the ASPPB or verification of the EPPP score sent directly from the state of initial licensure. The recommended passing score established by the ASPPB shall be considered passing.

b. Shows evidence of licensure requirements that are substantially equivalent to those required in Iowa by one of the following means:

(1) Provides:

1. Official copies of academic transcripts that have been sent directly from the school; and
2. Satisfactory evidence of the applicant's qualifications in writing on the prescribed forms by the applicant's supervisors. If verification of professional experience is not available, the board may consider submission of documentation from the jurisdiction in which the applicant is currently licensed or equivalent documentation of supervision; or

(2) Has an official copy of one of the following certifications sent directly to the board from the certifying organization:

1. Current credentialing at the doctoral level as a health service provider in psychology by the National Register of Health Service Providers in Psychology.

2. Board certification by the American Board of Professional Psychology that was originally granted on or after January 1, 1983.

240.10(5) Licensure by verification. A person who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 645—19.1(272C).

[ARC 9937B, IAB 12/28/11, effective 2/1/12; ARC 1029C, IAB 9/18/13, effective 10/23/13; ARC 5225C, IAB 10/7/20, effective 11/11/20; ARC 5777C, IAB 7/14/21, effective 8/18/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.11(147) Licensure by reciprocal agreement. The board may enter into a reciprocal agreement with the District of Columbia or any state, territory, province or foreign country with equal or similar requirements for licensure in psychology.

645—240.12(154B) Requirements for provisional license.

240.12(1) Predoctoral internship. An applicant for a provisional license for purposes of completing a predoctoral internship shall provide the following:

- a. A completed provisional license application. Applications are obtained and submitted via the board's website at ibpllicense.iowa.gov.
- b. The provisional application fee payable to the Board of Psychology. The fee is nonrefundable.
- c. A copy of the applicant's acceptance letter for the predoctoral internship.
- d. Identification of the training director and the training director's contact information.

e. Evidence that the applicant is enrolled in an educational program that meets the requirements of rule 645—240.3(154B).

240.12(2) Postdoctoral residency. An applicant for a provisional license for purposes of completing a postdoctoral residency shall provide the following:

a. A completed provisional license application. Applications are obtained and submitted via the board's website at ibplicense.iowa.gov.

b. The provisional application fee payable to the Board of Psychology. The fee is nonrefundable.

c. Official copies of academic transcripts sent directly from the school establishing that the requirements stated in rule 645—240.3(154B) are met.

d. A completed supervision plan on the prescribed board form, signed by the applicant's supervisors. A change in supervisor or in the supervision plan requires submission of a new supervision plan on the prescribed board form.

240.12(3) Duration. The provisional license is effective for two years from the date of issuance. A provisional license issued for purposes of completing a predoctoral internship can be used for purposes of completing a postdoctoral residency until the provisional license expires. The provisional licensee shall submit a completed supervision plan on the prescribed board form, signed by the licensee's supervisors, prior to beginning the postdoctoral residency. A change in supervisor or in the supervision plan requires submission of a new supervision plan on the prescribed board form. A provisional license may be renewed one time for a period of two years upon submission of the following:

a. A provisional license renewal application;

b. A provisional license renewal fee; and

c. A current supervision plan as required in these rules.

This rule is intended to implement Iowa Code section 154B.6.

[ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.13(147) License renewal.

240.13(1) The biennial license renewal period for a license to practice psychology shall begin on July 1 of even-numbered years and end on June 30 of the next even-numbered year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

240.13(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal date two years later.

240.13(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—241.2(272C) and the mandatory reporting requirements of subrule 240.13(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

240.13(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting as required by Iowa Code section 232.69(3) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 240.13(4) "e."

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of training in dependent adult abuse identification and reporting as required by Iowa Code section 235B.16(5) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 240.13(4) "e."

c. The course(s) shall be the curriculum provided by the Iowa department of human services.

d. The licensee shall maintain written documentation for three years after mandatory training as identified in paragraphs 240.13(4) "a" to "c," including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in rule 645—4.14(272C).

f. The board may select licensees for audit of compliance with the requirements in paragraphs 240.13(4)“a” to “e.”

240.13(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

240.13(6) A person licensed to practice as a psychologist shall keep the person’s license certificate and renewal displayed in a conspicuous public place at the primary site of practice.

240.13(7) Late renewal.

a. The license shall become late when the license has not been renewed by the expiration date on the renewal. The licensee shall be assessed a late fee as specified in 645—subrule 5.16(3).

b. To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

240.13(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a psychologist or health service provider in psychology in Iowa until the license is reactivated. A licensee who practices as a psychologist or health service provider in psychology in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 9937B, IAB 12/28/11, effective 2/1/12; ARC 1834C, IAB 1/21/15, effective 2/25/15; ARC 5073C, IAB 7/1/20, effective 8/5/20; ARC 5777C, IAB 7/14/21, effective 8/18/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.14(147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

240.14(1) Submit a reactivation application on a form provided by the board.

240.14(2) Pay the reactivation fee that is due as specified in 645—Chapter 5.

240.14(3) Provide verification of the license from the jurisdiction in which the applicant has most recently been licensed sent directly from the jurisdiction to the board office. The applicant must also disclose any public or pending complaints against the applicant in any other jurisdiction. Web-based verification may be substituted for verification direct from the jurisdiction’s board office if the verification provides:

a. Licensee’s name;

b. Date of initial licensure;

c. Current licensure status; and

d. Any disciplinary action taken against the license.

240.14(4) Provide verification of a current active license in another jurisdiction at the time of application or verification of completion of continuing education taken within two years of the application. If the license has been inactive for less than five years, the applicant must submit verification of 40 hours of continuing education, and if the license has been inactive for more than five years, the applicant must submit verification of 80 hours of continuing education.

This rule is intended to implement Iowa Code section 147.11.

[ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—240.15(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—240.14(17A,147,272C) prior to practicing as a psychologist or health service provider in psychology in this state.
[ARC 1834C, IAB 1/21/15, effective 2/25/15]

These rules are intended to implement Iowa Code chapters 17A, 147, and 272C.

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[Filed ARC 6938C (Notice ARC 6769C, IAB 12/28/22), IAB 3/8/23, effective 4/12/23]

[◇] Two or more ARCs

CHAPTER 241
CONTINUING EDUCATION FOR PSYCHOLOGISTS

645—241.1(272C) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Approved program/activity*” means a continuing education program/activity meeting the standards set forth in these rules.

“*Audit*” means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

“*Board*” means the board of psychology.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensee’s knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Independent study*” means a subject/program/activity that a person pursues autonomously that meets standards for approval criteria in the rules and includes a posttest.

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice independently as a psychologist in the state of Iowa and does not include persons with provisional licenses.

“*Practice of psychology*” means the application of established principles of learning, motivation, perception, thinking, psychophysiology and emotional relations to problems, behavior, group relations, and biobehavior by persons trained in psychology for compensation or other personal gain. The application of principles includes, but is not limited to, counseling and the use of psychological remedial measures with persons, in groups or individually, with adjustment or emotional problems in the areas of work, family, school and personal relationships. The practice of psychology also means measuring and testing personality, mood-motivation, intelligence/aptitudes, attitudes/public opinion, and skills; the teaching of such subject matter; and the conducting of research on the problems relating to human behavior.

[ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—241.2(272C) Continuing education requirements.

241.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on July 1 of even-numbered years and ending on June 30 of even-numbered years. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 40 hours of continuing education approved by the board.

241.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 40 hours of continuing education per biennium for each subsequent license renewal.

241.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

241.2(4) No hours of continuing education shall be carried over into the next biennium except as stated for the second renewal. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

241.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

241.2(6) No hours of continuing education are required to renew a provisional license.
 [ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—241.3(154B,272C) Standards.

241.3(1) General criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program.

At the time of audit, the board may request the qualifications of presenters;

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

- (1) Date, location, course title, presenter(s);
- (2) Number of program contact hours; and
- (3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

241.3(2) Specific criteria.

a. For the second license renewal, licensees shall obtain 6 hours of continuing education pertaining to the practice of psychology in either of the following areas: Iowa mental health laws and regulations, or risk management.

b. For all renewal periods following the second license renewal, licensees shall obtain 6 hours of continuing education pertaining to the practice of psychology in any of the following areas: ethical issues, federal mental health laws and regulations, Iowa mental health laws and regulations, or risk management. For all board members, a maximum of 2 of these hours may be obtained by providing service as a member of the board as follows:

- (1) One hour of credit for attendance and participation at a minimum of three regular quarterly board meetings during the license biennium, or
- (2) Two hours of credit for attendance and participation at a minimum of six regular quarterly board meetings during the license biennium.

c. A licensee may obtain the remainder of continuing education hours of credit by:

- (1) Completing training to comply with mandatory reporter training requirements, as specified in 645—subrule 240.13(4). Hours reported for credit shall not exceed the hours required to maintain compliance with required training.

- (2) Attending programs/activities that are sponsored by the American Psychological Association or the Iowa Psychological Association.

- (3) Attending workshops, conferences, or symposiums that meet the criteria in subrule 241.3(1).

- (4) Completing academic coursework that meets the criteria set forth in these rules. Continuing education credit equivalents are as follows:

1 academic semester hour = 15 continuing education hours

1 academic quarter hour = 10 continuing education hours

- (5) Completing home study courses for which a certificate of completion is issued.

- (6) Completing electronically transmitted courses for which a certificate of completion is issued.

- (7) Conducting scholarly research, the results of which are published in a recognized professional publication. In order to claim such credit, the licensee must attest to the hours actually spent conducting research, demonstrate that the research is integrally related to the practice of psychology, explain how the research advances the licensee's knowledge in the field, and provide the published work.

- (8) Preparing new courses on material that is integrally related to the practice of psychology and is beyond entry level. In order to claim such credit, the licensee must: attest that the licensee has not taught the course in the past or that the licensee has not substantially altered the course content; request a specific amount of continuing education credit; describe how the course is integrally related to the practice of the

profession and advances the licensee's knowledge in the field; and supply a course syllabus that supports the licensee's request for credit.

(9) Presenting to other professionals. A licensee may receive credit on a one-time basis for presenting continuing education programs that meet the criteria of subrule 241.3(1). Two hours of credit will be awarded for each hour of presentation.

d. A combined maximum of 30 hours of credit per biennium may be used for scholarly research, preparation of new courses, and presentations to other professionals.

[ARC 1029C, IAB 9/18/13, effective 10/23/13; ARC 1834C, IAB 1/21/15, effective 2/25/15; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—241.4(154B,272C) Audit of continuing education report. Rescinded IAB 9/24/08, effective 10/29/08.

645—241.5(154B,272C) Automatic exemption. Rescinded IAB 9/24/08, effective 10/29/08.

645—241.6(154B,272C) Continuing education exemption for disability or illness. Rescinded IAB 9/24/08, effective 10/29/08.

645—241.7(154B,272C) Grounds for disciplinary action. Rescinded IAB 9/24/08, effective 10/29/08.

645—241.8(272C) Continuing education waiver for disability or illness. Rescinded IAB 8/31/05, effective 10/5/05.

645—241.9(272C) Reinstatement of inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—241.10(272C) Hearings. Rescinded IAB 8/31/05, effective 10/5/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 154B.

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[Filed ARC 6938C (Notice ARC 6769C, IAB 12/28/22), IAB 3/8/23, effective 4/12/23]

[◇] Two or more ARCs

CHAPTER 242
DISCIPLINE FOR PSYCHOLOGISTS
[Prior to 7/11/01, see 645—Chapter 240]

645—242.1(154B) Definitions.

“*Board*” means the board of psychology.

“*Discipline*” means any sanction the board may impose upon licensees.

“*Licensee*” means a person licensed to practice psychology in Iowa.

645—242.2(147,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—242.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

242.2(1) Failure to comply with the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association, as published in the December 2002 edition of American Psychologist and including amendments effective January 1, 2017, hereby adopted by reference. Copies of the Ethical Principles of Psychologists and Code of Conduct may be obtained from the American Psychological Association’s website at www.apa.org.

242.2(2) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice in this state, which includes the following:

a. False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state; or

b. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

242.2(3) Professional incompetence. Professional incompetence includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other psychologists in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average psychologist acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of a licensed psychologist in this state.

e. Mental or physical inability reasonably related to and adversely affecting the licensee’s ability to practice in a safe and component manner.

f. Being adjudged mentally incompetent by a court of competent jurisdiction.

242.2(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of psychology or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

242.2(5) Practice outside the scope of the profession.

242.2(6) Use of untruthful or improbable statements in advertisements.

242.2(7) Habitual intoxication or addiction to the use of drugs.

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee’s ability to practice with reasonable skill or safety.

242.2(8) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

242.2(9) Falsification, alteration or destruction of client or patient records with the intent to deceive.

242.2(10) Acceptance of any fee by fraud or misrepresentation.

242.2(11) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care, including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

242.2(12) Being convicted of an offense that directly relates to the duties and responsibilities of the profession. A conviction includes a guilty plea, including Alford and nolo contendere pleas, or a finding or verdict of guilt, even if the adjudication of guilt is deferred, withheld, or not entered. A copy of the guilty plea or order of conviction constitutes conclusive evidence of conviction. An offense directly relates to the duties and responsibilities of the profession if the actions taken in furtherance of the offense are actions customarily performed within the scope of practice of the profession or the circumstances under which the offense was committed are circumstances customary to the profession.

242.2(13) Violation of a regulation, rule, or law of this state, another state, or the United States, which relates to the practice of psychology.

242.2(14) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory or country; or failure of the licensee to report such action within 30 days of the final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report shall be expunged from the records of the board.

242.2(15) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the individual's practice of psychology in another state, district, territory or country.

242.2(16) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

242.2(17) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

242.2(18) Engaging in any conduct that subverts or attempts to subvert a board investigation.

242.2(19) Failure to comply with a subpoena issued by the board or failure to cooperate with an investigation of the board.

242.2(20) Failure to respond within 30 days of receipt of communication from the board which was sent by registered or certified mail.

242.2(21) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

242.2(22) Failure to pay costs assessed in any disciplinary action.

242.2(23) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

242.2(24) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

242.2(25) Knowingly aiding, assisting, or advising a person to unlawfully practice psychology.

242.2(26) Failure to report a change of name or address within 30 days after it occurs. Name and address changes may be reported on the form provided by the board at: hhs.iowa.gov/licensure.

242.2(27) Representing oneself as a licensed psychologist when one's license has been suspended or revoked, or when one's license is on inactive status.

242.2(28) Permitting another person to use the licensee's license for any purpose.

242.2(29) Permitting an unlicensed employee or person under the licensee's control to perform activities that require a license to practice psychology.

242.2(30) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but is not limited to, the following:

- a. Verbally or physically abusing a patient or client.
- b. Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.
- c. Betrayal of a professional confidence.

d. Engaging in a professional conflict of interest.

242.2(31) Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

242.2(32) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[ARC 9945B, IAB 12/28/11, effective 2/1/12; ARC 5777C, IAB 7/14/21, effective 8/18/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—242.3(147,272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the licensee's engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed \$1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—242.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care for the citizens of this state;
2. The facts of the particular violation;
3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;
6. Whether remedial action has been taken; and
7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

These rules are intended to implement Iowa Code chapters 147, 154B and 272C.

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CHAPTER 243
PRACTICE OF PSYCHOLOGY

645—243.1(154B) Definitions.

“*APA*” means the American Psychological Association.

“*Clinical records*” means records created by a licensee regarding the observation and treatment of patients, such as progress notes, but does not include psychotherapy notes.

“*Examinee*” means a person who is the subject of a forensic examination for the purpose of informing a decision maker or attorney about the psychological functioning of that examinee.

“*HIPAA*” means the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder.

“*Licensee*” or “*licensed*” means an individual with an active license to practice psychology, including a provisional license, or a certificate of exemption issued by the board.

“*Patient*” means an individual under the care of a licensee in a clinical role and is synonymous with the term client.

“*Personal representative*” means a person authorized to act on behalf of the patient in making health care-related decisions. A personal representative may include a parent or legal guardian, an individual with a health care power of attorney, an individual with a general power of attorney or durable power of attorney that includes the power to make health care decisions, or a court-appointed legal guardian.

“*Psychotherapy notes*” means notes recorded by a licensee documenting or analyzing the contents of a conversation during a private therapy session with a patient, or a group, joint, or family therapy session, that are maintained separately from the patient’s clinical records. Psychotherapy notes excludes medication prescription monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of any clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

“*Telepsychology*” means the provision of psychological services using telecommunication technologies.

“*Test data*” means raw and scaled scores, patient responses to test questions or stimuli, and notes and recordings concerning patient statements and behavior during an examination.

“*Test materials*” means the test questions, scoring keys, protocols, and manuals that do not include personally identifying information about the subject of the test.

[ARC 5905C, IAB 9/8/21, effective 10/13/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—243.2(147,154B,272C) Purpose and scope. The purpose of this chapter is to set the minimum standards of practice for licensees practicing in Iowa. The practice of psychology is occurring in Iowa if the patient or examinee is located in Iowa. Licensees shall ensure any interns or residents under supervision adhere to the minimum standards of practice and must comply with the requirements set forth in rule 645—240.9(154B). The APA Code of Ethics is applicable and enforceable to the extent it does not conflict with any standards of practice set forth in this chapter. A licensee may be disciplined for any violation of this chapter or the APA Code of Ethics.

[ARC 5905C, IAB 9/8/21, effective 10/13/21]

645—243.3(154B) Access to records.

243.3(1) *Clinical records generally.* Upon a signed release from the patient or the patient’s personal representative, a licensee shall provide clinical records in accordance with the release unless there is a ground for denial under HIPAA.

243.3(2) *Psychotherapy notes.* A licensee is not required to release psychotherapy notes in response to a signed release, but a licensee who chooses to release psychotherapy notes may only provide psychotherapy notes if the signed release specifically authorizes the release of psychotherapy notes.

243.3(3) *Substance use disorder treatment programs.* Licensees who practice in a federally assisted substance use disorder treatment program, also known as a part 2 program, are prohibited from disclosing any information that would identify a patient as having a substance use disorder unless the patient provides written consent in compliance with part 2 requirements.

243.3(4) *Clinical records of minor patients.* A minor patient is a patient who is under the age of 18 and is not emancipated. A licensee is not required to release the clinical records of a minor patient to the minor's personal representative if releasing such records is not in the minor's best interest. When a minor patient reaches the age of 18, the clinical records belong to the patient.

243.3(5) *Clinical records of deceased patients.* A licensee shall provide the clinical records of a deceased patient to the deceased patient's executor upon a written request accompanied by a copy of the patient's death certificate and a copy of the legal document identifying the requestor as the patient's executor.

243.3(6) *Forensic records.* A licensee shall provide forensic records consistent with the APA Specialty Guidelines for Forensic Psychology.

243.3(7) *Board.* A licensee shall provide clinical records, test data, or forensic records to the board as requested during the investigation of a complaint. A licensee is not required to obtain a patient release to send such information to the board because the board is a health oversight agency.

243.3(8) *Exceptions.* Nothing herein shall be construed as requiring a licensee to disclose information when there is a legal basis for not disclosing the information.

[ARC 5905C, IAB 9/8/21, effective 10/13/21]

645—243.4(154B) Psychological testing. A licensee may administer psychological tests and assessments to a patient or examinee provided the licensee has appropriate training for any psychological test or assessment utilized and the test or assessment is scientifically founded.

243.4(1) *Use of proctors.* A licensee may delegate the administration of a standardized test, intelligence test, or objective personality assessment to an appropriately trained individual. The licensee is responsible for supervising any proctors.

243.4(2) *Release of test data.* A licensee shall not provide test data to any person, except that upon a written request of a patient or examinee who is the subject of a test, the test data shall be disclosed to a licensed psychologist designated by the patient or examinee. A psychologist who receives test data in this manner may not further disseminate the test data.

243.4(3) *Release of test materials.* A licensee shall not disclose test materials to any person, except for another licensed psychologist who has been designated in writing by the subject of a psychological test to receive the records associated with the psychological testing of the subject. A licensee shall not disclose test materials in any administrative, judicial, or legislative proceeding.

[ARC 5905C, IAB 9/8/21, effective 10/13/21; ARC 6938C, IAB 3/8/23, effective 4/12/23]

645—243.5(154B) Judicial proceedings. Prior to participating in a judicial proceeding, a licensee shall become familiar with the rules governing the proceeding. A licensee shall understand and clearly identify the licensee's role in the proceeding.

243.5(1) *Licensure.* A license to practice psychology in Iowa or an exemption from licensure is not required solely to testify as an expert witness in court, provided the psychologist did not personally examine the examinee. A psychologist who personally examines an examinee located in Iowa for the purpose of providing an expert opinion is required to be licensed or exempt from licensure at the time of the evaluation.

243.5(2) *Custody evaluations.* A licensee who performs a child custody evaluation shall comply with the APA Guidelines for Child Custody Evaluations in Family Law Proceedings.

[ARC 5905C, IAB 9/8/21, effective 10/13/21]

645—243.6(147,154B,272C) Reports required. Within 30 days, a licensee shall report to the board the following:

243.6(1) A change of name or address. Name and address changes may be reported at www.idph.iowa.gov/Licensure.

243.6(2) A criminal conviction, even if the adjudication of guilt is deferred, withheld, or not entered. A conviction includes Alford pleas and pleas of nolo contendere.

243.6(3) Any disciplinary action taken by another licensing authority in this state, another state, territory, or country.

243.6(4) Any occurrence of any judgment or settlement of a malpractice claim or action.

243.6(5) Acts or omissions of the board's statute or administrative rules committed by another person licensed to practice by the board when a licensee has first-hand knowledge of such acts or omissions. This duty to report does not apply when a licensee has knowledge as a result of the other licensee being a patient.

[ARC 5905C, IAB 9/8/21, effective 10/13/21]

645—243.7(154B) Telepsychology. A psychologist may practice telepsychology provided the following are met:

243.7(1) The psychologist must be licensed or be exempt from licensure in the jurisdiction where the patient or examinee is located.

243.7(2) Prior to initiating telepsychology with a new patient or examinee, a licensee shall take reasonable steps to verify the identity and location of the patient or examinee.

243.7(3) A licensee shall ensure informed consent for telepsychology includes a description of any limitations of services as a result of the technology utilized.

243.7(4) A licensee shall gain competency in the use of a particular technology prior to utilizing it in practice. A licensee shall only use technologies that are secure and functioning properly.

243.7(5) A licensee shall apply the same ethical and professional standards of care and professional practice that are required when providing in-person psychological services. If the same standard of care cannot be met with telepsychology, a licensee shall not utilize telepsychology.

[ARC 5905C, IAB 9/8/21, effective 10/13/21]

645—243.8(154B) Records. A licensee shall complete clinical records as soon as practicable to ensure continuity of services. All clinical records shall be completed within 30 days after the service or evaluation is complete in the absence of significant extenuating circumstances. Clinical records and psychotherapy notes shall be retained for at least seven years after the last date of service, or until at least three years after a minor reaches the age of 18, whichever is later. Forensic records shall be completed and retained consistent with the APA Specialty Guidelines for Forensic Psychology.

[ARC 5905C, IAB 9/8/21, effective 10/13/21]

These rules are intended to implement Iowa Code chapters 147, 154B, and 272C.

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CHAPTER 11
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[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—11.1(147,153) Applicant responsibilities. An applicant for dental or dental hygiene licensure or dental assistant registration bears full responsibility for each of the following:

1. Paying all fees charged by regulatory authorities, national testing or credentialing organizations, health facilities, and educational institutions providing the information required to complete a license, registration or permit application;

2. Providing accurate, up-to-date, and truthful information on the application form including, but not limited to, prior professional experience, education, training, examination scores, and disciplinary history; and

3. Submitting complete application materials. An application for a license, permit, or registration or reinstatement of a license or registration will be considered active for 180 days from the date the application is received. For purposes of establishing timely filing, the postmark on a paper submittal will be used, and for applications submitted online, the electronic timestamp will be deemed the date of filing. If the applicant does not submit all materials, including a completed fingerprint packet, within this time period or if the applicant does not meet the requirements for the license, permit, registration or reinstatement, the application shall be considered incomplete. An applicant whose application is filed incomplete must submit a new application and application fee.

This rule is intended to implement Iowa Code sections 147.2 and 153.39.

[ARC 9218B, IAB 11/3/10, effective 12/8/10; ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 6673C, IAB 11/16/22, effective 12/21/22]

650—11.2(147,153) Dental licensure by examination.

11.2(1) Applications for licensure by examination to practice dentistry in this state shall be made on the form provided by the board and must be completely answered, including required credentials and documents. An applicant who has held a dental license issued in another state for one year or longer must apply for licensure by credentials pursuant to rule 650—11.3(153).

11.2(2) Applications for licensure must be filed with the board along with:

a. *Documentation of graduation from dental college.* Satisfactory evidence of graduation with a DDS or DMD from an accredited dental college approved by the board or satisfactory evidence of meeting the requirements specified in rule 650—11.4(153).

b. *Certification of good standing from dean or designee.* Certification by the dean or other authorized representative of the dental school that the applicant has been a student in good standing while attending that dental school.

c. *Documentation of passage of national dental examination.* Evidence of successful passage of the examination administered by the Joint Commission on National Dental Examinations.

d. *Documentation of passage of a clinical examination.* Successful passage of a board-approved clinical examination within the previous five-year period.

(1) The following patient-based regional clinical examinations are approved by the board for purposes of licensure by examination: the Central Regional Dental Testing Service, Inc. examination as administered by the Central Regional Dental Testing Service, Inc. (CRDTS), the Western Regional Examining Board examination as administered by the Western Regional Examining Board (WREB), the Southern Regional Testing Agency, Inc. examination as administered by the Southern Regional Testing Agency, Inc. (SRTA), and the American Board of Dental Examiners, Inc. examination as administered by the Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies, Inc. (CITA).

(2) The following manikin-based regional clinical examinations are approved by the board for purposes of licensure by examination: the Central Regional Dental Testing Service, Inc. examination as administered by the Central Regional Dental Testing Service, Inc. (CRDTS), and the American Board of Dental Examiners, Inc. examination as administered by the Commission on Dental Competency Assessments (CDCA).

(3) Beginning January 1, 2018, the 2014 California portfolio examination is approved by the board for the purposes of licensure by examination. To be eligible for licensure on the basis of portfolio examination, an applicant must be a student at the University of Iowa College of Dentistry or have graduated from the University of Iowa College of Dentistry within one year of the date of application.

e. Explanation of any legal or administrative actions. A statement disclosing and explaining any disciplinary actions, investigations, complaints, malpractice claims, judgments, settlements, or criminal charges.

f. Payment of application, fingerprint and background check fees. The nonrefundable application fee, plus the fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), as specified in 650—Chapter 15.

g. Documentation of passage of jurisprudence examination. Evidence of successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.

h. Current CPR certification. A statement:

(1) Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;

(2) Providing the expiration date of the CPR certificate; and

(3) Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

i. Completed fingerprint packet. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

11.2(3) The board may require a personal appearance or any additional information relating to the character, education and experience of the applicant.

11.2(4) Applications must be signed and verified as to the truth of the statements contained therein.

This rule is intended to implement Iowa Code sections 147.3, 147.29, and 147.34.

[ARC 9218B, IAB 11/3/10, effective 12/8/10; ARC 9510B, IAB 5/18/11, effective 6/22/11; ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2870C, IAB 12/21/16, effective 1/25/17; ARC 3488C, IAB 12/6/17, effective 1/10/18; ARC 5366C, IAB 12/30/20, effective 2/3/21]

650—11.3(153) Dental licensure by credentials.

11.3(1) Applications for licensure by credentials to practice dentistry in this state shall be made on the form provided by the board and must be completely answered, including required credentials and documents.

11.3(2) Applications must be filed with the board along with:

a. Satisfactory evidence of graduation with a DDS or DMD from an accredited dental college approved by the board or satisfactory evidence of meeting the requirements specified in rule 650—11.4(153).

b. Evidence of successful passage of the Joint Commission on National Dental Examinations. Any dentist who has lawfully practiced dentistry in another state or territory for five years may be exempted from presenting this evidence.

c. A statement of any dental examinations taken by the applicant, with indication of pass/fail for each examination taken. Any dentist who has lawfully practiced dentistry in another state or territory for five or more years may be exempted from presenting this evidence.

d. Evidence of a current, valid license to practice dentistry in another state, territory or district of the United States issued under requirements equivalent or substantially equivalent to those of this state.

e. Evidence that the applicant has met at least one of the following:

(1) Has less than three consecutive years of practice immediately prior to the filing of the application and evidence of successful passage of a board-approved clinical examination pursuant to subrule 11.2(2) within the previous five-year period; or

(2) Has for three consecutive years immediately prior to the filing of the application been in the lawful practice of dentistry in such other state, territory or district of the United States.

f. Evidence from the state board of dentistry, or equivalent authority, from each state in which applicant has been licensed to practice dentistry, that the applicant has not been the subject of final or pending disciplinary action.

g. A statement disclosing and explaining any disciplinary actions, investigations, malpractice claims, complaints, judgments, settlements, or criminal charges, including the results of a self-query of the National Practitioner Data Bank (NPDB).

h. The nonrefundable application fee for licensure by credentials, plus the fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), as specified in 650—Chapter 15.

i. Current CPR certification. A statement:

(1) Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;

(2) Providing the expiration date of the CPR certificate; and

(3) Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

j. Evidence of successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.

k. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

11.3(3) The board may require a personal appearance or may require any additional information relating to the character, education, and experience of the applicant.

11.3(4) The board may also require such examinations as may be necessary to evaluate the applicant for licensure by credentials.

11.3(5) Applications must be signed and verified attesting to the truth of the statements contained therein.

11.3(6) A dentist who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by credentials may apply for licensure by verification, if eligible, in accordance with rule 650—11.12(272C).

This rule is intended to implement Iowa Code chapters 147 and 153.

[**ARC 9218B**, IAB 11/3/10, effective 12/8/10; **ARC 0265C**, IAB 8/8/12, effective 9/12/12; **ARC 2870C**, IAB 12/21/16, effective 1/25/17; **ARC 3488C**, IAB 12/6/17, effective 1/10/18; **ARC 5366C**, IAB 12/30/20, effective 2/3/21; **ARC 5747C**, IAB 7/14/21, effective 8/18/21]

650—11.4(153) Graduates of foreign dental schools. In addition to meeting the other requirements for licensure specified in rule 650—11.2(147,153) or 650—11.3(153), an applicant for dental licensure who did not graduate with a DDS or DMD from an accredited dental college approved by the board must provide satisfactory evidence of meeting the following requirements.

11.4(1) The applicant must complete a full-time dental education program at an accredited dental college. The program must consist of either:

a. An undergraduate supplemental dental education program of at least two academic years. The undergraduate supplemental dental education program must provide didactic and clinical education to the level of a DDS or DMD graduate of the accredited dental college; or

b. A postgraduate general practice residency program of at least one academic year.

11.4(2) The applicant must receive a dental diploma, degree or certificate from the accredited dental college upon successful completion of the program.

11.4(3) The applicant must present to the board the following documents:

a. Satisfactory evidence of completion of board-approved dental education at an accredited dental college;

b. A final, official transcript verifying graduation from the foreign dental school at which the applicant originally obtained a dental degree. If the transcript is written in a language other than English, an original, official translation shall also be submitted; and

c. Verification from the appropriate governmental authority that the applicant was licensed or otherwise authorized by law to practice dentistry in the country in which the applicant received foreign dental school training and that no adverse action was taken against the license.

11.4(4) The applicant must demonstrate to the satisfaction of the board an ability to read, write, speak, understand, and be understood in the English language. The applicant may demonstrate English proficiency by submitting to the board evidence of achieving a score sufficient to be rated in the highest level of ability on each section of the Test of English as a Foreign Language (TOEFL) as administered by the Educational Testing Service (ETS).

11.4(5) A dentist who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure in this rule may apply for licensure by verification, if eligible, in accordance with rule 650—11.12(272C).

This rule is intended to implement Iowa Code chapters 147 and 153.
[ARC 3961C, IAB 8/15/18, effective 9/19/18; ARC 5747C, IAB 7/14/21, effective 8/18/21]

650—11.5(147,153) Dental hygiene licensure by examination.

11.5(1) Applications for licensure to practice dental hygiene in this state shall be made on the form provided by the dental hygiene committee and must be completely answered, including required credentials and documents. An applicant who has held a dental hygiene license issued in another state for one year or longer must apply for licensure by credentials pursuant to rule 650—11.6(153).

11.5(2) Applications for licensure must be filed with the dental hygiene committee along with:

a. *Documentation of graduation from dental hygiene school.* Satisfactory evidence of graduation from an accredited school of dental hygiene approved by the dental hygiene committee.

b. *Certification of good standing from dean or designee.* Certification by the dean or other authorized representative of the school of dental hygiene that the applicant has been a student in good standing while attending that dental hygiene school.

c. *Documentation of passage of national dental hygiene examination.* Evidence of successful passage of the examination administered by the Joint Commission on National Dental Examinations.

d. *Documentation of passage of a regional clinical examination.* Successful passage of a board-approved clinical examination within the previous five-year period.

(1) The following patient-based regional examinations are approved by the board for purposes of licensure by examination: the Central Regional Dental Testing Service, Inc. examination as administered by the Central Regional Dental Testing Service, Inc. (CRDTS), the Western Regional Examining Board examination as administered by the Western Regional Examining Board (WREB), the Southern Regional Testing Agency, Inc. examination as administered by the Southern Regional Testing Agency, Inc. (SRTA), and the American Board of Dental Examiners, Inc. examination as administered by the Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies, Inc. (CITA).

(2) The following manikin-based regional clinical examinations are approved by the board for purposes of licensure by examination: the examination administered by the Central Regional Dental Testing Service, Inc. (CRDTS), the American Board of Dental Examiners, Inc. examination as administered by the Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies (CITA), and the examination administered by the Western Regional Examining Board (WREB).

e. *Payment of application, fingerprint and background check fees.* The nonrefundable application fee, plus the fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), as specified in 650—Chapter 15.

f. *Documentation of passage of jurisprudence examination.* Evidence of successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.

g. *Current CPR certification.* A statement:

(1) Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;

- (2) Providing the expiration date of the CPR certificate; and
- (3) Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

h. Explanation of any legal or administrative actions. A statement disclosing and explaining any disciplinary actions, investigations, complaints, malpractice claims, judgments, settlements, or criminal charges.

i. Completed fingerprint packet. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

11.5(3) The dental hygiene committee may require a personal appearance or any additional information relating to the character, education and experience of the applicant.

11.5(4) Applications must be signed and verified as to the truth of the statements contained therein.

11.5(5) Following review by the dental hygiene committee, the committee shall make recommendation to the board regarding the issuance or denial of any license to practice dental hygiene. The board's review of the dental hygiene committee recommendation is subject to 650—Chapter 1.

This rule is intended to implement Iowa Code chapters 147 and 153.

[**ARC 7790B**, IAB 5/20/09, effective 6/24/09; **ARC 9218B**, IAB 11/3/10, effective 12/8/10; **ARC 9510B**, IAB 5/18/11, effective 6/22/11; **ARC 0265C**, IAB 8/8/12, effective 9/12/12; **ARC 2870C**, IAB 12/21/16, effective 1/25/17; **ARC 5366C**, IAB 12/30/20, effective 2/3/21; **ARC 5539C**, IAB 4/7/21, effective 5/12/21]

650—11.6(153) Dental hygiene licensure by credentials. To be issued a license to practice dental hygiene in Iowa on the basis of credentials, an applicant shall meet the following requirements.

11.6(1) Applications for licensure by credentials to practice dental hygiene in this state shall be made on the form provided by the dental hygiene committee and must be completely answered, including required credentials and documents.

11.6(2) Applications must be filed with the dental hygiene committee along with:

a. Satisfactory evidence of graduation from an accredited school of dental hygiene approved by the dental hygiene committee.

b. Evidence of successful passage of the examination of the Joint Commission on National Dental Examinations. Any dental hygienist who has lawfully practiced dental hygiene in another state or territory for five or more years may be exempted from presenting this evidence.

c. A statement of any dental hygiene examinations taken by the applicant, with indication of pass/fail for each examination taken. Any dental hygienist who has lawfully practiced dental hygiene in another state or territory for five or more years may be exempted from presenting this evidence.

d. Evidence of a current, valid license to practice dental hygiene in another state, territory or district of the United States issued under requirements equivalent or substantially equivalent to those of this state.

e. Evidence that the applicant has met at least one of the following:

(1) Has less than three consecutive years of practice immediately prior to the filing of the application and evidence of successful passage of a regional clinical examination pursuant to subrule 11.5(2) within the previous five-year period; or

(2) Has for three consecutive years immediately prior to the filing of the application been in the lawful practice of dental hygiene in such other state, territory or district of the United States.

f. Evidence from the state board of dentistry, or equivalent authority, in each state in which applicant has been licensed to practice dental hygiene, that the applicant has not been the subject of final or pending disciplinary action.

g. A statement disclosing and explaining any disciplinary actions, investigations, complaints, malpractice claims, judgments, settlements, or criminal charges, including the results of a self-query of the National Practitioner Data Bank (NPDB).

h. The nonrefundable application fee for licensure by credentials, the initial licensure fee and the fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), as specified in 650—Chapter 15.

i. A statement:

- (1) Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;
- (2) Providing the expiration date of the CPR certificate; and
- (3) Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

j. Successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.

k. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

11.6(3) Applicant shall appear for a personal interview conducted by the dental hygiene committee or the board by request only.

11.6(4) The dental hygiene committee may also require such examinations as may be necessary to evaluate the applicant for licensure by credentials.

11.6(5) Applications must be signed and verified attesting to the truth of the statements contained therein.

11.6(6) Following review by the dental hygiene committee, the committee shall make a recommendation to the board regarding issuance or denial of a dental hygiene license. The board’s review of the dental hygiene committee recommendation is subject to 650—Chapter 1.

11.6(7) A dental hygienist who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by credentials may apply for licensure by verification, if eligible, in accordance with rule 650—11.12(272C).

This rule is intended to implement Iowa Code section 147.80 and chapter 153.

[**ARC 9218B**, IAB 11/3/10, effective 12/8/10; **ARC 0265C**, IAB 8/8/12, effective 9/12/12; **ARC 0618C**, IAB 3/6/13, effective 4/10/13; **ARC 2870C**, IAB 12/21/16, effective 1/25/17; **ARC 5366C**, IAB 12/30/20, effective 2/3/21; **ARC 5539C**, IAB 4/7/21, effective 5/12/21; **ARC 5747C**, IAB 7/14/21, effective 8/18/21]

650—11.7(147,153) Dental hygiene application for local anesthesia permit. A licensed dental hygienist may administer local anesthesia provided the following requirements are met:

1. The dental hygienist holds a current local anesthesia permit issued by the board.
2. The local anesthesia is prescribed by a licensed dentist.
3. The local anesthesia is administered under the direct supervision of a licensed dentist.

11.7(1) Application for permit. A dental hygienist shall make application for a permit to administer local anesthesia on the form approved by the dental hygiene committee and provide the following:

- a.* The fee for a permit to administer local anesthesia as specified in 650—Chapter 15; and
- b.* Evidence that formal training in the administration of local anesthesia has been completed within 12 months of the date of application. The formal training shall be approved by the dental hygiene committee and conducted by a school accredited by the American Dental Association Commission on Dental Education; or
- c.* Evidence of completion of formal training in the administration of local anesthesia approved by the dental hygiene committee and documented evidence of ongoing practice in the administration of local anesthesia in another state or jurisdiction that authorizes a dental hygienist to administer local anesthesia.

11.7(2) Permit renewal. The permit shall expire on August 31 of every odd-numbered year. To renew the permit, the dental hygienist must:

- a.* At the time of renewal, document evidence of holding an active Iowa dental hygiene license.
- b.* Submit the application fee for renewal of the permit as specified in 650—Chapter 15.

11.7(3) Failure to meet the requirements for renewal shall cause the permit to lapse and become invalid.

11.7(4) A permit that has been lapsed for two years or less may be reinstated upon the permit holder’s application for reinstatement and payment of the reinstatement fee as specified in 650—Chapter 15. A permit that has been lapsed for more than two years may be reinstated upon application for reinstatement,

documentation of meeting the requirements of 11.7(1) “b” or “c,” and payment of the reinstatement fee as specified in 650—Chapter 15.

This rule is intended to implement Iowa Code sections 147.10 and 147.80 and chapter 153.
[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 5366C, IAB 12/30/20, effective 2/3/21]

650—11.8(153) Dental assistant registration.

11.8(1) General. An applicant must satisfy all of the following requirements:

a. Successful completion of board-approved training or education in dental assisting in accordance with subrule 11.8(2);

b. Evidence of current certification in cardiopulmonary resuscitation that included a hands-on component; and

c. Successful completion of board-approved examination in the areas of infection control/hazardous materials and jurisprudence in accordance with subrule 11.8(3). Successful completion of board-approved examination in the area of dental radiography is also required if an applicant is applying for a radiography qualification in accordance with rule 650—22.5(136C,153).

11.8(2) Education and training. An applicant must meet one of the following:

a. Work in a dental office as a dental assistant trainee until competency is achieved as determined by the supervising dentist;

b. Work as a dental assistant in another state, district or territory within five years prior to the date of application; or

c. Be a graduate of an accredited dental assisting program.

11.8(3) Examination. An applicant for registration must successfully complete examinations as required pursuant to subrule 11.8(2). Applicants may complete a single comprehensive examination or complete separate board-approved examinations in the required areas.

a. The following examinations are approved for the purposes of this subrule:

(1) Board-approved examinations;

(2) The Dental Assisting National Board’s (DANB’s) Infection Control Examination (ICE);

(3) The DANB’s Radiation Health and Safety (RHS) Examination;

(4) Examinations administered by accredited dental assisting programs; or

(5) Board-approved continuing education courses, which include posttest examination.

b. A score of 75 percent or better on the board-approved examinations shall be considered successful completion of the examination. The board also accepts the passing standard established by DANB for applicants who take the ICE or RHS examination.

c. An examinee must meet such other requirements as may be imposed by the board’s approved dental assistant testing centers.

11.8(4) Applications. Applications for registration as a registered dental assistant must be filed on official board forms and include the following:

a. The fee as specified in 650—Chapter 15.

b. Evidence of meeting the education and training requirements specified in subrule 11.8(2).

c. Evidence of successful completion of a board-approved examination in the areas of infection control, hazardous materials and jurisprudence as specified in subrule 11.8(3), and dental radiography, if the applicant is also applying for a qualification in dental radiography in accordance with rule 650—22.5(136,153).

d. Evidence of meeting the qualifications of 650—Chapter 22 if the applicant is engaging in dental radiography.

e. Evidence of current certification in cardiopulmonary resuscitation that included a hands-on component.

f. Any additional information required by the board relating to the character, education and experience of the applicant as may be necessary to evaluate the applicant’s qualifications.

11.8(5) Attestation. All applications must be signed and verified by the applicant as to the truth of the documents and statements contained therein.

11.8(6) *Alternate pathway for registration.* A dental assistant who is licensed or registered in another jurisdiction but who is unable to satisfy the requirements for registration in this rule may apply for registration by verification, if eligible, in accordance with rule 650—11.9(272C).

This rule is intended to implement Iowa Code section 153.39.
[ARC 6673C, IAB 11/16/22, effective 12/21/22]

650—11.9(272C) Registration by verification. Registration by verification is available in accordance with the following:

11.9(1) *Eligibility.* A dental assistant may seek registration by verification if the person is currently licensed or registered as a dental assistant in at least one other jurisdiction that has a scope of practice substantially similar to that of Iowa.

11.9(2) *Board application.* The applicant must submit the following:

- a. A completed application for registration.
- b. Payment of the application fee.
- c. A verification form, completed by the licensing authority in the jurisdiction that issued the applicant's license or registration, verifying that the applicant's license or registration in that jurisdiction complies with the requirements of Iowa Code section 272C.12. The completed verification form must be sent directly from the licensing authority to the board.
- d. Evidence of successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.
- e. Copies of complete criminal record, if the applicant has a criminal history.
- f. A copy of the relevant disciplinary documents, if another jurisdiction has taken disciplinary action against the applicant.
- g. A written statement from the applicant detailing the scope of practice in the other state.
- h. Copies of relevant laws setting forth the scope of practice in the other state.

11.9(3) *Applicants with prior discipline.* If another jurisdiction has taken disciplinary action against an applicant, the board will determine whether the cause for the disciplinary action has been corrected and the matter has been resolved. If the board determines the disciplinary matter has not been resolved, the board will neither issue a registration nor deny the application for registration until the matter is resolved. A person who has had a license or registration revoked, or who has voluntarily surrendered a license or registration, in another jurisdiction is ineligible for registration by verification.

11.9(4) *Applicants with pending complaints or investigations.* If an applicant is currently the subject of a complaint, allegation, or investigation relating to unprofessional conduct pending before any regulating entity in another jurisdiction, the board will neither issue a registration nor deny the application for registration until the complaint, allegation, or investigation is resolved.

11.9(5) *Temporary registrations.* Applicants who satisfy all requirements for a registration under this rule except for passing the jurisprudence examination may be issued a temporary registration in accordance with the following:

- a. A temporary registration is valid for a period of three months.
- b. A temporary registration may be renewed once for an additional period of three months if the applicant has not failed the jurisprudence examination.
- c. A temporary registrant shall display the board-issued registration renewal card that indicates the registration is a temporary registration, which will satisfy the requirements in rule 650—10.2(147,153).
- d. The temporary registrant must submit proof of passing the jurisprudence examination before the temporary registration expires. When the temporary registrant submits proof of passing the jurisprudence examination, the temporary registration will convert to a standard registration and be assigned an expiration date consistent with standard registrations.
- e. If the temporary registrant does not submit proof of passing the jurisprudence examination prior to the expiration of the temporary registration, the temporary registrant must cease practice until a standard registration is issued.

This rule is intended to implement Iowa Code section 272C.12.
[ARC 6673C, IAB 11/16/22, effective 12/21/22; ARC 6940C, IAB 3/8/23, effective 4/12/23]

650—11.10(147,153) Review of applications. Upon receipt of a completed application, the executive director as authorized by the board has discretion to:

1. Authorize the issuance of the license, permit, or registration.
2. Refer the license, permit, or registration application to the license and registration committee for review and consideration when the executive director determines that matters including, but not limited to, prior criminal history, chemical dependence, competency, physical or psychological illness, malpractice claims or settlements, or professional disciplinary history are relevant in determining the applicants' qualifications for license, permit, or registration.

11.10(1) Following review and consideration of an application referred by the executive director, the license and registration committee may at its discretion:

- a. Authorize the executive director to issue the license, permit, or registration.
- b. Send the license, permit, or registration application to the board for further review and consideration.

11.10(2) Following review and consideration of a license, permit, or registration application referred by the license and registration committee, the board shall:

- a. Authorize the issuance of the license, permit, or registration,
- b. Deny the issuance of the license, permit, or registration, or
- c. Authorize the issuance of the license, permit, or registration under certain terms and conditions or with certain restrictions.

11.10(3) The license and registration committee or board may require an applicant to appear for an interview before the committee or the full board as part of the application process.

11.10(4) The license and registration committee or board may defer final action on an application if there is an investigation or disciplinary action pending against an applicant, who may otherwise meet the requirements for license, permit, or registration, until such time as the committee or board is satisfied that licensure or registration of the applicant poses no risk to the health and safety of Iowans.

11.10(5) The dental hygiene committee shall be responsible for reviewing any applications submitted by a dental hygienist that require review in accordance with this rule. Following review by the dental hygiene committee, the committee shall make a recommendation to the board regarding issuance of the license or permit. The board's review of the dental hygiene committee's recommendation is subject to 650—Chapter 1.

11.10(6) An application for a license, permit, or reinstatement of a license will be considered complete prior to receipt of the criminal history background check on the applicant by the FBI for purposes of review and consideration by the executive director, the license and registration committee, or the board. However, an applicant is required to submit an additional completed fingerprint packet and fee within 30 days of a request by the board if an earlier fingerprint submission has been determined to be unacceptable by the DCI or FBI.

This rule is intended to implement Iowa Code section 153.33B.

[ARC 4187C, IAB 12/19/18, effective 1/23/19; ARC 6673C, IAB 11/16/22, effective 12/21/22]

650—11.11(147,153) Grounds for denial of application. The board may deny an application for license, registration or permit for any of the following reasons:

1. Failure to meet the requirements for license, registration or permit as specified in these rules.
2. Failure to provide accurate and truthful information, or the omission of material information.
3. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure or registration may be revoked or suspended.
4. Pursuant to 650—Chapter 50, for having a disqualifying offense.

This rule is intended to implement Iowa Code section 147.4.

[ARC 5747C, IAB 7/14/21, effective 8/18/21; ARC 6673C, IAB 11/16/22, effective 12/21/22]

650—11.12(147) Denial of licensure—appeal procedure.

11.12(1) Preliminary notice of denial. Prior to the denial of licensure or registration to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail. The preliminary notice of denial is a public record and shall cite the factual and legal basis for

denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

11.12(2) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the notice and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The request is deemed filed on the date it is received in the board office. The request shall provide the applicant's current address, specify the factual or legal errors in the preliminary notice of denial, indicate if the applicant wants an evidentiary hearing, and provide any additional written information or documents in support of licensure.

11.12(3) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with rule 650—51.20(17A). License or registration denial hearings are open to the public. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.

a. The applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

b. The board, after a hearing on license or registration denial, may grant the license or registration, grant the license or registration with restrictions, or deny the license or registration. The board shall state the reasons for its final decision, which is a public record.

c. Judicial review of a final order of the board to deny a license or registration, or to issue a license or registration with restrictions, may be sought in accordance with the provisions of Iowa Code section 17A.19.

11.12(4) *Finality.* If an applicant does not appeal a preliminary notice of denial, the preliminary notice of denial automatically becomes final and a notice of denial will be issued. The final notice of denial is a public record.

11.12(5) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with subrule 11.10(2), but the applicant fails to pursue that appeal to a final decision within six months from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 14 days after the written notice is sent. Upon dismissal of an appeal, the preliminary notice of denial becomes final.

11.12(6) *Disqualifying offenses.* Any denial of licensure or registration based on a disqualifying offense is governed by 650—Chapter 50 and not this rule.

This rule is intended to implement Iowa Code sections 147.3 and 147.4.

[ARC 7789B, IAB 5/20/09, effective 6/24/09; ARC 5747C, IAB 7/14/21, effective 8/18/21; ARC 6673C, IAB 11/16/22, effective 12/21/22]

650—11.13(252J) Receipt of certificate of noncompliance. The board shall consider the receipt of a certificate of noncompliance of a support order from the child support recovery unit pursuant to Iowa Code chapter 252J and 650—Chapter 33 of these rules. License denial shall follow the procedures in the statutes and board rules as set forth in this rule.

This rule is intended to implement Iowa Code chapter 252J.

[ARC 4747C, IAB 11/6/19, effective 12/11/19; ARC 6673C, IAB 11/16/22, effective 12/21/22]

650—11.14(272C) Licensure by verification. Licensure by verification is available in accordance with the following:

11.14(1) *Eligibility.* A dentist or dental hygienist may seek licensure by verification if the person is currently licensed as a dentist or dental hygienist in at least one other jurisdiction that has a scope of practice substantially similar to that of Iowa.

11.14(2) *Board application.* The applicant must submit the following:

a. A completed application for licensure.

- b. Payment of the application fee.
- c. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.
- d. A verification form, completed by the licensing authority in the jurisdiction that issued the applicant's license, verifying that the applicant's license in that jurisdiction complies with the requirements of Iowa Code section 272C.12. The completed verification form must be sent directly from the licensing authority to the board.
- e. Evidence of successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.
- f. Copies of complete criminal record, if the applicant has a criminal history.
- g. A copy of the relevant disciplinary documents, if another jurisdiction has taken disciplinary action against the applicant.
- h. A written statement from the applicant detailing the scope of practice in the other state.
- i. Copies of relevant laws setting forth the scope of practice in the other state.

11.14(3) Applicants with prior discipline. If another jurisdiction has taken disciplinary action against an applicant, the board will determine whether the cause for the disciplinary action has been corrected and the matter has been resolved. If the board determines the disciplinary matter has not been resolved, the board will neither issue a license nor deny the application for licensure until the matter is resolved. A person who has had a license revoked, or who has voluntarily surrendered a license, in another jurisdiction is ineligible for licensure by verification.

11.14(4) Applicants with pending complaints or investigations. If an applicant is currently the subject of a complaint, allegation, or investigation relating to unprofessional conduct pending before any regulating entity in another jurisdiction, the board will neither issue a license nor deny the application for licensure until the complaint, allegation, or investigation is resolved.

11.14(5) Temporary licenses. Applicants who satisfy all requirements for a license under this rule except for passing the jurisprudence examination may be issued a temporary license in accordance with the following:

- a. A temporary license is valid for a period of three months.
- b. A temporary license may be renewed once for an additional period of three months if the applicant has not failed the jurisprudence examination.
- c. A temporary licensee shall display the board-issued license renewal card that indicates the license is a temporary license, which will satisfy the requirements in rule 650—10.2(147,153).
- d. The temporary licensee must submit proof of passing the jurisprudence examination before the temporary license expires. When the temporary licensee submits proof of passing the jurisprudence examination, the temporary license will convert to a standard license and be assigned an expiration date consistent with standard licenses.
- e. If the temporary licensee does not submit proof of passing the jurisprudence examination prior to the expiration of the temporary license, the temporary licensee must cease practice until a standard license is issued.

This rule is intended to implement Iowa Code section 272C.12.

[ARC 5747C, IAB 7/14/21, effective 8/18/21; ARC 6673C, IAB 11/16/22, effective 12/21/22; ARC 6940C, IAB 3/8/23, effective 4/12/23]

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[Filed ARC 9218B (Notice ARC 8846B, IAB 6/16/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9510B (Notice ARC 9243B, IAB 12/1/10), IAB 5/18/11, effective 6/22/11]
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[Filed ARC 2870C (Notice ARC 2701C, IAB 8/31/16), IAB 12/21/16, effective 1/25/17]
[Filed ARC 3488C (Notice ARC 3252C, IAB 8/16/17), IAB 12/6/17, effective 1/10/18]
[Filed ARC 3961C (Notice ARC 3705C, IAB 3/28/18), IAB 8/15/18, effective 9/19/18]
[Filed ARC 4187C (Notice ARC 4005C, IAB 9/26/18), IAB 12/19/18, effective 1/23/19]
[Filed ARC 4747C (Notice ARC 4526C, IAB 7/3/19), IAB 11/6/19, effective 12/11/19]
[Filed ARC 5366C (Notice ARC 5264C, IAB 11/4/20), IAB 12/30/20, effective 2/3/21]
[Filed ARC 5539C (Notice ARC 5382C, IAB 1/13/21), IAB 4/7/21, effective 5/12/21]
[Filed ARC 5747C (Notice ARC 5371C, IAB 12/30/20), IAB 7/14/21, effective 8/18/21]
[Filed ARC 6673C (Notice ARC 6514C, IAB 9/7/22), IAB 11/16/22, effective 12/21/22]
[Filed ARC 6940C (Notice ARC 6666C, IAB 11/16/22), IAB 3/8/23, effective 4/12/23]

CHAPTER 52
MILITARY SERVICE AND VETERAN RECIPROCITY

650—52.1(272C) Definitions.

“*License*” or “*licensure*” means any license, registration, certificate or permit that may be granted by the board.

“*Military service*” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

“*Military service applicant*” means an individual who is requesting credit toward licensure or registration for military education, training, or service obtained or completed in military service.

“*Reciprocity*” means the process by which an individual licensed in another jurisdiction becomes licensed in Iowa and may also be referred to in other board rules as “licensure by credentials.”

“*Spouse*” means a spouse of an active duty member of the military forces of the United States.

“*Veteran*” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).
[ARC 1811C, IAB 1/7/15, effective 2/11/15; ARC 4749C, IAB 11/6/19, effective 12/11/19; ARC 5747C, IAB 7/14/21, effective 8/18/21; ARC 6940C, IAB 3/8/23, effective 4/12/23]

650—52.2(272C) Military education, training, and service credit. A military service applicant may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting a military service application form to the board office.

52.2(1) The completed military service application may be submitted with an application for licensure or examination or prior to an applicant’s applying for licensure or to take an examination. No fee is required with submission of an application for military service credit.

52.2(2) The applicant shall identify the experience or educational licensure requirement to which the credit would be applied if granted. Credit shall not be applied to an examination requirement.

52.2(3) The applicant shall provide documents, military transcripts, a certified affidavit, or forms that verify completion of the relevant military education, training, or service, which may include, when applicable, the applicant’s Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET) (DD Form 2586).

52.2(4) Upon receipt of a completed military service application, the board shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational licensure requirement.

52.2(5) The board shall grant the application in whole or in part if the board determines that the verified military education, training, or service satisfies all or part of the experience or educational qualifications for licensure.

52.2(6) The board shall inform the military service applicant in writing of the credit, if any, given toward an experience or educational qualification for licensure or explain why no credit was granted. The applicant may request reconsideration upon submission of additional documentation or information.

52.2(7) A military service applicant who is aggrieved by the board’s decision may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board’s decision. No fees or costs shall be assessed against the military service applicant in connection with a contested case conducted pursuant to this subrule.

52.2(8) The board shall grant or deny the military service application prior to ruling on the application for licensure. The applicant shall not be required to submit any fees in connection with the licensure application unless the board grants the military service application. If the board does not grant the military service application, the applicant may withdraw the licensure application or request that the licensure application be placed in pending status for up to one year or as mutually agreed. The

withdrawal of a licensure application shall not preclude subsequent applications supported by additional documentation or information.

[ARC 1811C, IAB 1/7/15, effective 2/11/15; ARC 4749C, IAB 11/6/19, effective 12/11/19; ARC 5747C, IAB 7/14/21, effective 8/18/21]

650—52.3(272C) Veteran and spouse reciprocity.

52.3(1) A veteran or spouse with an unrestricted professional license in another jurisdiction may apply for licensure in Iowa through reciprocity. A veteran or spouse must pass any examinations required for licensure to be eligible for licensure through reciprocity. A fully completed application for licensure submitted by a veteran or spouse under this subrule shall be given priority and shall be expedited.

52.3(2) An application for licensure by reciprocity shall contain all of the information required of all applicants for licensure who hold unrestricted licenses in other jurisdictions and who are applying for licensure by reciprocity including, but not limited to, completion of all required forms, payment of applicable fees, disclosure of criminal or disciplinary history, and, if applicable, a criminal history background check. The applicant shall use the same forms as any other applicant for licensure by reciprocity and shall additionally provide such documentation as is reasonably needed to verify the applicant's status as a veteran under Iowa Code section 35.1(2) or as a spouse of an active duty member of the military forces of the United States.

52.3(3) Upon receipt of a fully completed licensure application, the board shall promptly determine if the scope of practice in the jurisdiction where the applicant is licensed is substantially equivalent to the scope of practice in Iowa. The board shall make this determination based on information supplied by the applicant and such additional information as the board may acquire from the applicable jurisdiction.

52.3(4) The board shall promptly grant a license to the applicant if the applicant is licensed in the same or similar profession in another jurisdiction whose scope of practice is substantially equivalent to the scope of practice in Iowa, unless the applicant is ineligible for licensure based on other grounds, for example, the applicant's disciplinary or criminal background.

52.3(5) If the board determines that the scope of practice in the jurisdiction in which the applicant is licensed is not substantially equivalent to the scope of practice in Iowa, the board shall promptly inform the applicant of the additional education or training required for licensure in Iowa. Unless the applicant is ineligible for licensure based on other grounds, such as disciplinary or criminal background, the following shall apply:

a. If an applicant has not passed the required examination(s) for licensure, the applicant may not be issued a temporary license but may request that the licensure application be placed in pending status for up to one year or as mutually agreed to provide the applicant with the opportunity to satisfy the examination requirements.

b. If additional education or training is required, the applicant may request that the board issue a temporary license for a specified period of time during which the applicant will successfully complete the necessary education or training. The board shall issue a temporary license for a specified period of time upon such conditions as the board deems reasonably necessary to protect the health, welfare or safety of the public unless the board determines that the deficiency is of a character that the public health, welfare or safety will be adversely affected if a temporary license is granted.

c. If a request for a temporary license is denied, the board shall issue an order fully explaining the decision and shall inform the applicant of the steps the applicant may take in order to receive a temporary license.

d. If a temporary license is issued, the application for full licensure shall be placed in pending status until the necessary education or training has been successfully completed or the temporary license expires, whichever occurs first. The board may extend a temporary license on a case-by-case basis for good cause.

52.3(6) An applicant who is aggrieved by the board's decision to deny an application for a reciprocal license or a temporary license or is aggrieved by the terms under which a temporary license will be granted may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board's

decision. No fees or costs shall be assessed against the applicant in connection with a contested case conducted pursuant to this subrule.

[ARC 1811C, IAB 1/7/15, effective 2/11/15; ARC 4749C, IAB 11/6/19, effective 12/11/19; ARC 5747C, IAB 7/14/21, effective 8/18/21; ARC 6940C, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code sections 272C.4(11) and 272C.4(12).

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[Filed ARC 6940C (Notice ARC 6666C, IAB 11/16/22), IAB 3/8/23, effective 4/12/23]

MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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CHAPTER 13
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

[Prior to 5/4/88, see 470—135.251 to 470—135.402]

653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

13.1(1) A physician shall dispense a prescription drug only in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. ss. 301 et seq. (2001).

13.1(2) A label shall be affixed to a container in which a prescription drug is dispensed by a physician which shall include:

1. The name and address of the physician.
2. The name of the patient.
3. The date dispensed.
4. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
5. The name and strength of the prescription drug in the container.

13.1(3) The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

13.1(4) A physician shall keep a record of all prescription drugs dispensed by the physician to a patient which shall contain the information required by subrule 13.1(2) to be included on the label. Noting such information on the patient's chart or record maintained by the physician is sufficient.

This rule is intended to implement Iowa Code sections 147.55, 148.6, 272C.3 and 272C.4.

653—13.2(124,148,272C) Standards of practice—appropriate pain management. This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of nonopioid pharmacologic therapy and nonpharmacologic therapy, including but not limited to adjunct therapies such as acupuncture, physical therapy and massage, osteopathic manipulative therapy and occupational therapy in the treatment of acute and chronic pain.

1. This rule is intended to encourage appropriate pain management, including the use of opioids for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

2. The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.

3. The board recognizes that pain management is an important part of medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

4. Physicians should not fear board action for treating pain with opioids as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

5. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(1) Definitions. For the purposes of this rule, the following terms are defined as follows:

“Acute pain” means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

“Addiction” means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors

that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

“*Chronic pain*” means pain that typically lasts longer than three months or past the time of normal tissue healing. Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause.

“*Opioid*” means any U.S. Food and Drug Administration (FDA)-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“*Pain*” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

“*Physical dependence*” means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

“*Pseudoaddiction*” means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

“*Substance abuse*” means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

“*Tolerance*” means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

“*Undertreatment of pain*” means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(2) *Laws and regulations.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations.

13.2(3) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use opioids for terminal pain due to the physician’s concern with addicting the patient, or a failure to use an adequate level of pain management.

13.2(4) *Assessment and treatment of acute and chronic pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute and chronic pain.

a. Prescribing opioids for the treatment of acute and chronic pain should be based on clearly diagnosed and documented pain. Appropriate management of acute and chronic pain should include an assessment of the mechanism, type and intensity of pain. The patient’s medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

b. Prescribing opioids for the treatment of acute and chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain.

c. On March 15, 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 years of age and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. A

physician who prescribes, dispenses or administers opioids to patients for the treatment of chronic pain should become familiar with the CDC Guideline for Prescribing Opioids for Chronic Pain.

13.2(5) *Effective management of chronic pain.* To ensure that chronic pain is properly assessed and treated, a physician who prescribes, dispenses or administers opioids to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

b. Treatment plan. The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for opioids from a single physician and a single pharmacy whenever possible.

c. Informed consent. The physician shall document discussion of the risks and benefits of opioids with the patient or person representing the patient.

d. Periodic review. The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

e. Consultation/referral. A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, and other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Pain management agreements. A physician who treats patients for chronic pain with opioids shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with opioids. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes opioids to a patient for more than 90 days for the treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient's medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. Sample pain management agreement and prescription drug risk assessment tools may be found on the board's website at www.medicalboard.iowa.gov.

h. Substance abuse history or comorbid psychiatric disorder. A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. Drug testing. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. Termination of care. The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

13.2(6) Pain management for terminal illness. The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opioids to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(7) Prescription monitoring program. The Iowa board of pharmacy has established a prescription monitoring program pursuant to Iowa Code sections 124.551 to 124.558 to assist prescribers and pharmacists in monitoring the prescription of controlled substances to patients. A physician shall register for the prescription monitoring program at the same time the physician applies for registration or renews registration to prescribe controlled substances as required by the Iowa board of pharmacy. A physician or the physician's designated agent shall utilize the prescription monitoring program prior to issuing an opioid prescription to assist the physician in determining appropriate treatment options and to improve the quality of patient care. A physician is not required to utilize the prescription monitoring program to assist in the treatment of a patient receiving inpatient hospice care or long-term residential facility patient care. An order issued in an inpatient hospital setting is not considered a prescription for the purposes of these rules. Patient safety is adequately protected in an inpatient hospital setting, and physicians caring for patients in an inpatient hospital setting do not prescribe. A link to the prescription monitoring program may be found at the board's website at www.medicalboard.iowa.gov.

13.2(8) Electronic prescriptions. Beginning January 1, 2020, all prescriptions (controlled and noncontrolled substances) shall be transmitted electronically as electronic prescriptions pursuant to Iowa Code section 124.308. A prescription shall be transmitted to a pharmacy by the physician or the physician's authorized agent in compliance with federal law and regulation for electronic prescriptions of controlled substances.

13.2(9) Pain management resources. The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the

convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group in collaboration with an expert advisory panel, actively practicing providers and public stakeholders, the guideline focuses on evidence-based treatment for chronic-pain patients. The guideline was published in 2007 and updated in 2015.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

h. CDC Guideline for Prescribing Opioids for Chronic Pain. On March 15, 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued a guideline to provide recommendations for the prescribing of opioid pain medication for patients 18 years of age and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

13.2(10) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules, the rules found in 653—Chapter 23, or any of the following:

a. A physician who prescribes opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent physician in the state of Iowa acting in the same or similar circumstances.

b. A physician who knowingly fails to comply with the confidentiality requirements of Iowa Code section 124.553 or who delegates program information access to another individual except as provided in Iowa Code section 124.553.

c. A physician who knowingly fails to comply with other requirements of Iowa Code chapter 124.

13.2(11) *Unlawful access, disclosure, or use of information.* A person who intentionally or knowingly accesses, uses, or discloses information from the prescription monitoring program in violation of Iowa Code section 124.553, unless otherwise authorized by law, is guilty of a class “D” felony. This subrule shall not preclude a physician who requests and receives information from the prescription monitoring program consistent with the requirements of Iowa Code section 124.553 from otherwise lawfully providing that information to any other person for medical care purposes.

This rule is intended to implement Iowa Code chapters 124, 148 and 272C.

[ARC 9599B, IAB 7/13/11, effective 8/17/11; ARC 2705C, IAB 9/14/16, effective 10/19/16; ARC 4714C, IAB 10/23/19, effective 11/27/19]

653—13.3(147) Supervision of pharmacists who administer adult immunizations. Rescinded ARC 1033C, IAB 10/2/13, effective 11/6/13.

653—13.4(148) Supervision of pharmacists engaged in collaborative drug therapy management. Rescinded ARC 6442C, IAB 8/10/22, effective 9/14/22.

653—13.5(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

This rule is intended to implement Iowa Code chapters 147 and 148.

653—13.6(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician shall be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

13.6(1) An internal quality control assurance plan shall include the following elements:

- a. The name of the physician responsible for the internal quality assurance plan and testing;
- b. Methods that the dispensing system employs, e.g., bar coding, to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;
- c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;
- d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;
- e. Staff training and qualifications for dispensing via the dispensing system;
- f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;
- g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;
- h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;
- i. A plan for interval testing of the accuracy of dispensing, at least annually; and
- j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

13.6(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

13.6(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.

This rule is intended to implement Iowa Code section 147.107 and 2001 Iowa Acts, House File 726, section 5(10), paragraph "i."

653—13.7(147,148,272C) Standards of practice—office practices.

13.7(1) Termination of the physician-patient relationship. A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician shall provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.7(2) Patient referrals. A physician shall not pay or receive compensation for patient referrals.

13.7(3) Confidentiality. A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.7(4) Sexual conduct. It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct which violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor, regardless of whether the patient consents to that conduct.

13.7(5) Disruptive behavior. A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

13.7(6) Sexual harassment. A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature which interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

13.7(7) Transfer of medical records. A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

13.7(8) Retention of medical records.

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Beginning July 1, 2023, a physician must appoint another Iowa-licensed physician, or other representative or entity that is held to the same standards of confidentiality as the physician, to ensure that all requirements of this subrule are met in the event of the physician's death or incapacitation. Upon request by the board, the physician must be able to establish by sufficient proof the appointment of a representative pursuant to this paragraph.

d. Upon a physician's death or retirement, the sale of a medical practice, or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician or the physician's representative shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

[ARC 6683C, IAB 11/30/22, effective 1/4/23]

653—13.8(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians. This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa.

13.8(1) Definitions. As used in this rule:

“*Alter*” means to change the cellular structure of living tissue.

“*Capable of*” means any means, method, device or instrument which, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

“*Damage*” means to cause a harmful change in the cellular structure of living tissue.

“*Delegate*” means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians.

“*Medical aesthetic service*” means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; collagen induction therapy (microneedling); fat-freezing treatment (cool sculpting); botox injections; collagen injections; and tattoo removal.

“*Medical director*” means a physician who assumes the role of, or holds oneself out as, medical director at a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa. The medical director is ultimately responsible for all medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa.

“*Medical spa*” means any entity, however organized, which is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice which is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

“*Nonsuperficial*” means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

“*Qualified laser technician*” means any person, licensed or unlicensed, who has successfully completed a minimum of 120 hours of training, including a minimum of 40 hours of didactic study and 80 hours of clinical training, in the safe and effective use of lasers in the performance of medical aesthetic services at an accredited laser training program. For the purposes of this rule, a qualified laser technician may only use lasers in the performance of delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa. An unlicensed qualified laser technician may not perform any other medical aesthetic services defined in this rule.

“*Qualified licensed or certified nonphysician person*” means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another health- or skin care-related licensing board in Iowa and is qualified to perform delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa.

“*Supervision*” means the oversight of qualified licensed or certified nonphysician persons or qualified laser technicians who perform medical aesthetic services delegated by a medical director.

13.8(2) Practice of medicine. The performance of medical aesthetic services is the practice of medicine. A medical aesthetic service shall only be performed by qualified licensed or certified

nonphysician persons or qualified laser technicians if the service has been delegated by a medical director who is responsible for supervision of the services performed at a medical spa in Iowa.

13.8(3) *Medical director.* A physician who serves as medical director at a medical spa shall:

- a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;
- b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;
- c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and
- e. Be clearly identified as the medical director in all advertising activities, Internet websites and signage related to the medical spa.

13.8(4) *Delegated medical aesthetic service.* When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians, the service shall be:

- a. Within the medical director's scope of practice and medical competence to supervise;
- b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and
- c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

13.8(5) *Supervision.* A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians is responsible for providing appropriate supervision. The medical director shall:

- a. Ensure that all licensed or certified nonphysician persons or qualified laser technicians are qualified and competent to safely perform each delegated medical aesthetic service by personally assessing the person's education, training, experience and ability;
- b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services which are beyond the scope of that person's license or certification unless the person is supervised by a qualified supervising physician;
- c. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician at least four hours each week and that the regular supervision is documented;
- d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- e. Be physically located, at all times, within 60 miles of the location where delegated medical aesthetic services are performed;
- f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services, particularly in case of injury or an emergency;
- g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services;
- h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving delegated medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- i. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians maintain accurate and timely medical records for the delegated medical aesthetic services they perform;
- j. Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or

certified nonphysician persons or qualified laser technicians and that such informed consent is timely documented in the patient's medical record;

k. Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians, and all qualified licensed or certified nonphysician persons or qualified laser technicians are visibly displayed at each medical spa where they perform medical aesthetic services and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

l. Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services at a medical spa, within 14 days of a request by the board.

13.8(6) Continuing medical education. All medical directors, qualified licensed or certified nonphysician persons and qualified laser technicians who practice at a medical spa in Iowa shall complete a minimum of 20 hours of continuing medical education in the safe and effective performance of medical aesthetic services each year.

13.8(7) Exceptions. This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

13.8(8) Physician assistants. Nothing in this rule shall be interpreted to contradict or supersede the rules established in 645—Chapters 326 and 327.

[ARC 9088B, IAB 9/22/10, effective 10/27/10; ARC 4247C, IAB 1/16/19, effective 2/20/19]

653—13.9(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

13.9(1) Definition. As used in this rule:

“*Interventional chronic pain management*” means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve.

13.9(2) Interventional chronic pain management. The practice of interventional chronic pain management shall include the following:

- a.* Comprehensive assessment of the patient;
- b.* Diagnosis of the cause of the patient's pain;
- c.* Evaluation of alternative treatment options;
- d.* Selection of appropriate treatment options;
- e.* Termination of prescribed treatment options when appropriate;
- f.* Follow-up care; and
- g.* Collaboration with other health care providers.

13.9(3) Practice of medicine. Interventional chronic pain management is the practice of medicine.
[ARC 8918B, IAB 6/30/10, effective 8/4/10]

653—13.10(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.

13.10(1) Definition. As used in this rule:

“*Abortion-inducing drug*” means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

13.10(2) Physical examination required. A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first performed a physical examination of the woman to determine, and document in the woman’s medical record, the gestational age and intrauterine location of the pregnancy.

13.10(3) Physician’s physical presence required. When inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided.

13.10(4) Follow-up appointment required. If an abortion is induced by an abortion-inducing drug, the physician inducing the abortion must schedule a follow-up appointment with the woman at the same facility where the abortion-inducing drug was provided, 12 to 18 days after the woman’s use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman’s medical condition. The physician shall use all reasonable efforts to ensure that the woman is aware of the follow-up appointment and that she returns for the appointment.

13.10(5) Parental notification regarding pregnant minors. A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L) adopted by the public health department.

[ARC 1034C, IAB 10/2/13, effective 11/6/13]

653—13.11(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

1. The board recognizes that technological advances have made it possible for licensees in one location to provide medical care to patients in another location with or without an intervening health care provider.

2. Telemedicine is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential cost savings.

3. The board advises that licensees using telemedicine will be held to the same standards of care and professional ethics as licensees using traditional in-person medical care.

4. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may subject the licensee to potential discipline by the board.

13.11(1) Definitions. As used in this rule:

“*Asynchronous store-and-forward transmission*” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

“*Board*” means the Iowa board of medicine.

“*In-person encounter*” means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

“*Licensee*” means a medical physician or osteopathic physician licensed by the board.

“*Telemedicine*” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an

audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

“*Telemedicine technologies*” means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

13.11(2) *Practice guidelines.* A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.11(3) *Iowa medical license required.* A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653—subrule 9.2(2).

13.11(4) *Standards of care and professional ethics.* A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.11(5) *Scope of practice.* A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee’s scope of practice, including the licensee’s education, training, experience, ability, licensure, and certification.

13.11(6) *Identification of patient and physician.* A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.11(7) *Physician-patient relationship.*

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

- (1) The person with a health-related matter seeks assistance from a licensee;
- (2) The licensee agrees to undertake diagnosis and treatment of the person; and
- (3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

- (1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;
- (2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient’s care; or
- (3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

13.11(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast

to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.11(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

13.11(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.11(11) *Coordination of care.* A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.11(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.11(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.11(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.11(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

- (1) Privacy;
- (2) Health care personnel who will process messages;
- (3) Hours of operation;
- (4) Types of transactions that will be permitted electronically;
- (5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;
- (6) Archiving and retrieval; and
- (7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.11(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies,

remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

a. The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;

b. The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and

c. The technology and equipment utilized in the provision of telemedicine services must be compliant with the Health Insurance Portability and Accountability Act.

13.11(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;

f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

13.11(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.11(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.11(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;

b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;

- c. Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- e. Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;
- f. Emergency situations in which the life or health of the patient is in imminent danger;
- g. Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;
- h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and
- i. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

13.11(21) *Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an Internet request or Internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 13.11(20).

13.11(22) *Medical abortion.* Nothing in this rule shall be interpreted to contradict or supersede the requirements established in rule 653—13.10(147,148,272C).

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.
[ARC 1983C, IAB 4/29/15, effective 6/3/15]

653—13.12(135,147,148,272C,280) Standards of practice—prescribing epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility.

13.12(1) Definition. For purposes of this rule:

“*Authorized facility*” means a facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school.

13.12(2) Notwithstanding any other provision of law to the contrary, a physician may prescribe epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A.

13.12(3) A physician who prescribes epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A, provided the physician has acted reasonably and in good faith, shall not be liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists.

[ARC 2387C, IAB 2/3/16, effective 3/9/16; ARC 6941C, IAB 3/8/23, effective 4/12/23]

653—13.13(144E,147,148,272C) Standards of practice—experimental treatments for patients with a terminal illness.

13.13(1) *Exemption from discipline.* To the extent consistent with state law, the board shall not revoke, fail to renew, suspend, or take any action against a physician's license based solely on the physician's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

13.13(2) *Eligible patient.* A physician shall ensure that a patient meets all of the following conditions prior to the use of an investigational drug, biological product, or device pursuant to this rule:

- a. The patient has a terminal illness, attested to by the patient's treating physician.
- b. The patient has considered and rejected or has tried and failed to respond to all other treatment options approved by the U.S. Food and Drug Administration (FDA).
- c. The patient has received a recommendation from the patient's physician for an investigational drug, biological product, or device.
- d. The patient has given written informed consent for the use of the investigational drug, biological product, or device.
- e. The patient has documentation from the patient's physician that the patient meets the requirements of this rule.

13.13(3) *Investigational drug, biological product, or device.* A physician may recommend access to or treatment with an investigational drug, biological product, or device that has successfully completed phase 1 of an FDA-approved clinical trial but has not yet been approved for general use by the FDA and remains under investigation in an FDA-approved clinical trial.

13.13(4) *Terminal illness.* A physician shall ensure that a patient has a terminal illness prior to the use of an investigational drug, biological product, or device pursuant to this rule. A terminal illness is a progressive disease or medical or surgical condition that entails significant functional impairment and that is not considered by a treating physician to be reversible even with administration of treatments approved by the FDA and that, without life-sustaining procedures, will result in death.

13.13(5) *Written informed consent.* A physician shall obtain written informed consent prior to the use of an investigational drug, biological product, or device pursuant to this rule. Written informed consent is a written document that is signed by a patient, a parent of a minor patient, or a legal guardian or other legal representative of the patient and attested to by the patient's treating physician and a witness and that includes all of the following:

- a. An explanation of the products and treatments approved by the FDA for the disease or condition from which the patient suffers.
- b. An attestation that the patient concurs with the patient's treating physician in believing that all products and treatments approved by the FDA are unlikely to prolong the patient's life.
- c. Clear identification of the specific proposed investigational drug, biological product, or device that the patient is seeking to use.
- d. A description of the best and worst potential outcomes of using the investigational drug, biological product, or device and a realistic description of the most likely outcome. The description shall include the possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by use of the proposed investigational drug, biological product, or device. The description shall be based on the treating physician's knowledge of the proposed investigational drug, biological product, or device in conjunction with an awareness of the patient's condition.
- e. A statement that the patient's health plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless the patient's health plan or third-party administrator and provider are specifically required to do so by law or contract.
- f. A statement that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.
- g. A statement that the patient understands that the patient is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the patient's estate unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

13.13(6) *Assisting suicide.* This rule shall not be construed to allow a patient's treating physician to assist the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

13.13(7) Grounds for discipline. A physician may be subject to disciplinary action for violation of rule 653—13.13(144E,147,148,272C) or 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

- a. The physician recommends access to or treatment with an investigational drug, biological product, or device to an individual who is not an eligible patient pursuant to this rule.
- b. The physician fails to obtain appropriate written informed consent prior to recommending access to or treatment with an investigational drug, biological product, or device pursuant to this rule.
- c. The physician assists the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

This rule is intended to implement Iowa Code chapters 144E, 147, 148 and 272C.
[ARC 3588C, IAB 1/17/18, effective 2/21/18]

653—13.14(147,148,272C) Standards of practice—tick-borne disease diagnosis and treatment.

13.14(1) Exemption from discipline. A person licensed by the board under Iowa Code chapter 148 shall not be subject to discipline under this chapter or the board's enabling statute based solely on the physician's recommendation or provision of a treatment method for Lyme disease or other tick-borne disease if the recommendation or provision of such treatment meets all the following criteria:

- a. The treatment is provided after an examination is performed and informed consent is received from the patient.
- b. The physician identifies a medical reason for recommending or providing the treatment.
- c. The treatment is provided after the physician informs the patient about other recognized treatment options and describes to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne disease.
- d. The physician uses the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.
- e. The treatment will not, in the opinion of the physician, result in the direct and proximate death of or serious bodily injury to the patient.

13.14(2) Lyme disease. According to the Centers for Disease Control and Prevention (CDC), Lyme disease is caused by the bacterium *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks, commonly known as deer ticks. Typical symptoms include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system. Lyme disease is diagnosed based on symptoms, physical findings (e.g., a rash), and the possibility of exposure to infected ticks. Laboratory testing is helpful if used correctly and performed with validated methods. Steps to prevent Lyme disease include using insect repellent, removing ticks promptly, applying pesticides, and reducing tick habitat. The ticks that transmit Lyme disease can occasionally transmit other tick-borne diseases as well.

13.14(3) Lyme disease treatment. Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics. Over the past several years, the International Lyme and Associated Diseases Society (ILADS) has supported longer courses of antibiotics for some patients, versus the prescribed treatment durations identified by the Infectious Diseases Society of America (IDSA) and referenced by the CDC. While IDSA has expressed concern about overtreatment, ILADS points out that treatment decisions should be based on a risk-benefit analysis. Both groups have published evidence-based guidelines.

13.14(4) Tick-borne diseases. According to the CDC, tick-borne diseases include:

- a. *Anaplasmosis* is transmitted to humans by tick bites primarily from the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the United States (U.S.) and the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.
- b. *Babesiosis* is caused by microscopic parasites that infect red blood cells. Most human cases of babesiosis in the U.S. are caused by *Babesia microti*. *Babesia microti* is transmitted by the blacklegged tick (*Ixodes scapularis*) and is found primarily in the northeastern and upper midwestern regions of the U.S.

c. *Borrelia mayonii* infection has recently been described as a cause of illness in the upper midwestern region of the U.S. This infection has been found in blacklegged ticks (*Ixodes scapularis*) in Minnesota and Wisconsin. *Borrelia mayonii* is a new species and is the only species besides *B. burgdorferi* known to cause Lyme disease in North America.

d. *Borrelia miyamotoi* infection has recently been described as a cause of illness in the U.S. This infection is transmitted by the blacklegged tick (*Ixodes scapularis*) and has a geographic range similar to that of Lyme disease.

e. *Bourbon virus* infection has been identified in a limited number of patients in the midwestern and southern regions of the U.S. At this time, it is not known if the virus might be found in other areas of the U.S.

f. *Colorado tick fever* is caused by a virus transmitted by the Rocky Mountain wood tick (*Dermacentor andersoni*). Colorado tick fever occurs in the Rocky Mountain states at elevations of 4,000 to 10,500 feet.

g. *Ehrlichiosis* is transmitted to humans by the lone star tick (*Amblyomma americanum*), found primarily in the south central and eastern regions of the U.S.

h. *Heartland virus* cases have been identified in the midwestern and southern regions of the U.S. Studies suggest that lone star ticks (*Amblyomma americanum*) can transmit the virus. It is unknown if the virus may be found in other areas of the U.S.

i. *Lyme disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the U.S. and by the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

j. *Powassan disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) and the groundhog tick (*Ixodes cookei*). Cases have been reported primarily from northeastern states and the Great Lakes region.

k. *Rickettsia parkeri rickettsiosis* is transmitted to humans by the Gulf Coast tick (*Amblyomma maculatum*).

l. *Rocky Mountain spotted fever* is transmitted by the American dog tick (*Dermacentor variabilis*), Rocky Mountain wood tick (*Dermacentor andersoni*), and the brown dog tick (*Rhipicephalus sanguineus*) in the U.S. The brown dog tick and other tick species are associated with Rocky Mountain spotted fever in Central America and South America.

m. *Southern tick-associated rash illness* is transmitted via bites from the lone star tick (*Amblyomma americanum*) found in the southeastern and eastern regions of the U.S.

n. *Tick-borne relapsing fever* is transmitted to humans through the bite of infected soft ticks. Tick-borne relapsing fever has been reported in 15 states: Arizona, California, Colorado, Idaho, Kansas, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Utah, Washington, and Wyoming and is associated with sleeping in rustic cabins and vacation homes.

o. *Tularemia* is transmitted to humans by the dog tick (*Dermacentor variabilis*), the wood tick (*Dermacentor andersoni*), and the lone star tick (*Amblyomma americanum*). Tularemia occurs throughout the U.S.

p. *364D rickettsiosis (Rickettsia phillipi)* is transmitted to humans by the Pacific Coast tick (*Dermacentor occidentalis*). This is a new disease that has been found in California.

13.14(5) Grounds for discipline. A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician fails to perform and document an appropriate examination or fails to obtain and document appropriate informed consent from the patient.

b. The physician fails to identify and document a medical reason for recommending or providing the treatment.

c. The physician fails to inform the patient about other recognized treatment options or fails to describe to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne diseases.

d. The physician fails to use the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment provided, in the opinion of the physician, will likely result in the direct and proximate death of or serious bodily injury to the patient.

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.
[ARC 3589C, IAB 1/17/18, effective 2/21/18]

653—13.15(124E,147,148,272C) Standards of practice—medical cannabidiol.

13.15(1) Definitions. For purposes of this rule:

“*Board of medicine*” means the board established pursuant to Iowa Code chapters 147 and 148.

“*Bordering state*” means the same as defined in Iowa Code section 331.910.

“*Debilitating medical condition*” means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson's disease.
9. Chronic pain.
10. Ulcerative colitis.
11. Severe, intractable autism with self-injurious or aggressive behaviors.
12. Corticobasal degeneration.
13. Post-traumatic stress disorder.

“*Department*” means the Iowa department of public health.

“*Form and quantity*” means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

“*Medical cannabidiol*” means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and adopted by the department pursuant to rule.

“*Medical cannabidiol board*” means the board established pursuant to Iowa Code section 124E.5.

“*Primary caregiver*” means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of this chapter.

“*Untreatable pain*” means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

“*Written certification*” means a document signed by a physician licensed pursuant to Iowa Code chapter 148 with whom the patient has established a patient-physician relationship and who is the

patient's primary care provider which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

13.15(2) *Written certification.* A physician who is a patient's primary care provider may provide the patient a written certification of diagnosis if, after examining and treating the patient, the physician determines, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

a. The physician shall provide explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

b. Subsequently, the physician shall do the following:

(1) Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, may issue the patient a new written certification of that diagnosis.

(2) Otherwise comply with all requirements established by the department pursuant to rule.

c. A physician may provide, but has no duty to provide, a written certification pursuant to this rule.

13.15(3) *Adding or removing debilitating medical conditions and amending form and quantity of medical cannabidiol.* Recommendations made by the medical cannabidiol board pursuant to Iowa Code section 124E.5 relating to the addition or removal of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial or to the amendment of the form and quantity of allowable medical uses of cannabidiol shall be made to the board of medicine for consideration. The medical cannabidiol board shall submit a written recommendation, a copy of the petition and all other information received during consideration of the petition. The board of medicine shall consider the information received from the medical cannabidiol board and may seek information from other sources if it is deemed relevant by the board of medicine. The decision regarding a recommendation by the medical cannabidiol board is at the sole discretion of the board of medicine. The board of medicine shall make its decision within 180 days of receipt of the recommendation from the medical cannabidiol board. If the recommendation is approved by the board of medicine, it shall be adopted by rule.

13.15(4) *Financial interests.* A physician shall not share office space with, accept referrals from, or have any financial relationship with a medical cannabidiol manufacturer or dispensary.

13.15(5) *Criminal prosecution.* A physician, including any authorized agent or employee thereof, shall not be subject to prosecution for the unlawful certification, possession, or administration of marijuana under the laws of this state for activities arising directly out of or directly related to the certification or use of medical cannabidiol in the treatment of a patient diagnosed with a debilitating medical condition as authorized by Iowa Code chapter 124E.

13.15(6) *Civil or disciplinary penalties.* A physician, including any authorized agent or employee thereof, shall not be subject to any civil or disciplinary penalties by the board of medicine or any business, occupational, or professional licensing board or entity, solely for activities conducted relating to a patient's possession or use of medical cannabidiol as authorized by Iowa Code chapter 124E. Nothing in this rule prevents the board of medicine from taking action in response to violations of any other sections of law or rule.

13.15(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician provides an individual a written certification without establishing a patient-physician relationship, including examining and treating the individual, or without being the individual's primary care provider.

b. The physician provides a patient a written certification without determining, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

c. The physician provides a patient a written certification without providing explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

d. The physician provides an individual a new written certification without determining, on an annual basis, that the patient continues to suffer from a debilitating medical condition.

e. The physician shares office space with, accepts referrals from, or has a financial relationship with a medical cannabidiol manufacturer or dispensary.

This rule is intended to implement Iowa Code chapters 124E, 147, 148 and 272C.
[ARC 3830C, IAB 6/6/18, effective 7/11/18; ARC 4248C, IAB 1/16/19, effective 2/20/19; ARC 4377C, IAB 3/27/19, effective 5/1/19; ARC 4658C, IAB 9/11/19, effective 10/16/19; ARC 5861C, IAB 8/25/21, effective 9/29/21]

653—13.16(146A) Abortion prerequisites.

13.16(1) Written certification. At least 24 hours prior to performing an abortion, a physician shall obtain written certification from the pregnant woman of each prerequisite as required in Iowa Code sections 146A.1(1)“a” through 146A.1(1)“d”(1). The written certification shall list each required prerequisite separately and shall include a line for date and signature of the pregnant woman. The physician shall maintain a copy of the certification as part of the pregnant woman’s medical records.

13.16(2) Exceptions. This rule shall not apply to abortions performed in a medical emergency, as provided in Iowa Code section 146A.1(2).

13.16(3) Discipline. Failure to comply with this rule or the requirements of Iowa Code section 146A.1 may constitute grounds for discipline.

This rule is intended to implement Iowa Code section 146A.1.
[ARC 6684C, IAB 11/30/22, effective 1/4/23]

653—13.17 to 13.19 Reserved.

653—13.20(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association shall be utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

13.20(1) Conflict of interest. A physician should not provide medical services under terms or conditions which tend to interfere with or impair the free and complete exercise of the physician’s medical judgment and skill or tend to cause a deterioration of the quality of medical care.

13.20(2) Fees. Any fee charged by a physician shall be reasonable.

653—13.21(17A,147,148,272C) Waiver prohibited. Rules in this chapter are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

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[Filed ARC 4658C (Notice ARC 4445C, IAB 5/22/19), IAB 9/11/19, effective 10/16/19]
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[Filed ARC 5600C (Notice ARC 5370C, IAB 12/30/20), IAB 5/5/21, effective 6/9/21]
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¹ Effective date of 13.2(148,272C) delayed 70 days by the Administrative Rules Review Committee at its meeting held May 14, 1996.

NURSING BOARD[655]

[Prior to 8/26/87, see Nursing, Board of[590], renamed Nursing Board[655]
under the "umbrella" of Public Health Department by 1986 Iowa Acts, ch 1245]

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CHAPTER 7
ADVANCED REGISTERED NURSE PRACTITIONERS
[Prior to 8/26/87, Nursing Board[590] Ch 7]

655—7.1(17A,124,147,152) Definitions.

“*Advanced registered nurse practitioner*” or “*ARNP*” means a person who is currently licensed as a registered nurse under Iowa Code chapter 152 or chapter 152E who is licensed by the board as an advanced registered nurse practitioner.

“*Asynchronous store-and-forward transmission*” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

“*Board*” as used in this chapter means the Iowa board of nursing.

“*Collaboration*” is the process whereby an ARNP and physician jointly manage the care of a client.

“*Controlled substance*” means a drug in Schedules II through V of subchapter II of Iowa Code chapter 124.

“*Cross-coverage*” means a licensee who engages in a remote evaluation of a patient, without in-person contact, at the request of another licensed health care provider who has established a proper practitioner-patient relationship with the patient.

“*Dispense*” means to provide a prescription drug to a patient for self-use outside of the ARNP’s practice location. “Dispense” does not include administration.

“*Licensee*” means an individual licensed by the board as an advanced registered nurse practitioner.

“*National professional certification organization*” means the American Academy of Nurse Practitioners, the American Association of Critical Care Nurses, the American Midwifery Certification Board, the American Nurses Credentialing Center, the National Board of Certification and Recertification for Nurse Anesthetists, the National Certification Corporation, and the Pediatric Nursing Certification Board.

“*On call*” means a licensee is available, where necessary, to attend to the urgent and follow-up needs of a patient for whom the licensee has temporarily assumed responsibility, as designated by the patient’s primary care licensee or other health care provider of record.

“*Opioid*” means a drug that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“*Prescription monitoring program database*” or “*PMP database*” means a centralized database of reportable controlled substance prescriptions dispensed to patients and includes data access logs, security tracking information, and records of each individual who requests prescription monitoring program (PMP) information as operated by the board of pharmacy.

“*Telehealth*” means the practice of nursing using electronic audiovisual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telehealth includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telehealth, for the purposes of this rule, shall not include the provision of nursing services only through an audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

[ARC 4308C, IAB 2/13/19, effective 3/20/19; ARC 6317C, IAB 5/18/22, effective 6/22/22]

655—7.2(152) Requirements for licensure as an ARNP.

7.2(1) Qualifications. An applicant for an ARNP license shall meet the following qualifications:

- a. Hold an active unrestricted license as a registered nurse in accordance with 655—Chapter 3.
- b. Graduation from an accredited graduate or postgraduate advanced practice educational program in one of the following roles, except as provided by subrule 7.2(2):

- (1) Certified nurse-midwife.
- (2) Certified registered nurse anesthetist.
- (3) Certified nurse practitioner.

(4) Clinical nurse specialist.

c. Current certification issued by a national professional certification organization as a certified nurse-midwife or certified registered nurse anesthetist, or as a certified nurse practitioner or clinical nurse specialist in at least one of the following population foci:

- (1) Women's health/gender-related.
- (2) Family (individual across the lifespan).
- (3) Psychiatric mental health.
- (4) Adult/gerontology.
- (5) Pediatrics.
- (6) Neonatal.

7.2(2) Exception. An applicant who has completed a formal advanced practice educational program but has not graduated from an accredited graduate or postgraduate advanced practice educational program may be licensed as an ARNP provided that the applicant possesses a current certification from a national professional certification organization as described in paragraph 7.2(1) "c." This exception is intended to allow for the grandfathering of ARNPs who completed educational programs before the board required graduation from an accredited graduate or postgraduate advanced practice educational program.

[ARC 4308C, IAB 2/13/19, effective 3/20/19]

655—7.3(17A,147,152) Application process.

7.3(1) An applicant who wishes to be licensed as an ARNP shall submit the following to the board:

- a. An ARNP application for each population focus.
- b. A dated copy of the applicant's current advanced level certification issued by the appropriate national professional certification organization.
- c. If the applicant is not licensed as a registered nurse in Iowa, verification of an active registered nurse license in another state recognized for licensure in this state pursuant to the nurse licensure compact contained in Iowa Code chapter 152E.
- d. A nonrefundable license fee of \$81.

7.3(2) The applicant shall request that official transcripts be sent directly to the board from the educational program verifying the coursework, date of completion of the program, and the degree conferred.

7.3(3) The executive director of the board or the executive director's designee shall have the authority to determine if all requirements have been met for licensure of the applicant as an ARNP. If all requirements have been met:

- a. The applicant shall be issued a license and a certificate to practice as an ARNP which clearly denotes the applicant's name, title, and population focus, and the expiration date of the license.
- b. The expiration date of the ARNP license shall be the same as the expiration date of the applicant's license to practice as a registered nurse.

7.3(4) Licensure completion. An applicant shall complete the ARNP licensure process within 12 months from the start of the application. The board reserves the right to destroy incomplete application materials after 12 months.

7.3(5) Renewal of licensure. An ARNP license may be renewed beginning 60 days prior to the license expiration date and ending 30 days after the expiration date. To renew, a licensee shall submit the information required by subrule 7.3(1). The expiration date assigned to a renewed ARNP license shall be the same as the expiration date of the licensee's license to practice as a registered nurse.

7.3(6) Inactive status. Failure to renew an ARNP license within 30 days after its expiration shall result in an inactive ARNP license.

- a. Continuing to work as an ARNP with an inactive ARNP license may result in disciplinary action.
- b. To reactivate the license, the licensee must reactivate the underlying license to practice as a registered nurse, if required, and shall complete the license renewal process for the ARNP license.

7.3(7) License denial. Rule 655—3.9(17A,272C) shall govern the denial of an application for an ARNP license.

[ARC 4308C, IAB 2/13/19, effective 3/20/19]

655—7.4(17A,147,152) Advanced nursing practice.

7.4(1) An ARNP shall practice within the ARNP's respective population foci. An ARNP shall practice in accordance with the applicable standard of care as described in guidelines published by national professional associations or other reputable sources.

7.4(2) An ARNP must maintain current certification with a national professional certification organization at all times while the ARNP license is active.

7.4(3) An ARNP licensed by the board may prescribe, administer, or dispense prescription drugs or devices, including controlled substances, within the ARNP's role and population foci and consistent with applicable state and federal laws.

7.4(4) An ARNP shall have the authority to practice to the full extent of the ARNP's license, education, and experience in the ARNP's respective population foci. An ARNP may:

- a. Assess health status;
- b. Obtain a relevant health and medical history;
- c. Perform physical examinations;
- d. Order preventive and diagnostic procedures;
- e. Formulate a differential diagnosis;
- f. Develop a treatment plan;
- g. Develop a patient education plan;
- h. Receive third-party reimbursement;
- i. Maintain hospital privileges; and
- j. Promote health maintenance.

7.4(5) Supervision of fluoroscopy. An ARNP shall be permitted to provide direct supervision in the use of fluoroscopic X-ray equipment, as defined in rule 641—38.2(136C).

a. The ARNP shall provide direct supervision of fluoroscopy pursuant to the following provisions:

(1) Completion of an educational course including content in radiation physics, radiobiology, radiological safety and radiation management applicable to the use of fluoroscopy, and maintenance of documentation verifying successful completion.

(2) Collaboration, as needed, as defined in rule 655—7.1(17A,124,147,152).

(3) Compliance with facility policies and procedures.

b. The ARNP shall complete an annual radiological safety course whose content includes, but is not limited to, the time, dose, distance, shielding and effects of radiation.

c. The ARNP shall maintain documentation of the initial educational course and all annual radiological safety updates.

d. The initial and annual education requirements are subject to audit by the board pursuant to 655—subrule 5.2(10).

7.4(6) Only a person currently licensed as an advanced registered nurse practitioner may use that title and the letters "ARNP" after the person's name. A person currently licensed as an ARNP shall utilize the title "advanced registered nurse practitioner" or the letters "ARNP" after the person's name. Utilization of the title which denotes the ARNP's certification or population foci is at the discretion of the ARNP.

[ARC 4308C, IAB 2/13/19, effective 3/20/19]

655—7.5(17A,147,152) Standards of practice for treating patients. An ARNP shall follow the standards of practice for the ARNP's respective population foci. Prior to treating a patient, an ARNP shall:

7.5(1) Establish a patient-provider relationship.

7.5(2) Perform and document the following, or have access to the patient's health records where all of the following have been documented by other providers in the care team:

- a. Chief complaint;

- b. Pertinent health history;
- c. A focused assessment;
- d. Diagnosis; and
- e. Plan of treatment.

[ARC 4308C, IAB 2/13/19, effective 3/20/19]

655—7.6(17A,124,147,152,272C) Standards of practice for controlled substances. In addition to following the standards of practice for treating a patient described in rule 655—7.5(17A,147,152), an ARNP who prescribes or administers a controlled substance shall practice in accordance with the following:

7.6(1) The health history shall include a personal and family substance abuse risk assessment, or the documented rationale for not performing the assessment.

7.6(2) The health record must include documentation of the presence of one or more recognized indications for the use of a controlled substance.

7.6(3) An ARNP is encouraged to utilize a treatment agreement if continuously prescribing one or more controlled substances.

7.6(4) Throughout the course of the patient's treatment, the ARNP shall provide ongoing education that includes, but is not limited to, the risks of using a controlled substance, and information regarding addiction, physical dependence, substance abuse, and tolerance, or document the rationale for not providing the education.

7.6(5) An ARNP shall maintain an active Drug Enforcement Administration (DEA) registration and an active controlled substances Act (CSA) registration to dispense, prescribe, or administer controlled substances, when required by the DEA and the board of pharmacy.

7.6(6) An ARNP shall not prescribe a controlled substance to the ARNP's self or to a family member unless the prescribing occurs in a clinical setting when an emergency situation arises and when there is no other qualified practitioner available to the patient.

7.6(7) The board may discipline an ARNP for prescribing opioids in dosage amounts that exceed what would be prescribed by a reasonably prudent ARNP in a similar practice.

7.6(8) An ARNP who has prescribed opioids to a patient during the renewal cycle is required to complete a minimum of two contact hours of continuing education regarding the U.S. Centers for Disease Control and Prevention guideline for prescribing opioids for chronic pain, including recommendations on limitations on dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacologic therapy options, as a condition of license renewal every three years. These hours may count towards the 36 contact hours required for license renewal. The ARNP shall maintain documentation of these hours, which may be subject to audit.

[ARC 4308C, IAB 2/13/19, effective 3/20/19]

655—7.7(124) Use of the prescription monitoring program.

7.7(1) Prior to the prescribing or dispensing of an opioid by an ARNP, the ARNP or the ARNP's authorized delegate shall query the PMP database and the ARNP shall review the patient's information contained in the PMP database.

7.7(2) This rule does not apply to an ARNP when treating a patient who is receiving inpatient hospice care or long-term residential facility care.

7.7(3) This rule does not apply to an ARNP who issues a medication order for an opioid to be administered to a patient at a hospital or clinic, because the ARNP is neither prescribing nor dispensing in this scenario.

7.7(4) An ARNP is responsible for understanding the board of pharmacy's rules governing use of the prescription monitoring program in 657—Chapter 37.

[ARC 4308C, IAB 2/13/19, effective 3/20/19]

655—7.8(152) Prescribing epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of a facility or school.

7.8(1) An ARNP may issue a prescription for one or more epinephrine auto-injectors in the name of a facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school.

7.8(2) An ARNP may issue a prescription for one or more bronchodilator canisters or bronchodilator canisters and spacers in the name of a school district or an accredited nonpublic school.

7.8(3) An ARNP may issue a prescription for one or more opioid antagonists in the name of a school district.

7.8(4) An ARNP who prescribes epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school, to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16, and 280.16A, provided the ARNP has acted reasonably and in good faith, shall not be liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector, bronchodilator canister, bronchodilator canister and spacer, or opioid antagonist.

[ARC 4308C, IAB 2/13/19, effective 3/20/19; ARC 6950C, IAB 3/8/23, effective 4/12/23]

655—7.9(152) Standards of practice for telehealth.

7.9(1) *Telehealth permitted.* A licensee may, in accordance with all applicable laws and rules, provide health care services to a patient through telehealth.

7.9(2) *License required.* An advanced registered nurse practitioner who provides services through telehealth to a patient physically located in Iowa must be licensed by the board. A licensee who provides services through telehealth to a patient physically located in another state shall be subject to the laws and jurisdiction of the state where the patient is physically located.

7.9(3) *Standard of care.*

a. A licensee who provides services through telehealth shall be held to the same standard of care as is applicable to in-person settings. A licensee shall not perform any service via telehealth unless the same standard of care can be achieved as if the service was performed in person.

b. Prior to initiating contact with a patient for the purpose of providing services to the patient using telehealth, a licensee shall:

- (1) Review the patient's history and all relevant medical records; and
- (2) Determine as to each unique patient encounter whether the licensee will be able to provide the same standard of care using telehealth as would be provided if the services were provided in person.

7.9(4) *Scope of practice.* A licensee who provides services through telehealth must practice within the licensee's respective population foci and ensure the services provided are consistent with the licensee's scope of practice, education, training, and experience.

7.9(5) *Practitioner-patient relationship.*

a. Prior to providing services through telehealth, the licensee shall first establish a practitioner-patient relationship. A practitioner-patient relationship is established when:

- (1) The person with a health-related matter seeks assistance from the licensee;
- (2) The licensee agrees to provide services; and
- (3) The person agrees to be treated, or the person's legal guardian or legal representative agrees to the person's being treated, by the licensee regardless of whether there has been a previous in-person encounter between the licensee and the person.

b. A practitioner-patient relationship can be established through an in-person encounter, consultation with another licensee or health care provider, or telehealth encounter.

c. Notwithstanding paragraphs 7.9(5) "a" and "b," services may be provided through telehealth without first establishing a practitioner-patient relationship in the following settings or circumstances:

- (1) Institutional settings;
- (2) Licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities, and hospice settings;
- (3) In response to an emergency or disaster;

(4) Informal consultations with another health care provider performed by a licensee outside of the context of a contractual relationship, or on an irregular or infrequent basis, without the expectation or exchange of direct or indirect compensation;

(5) Episodic consultations by a specialist located in another jurisdiction who provides consultation services upon request to a licensee;

(6) A substitute licensee acting on behalf and at the designation of an absent licensee or other health care provider in the same specialty on an on-call or cross-coverage basis; or

(7) When a sexually transmitted disease has been diagnosed in a patient, a licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention.

7.9(6) Consent to telehealth. Prior to providing services via telehealth, the licensee shall obtain consent from the patient, or the patient's legal guardian or legal representative, to receive services via telehealth.

7.9(7) Technology. A licensee providing services through telehealth shall utilize technology that is secure and compliant with the Health Insurance Portability and Accountability Act (HIPAA). The technology must be of sufficient quality, size, resolution, and clarity such that the licensee can safely and effectively provide the telehealth services and abide by the applicable standard of care.

7.9(8) Prescriptions. A licensee providing services through telehealth may issue a prescription to a patient as long as the issuance of such prescription is consistent with the standard of care applicable to the in-person setting.

7.9(9) Records. A licensee who provides services through telehealth shall maintain a record of the care provided to the patient. Such records shall comply with all applicable laws, rules, standards of care for recordkeeping, confidentiality, and disclosure of a patient's medical record.

7.9(10) Follow-up care. A licensee who provides services through telehealth shall refer a patient for follow-up care when required by the standard of care.

[ARC 6317C, IAB 5/18/22, effective 6/22/22]

These rules are intended to implement Iowa Code sections 17A.3, 124.551A, 124.552, 147.2, 147.10, 147.11, 147.72, 147.74, 147.76, 147.80, 147.107, 152.1, 152.6, 152.7, and 272C.2C.

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CHAPTER 132
IOWA BYWAYS PROGRAM

761—132.1(306D) Purpose, overview and information.

132.1(1) Purpose. The purpose of the Iowa Byways program is to designate and support qualifying Iowa roads as byways on the basis of scenic byway, heritage byway, or a combination of scenic and heritage byway qualities. These designations are intended to preserve the state's scenic, natural, and historic resources; to support economic development through travel and tourism; to highlight distinctive experiences; and to maintain the integrity of the Iowa Byways program.

132.1(2) Overview. Under the Iowa Byways program, proposed routes are identified via an application process. The department inventories the proposed routes and consults with program stakeholders before evaluating those routes for designation. The department provides identifying signs for the designated routes. Routes designated as an Iowa Byway are part of Iowa's scenic byway program and are therefore subject to the prohibition set forth in 23 U.S.C. Section 131(s).

132.1(3) Information and forms. Information, instructions and application forms may be obtained from the Systems Planning Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; by telephone at (515)239-1664; or through the department's website at www.iowadot.gov.
[ARC 3298C, IAB 8/30/17, effective 10/4/17; Editorial change: IAC Supplement 8/11/21; ARC 6931C, IAB 3/8/23, effective 4/12/23]

761—132.2(306D) Definitions.

"Department" means the Iowa department of transportation.

"Designation" means department approval of a route as an Iowa Byway.

"Heritage byway" means a route that has historic or cultural significance along its length or connects various areas or sites of historic or cultural significance along its length.

"Scenic byway" means a route that has naturally scenic features visible along its length.

"Stakeholder" means a group, state agency, local jurisdiction or organization with a vested interest in the Iowa Byways program or that may be impacted by the designation of a route. Examples may include but are not limited to an adjacent scenic, natural or historic resource or other tourism attraction; other designated Iowa Byways; private associations related to economic development or outdoor advertising; and organizations charged with the marketing of the state, regions or localities for tourism purposes.
[ARC 3298C, IAB 8/30/17, effective 10/4/17; ARC 6931C, IAB 3/8/23, effective 4/12/23]

761—132.3(306D) General requirements.

132.3(1) A route eligible for designation as an Iowa Byway must meet the definition of either a heritage byway or a scenic byway. A route may also be eligible for designation if segments of the route meet a combination of either a heritage byway or a scenic byway along its entire length.

132.3(2) Primary roads, secondary roads and city streets are eligible for designation as Iowa Byways.

132.3(3) A route eligible for designation as an Iowa Byway should be continuous and at least 20 miles in length.

132.3(4) The governing body of each city and county through which a route passes must pass a formal resolution endorsing the application for Iowa Byway designation and agreeing to the responsibilities of having jurisdiction over a portion of a designated route.

132.3(5) The initial installation of signs identifying an Iowa Byway including the accompanying posts and hardware necessary for installation shall be paid for and furnished by the department. Each roadway jurisdiction is responsible for the inventory and maintenance of signs provided by the department following the initial installation. The department will provide replacement signs for those that are damaged or missing and will be responsible for reinstallation on primary roads. The roadway jurisdiction will be responsible for reinstallation on secondary roads and city streets.
[ARC 3298C, IAB 8/30/17, effective 10/4/17; ARC 6931C, IAB 3/8/23, effective 4/12/23]

761—132.4(306D) Application and approval process.

132.4(1) Program cycle. The department may periodically announce a solicitation of applications for designation as demand and interest requires. Field inventories, evaluation, and rating of proposed routes will precede the designation of any new routes.

132.4(2) Application. Application to designate a route as an Iowa Byway or to propose an extension or loop to an existing route shall be on a form provided by the department and shall be received by the department by the stated application deadline included in the solicitation. The application must be accompanied by a formal resolution described in subrule 132.3(4). Applications must provide some discussion of the planned administration and governance of the proposed Iowa Byway as well as how the byway will be marketed to visitors.

132.4(3) Initial review. Applications shall be reviewed by the department. Program stakeholders will be consulted to gather information on the existence and quality of scenic, archaeological, cultural, historic, natural, and recreational resources along a proposed route; the proposed route's contribution to a diversity of experiences along designated routes; and the overall impact of the proposed route on the program's integrity.

132.4(4) Field inventory. The department shall conduct a field inventory of proposed routes which will address the following qualities:

a. Scenic value. Types and qualities of views along the proposed route contributing to the scenic quality of the route shall be identified as well as views that distract from or negatively affect the scenic quality of the route. The field inventory will provide an assessment of the visual character of the proposed route along its length.

b. Cultural and historic resources. Known cultural and historic resources will be identified along the length of the proposed route. Such resources may include archaeological, architectural, historical or other cultural sites of national or state significance and may also include interesting or unique local cultures or architecture that may appeal to visitors.

c. Natural resources. Resources including but not limited to agricultural lands, forests, river basins, and other distinctive landforms will be identified.

d. Recreational resources. Public lands and facilities providing opportunities for organized sport, outdoor recreation, or other recreation will be identified.

e. Transportation. An assessment will be made of existing and future traffic conditions, planned improvements to the proposed route, and any safety concerns whether existing or anticipated. If the route is being considered for heritage byway designation, historic elements specific to transportation will be identified.

132.4(5) Evaluation and rating. The department shall compile and evaluate the field inventory data for each proposed route, calculate an overall quality rating for each proposed route, and prepare a written report documenting these findings. The written report shall also consider the sustainability of the proposed route based on the information provided in the application for planned governance and marketing plans as well as how the proposed route will complement the existing Iowa Byways.

132.4(6) Designation. The department shall review the evaluations and will consider designating routes as Iowa Byways based on this information.

132.4(7) Signing. Upon the designation of Iowa Byways, the department will proceed with the initial design and installation of signage identifying new Iowa Byways.

[ARC 3298C, IAB 8/30/17, effective 10/4/17; ARC 6931C, IAB 3/8/23, effective 4/12/23]

761—132.5(306D) Reevaluation. At its discretion, the department may inventory and evaluate designated Iowa Byways or portions of byways to determine their continued eligibility for the program. The department reserves the right to remove a route or portion of a route from the program if the route no longer meets the designating criteria or if the route signage has not been maintained. The department may modify an existing route if an alternative route would better benefit the traveling public in cases of poor road conditions, closures or changes in available amenities.

[ARC 3298C, IAB 8/30/17, effective 10/4/17]

761—132.6(306D) Promotional and tourism efforts. The department is not responsible for economic development, promotional, or other tourism efforts for Iowa Byways.

[ARC 3298C, IAB 8/30/17, effective 10/4/17]

These rules are intended to implement Iowa Code chapter 306D.

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CHAPTER 163
RISE PROGRAM

[Prior to 6/3/87, Transportation Department[820]—(06,Q) Ch 4]

761—163.1(315) Definitions. When used in this chapter, unless the context otherwise requires:

“Brownfield site” means an abandoned, idled, or underutilized industrial or commercial facility where expansion or redevelopment is complicated by real or perceived environmental contamination.

“Commission” means the state transportation commission.

“Department” means the Iowa department of transportation.

“Direct jobs created” refers to jobs new to the state in firms, developments, or sites specifically assisted by a RISE project.

“Direct jobs retained” refers to existing Iowa jobs that would otherwise be lost in firms, developments, or sites specifically assisted by a RISE project.

“Economic development” means private investment involving the creation of new jobs and income or the retention of existing jobs and income that would otherwise be lost. For the purposes of this program, economic development shall be viewed from a statewide perspective rather than a local or substate, regional perspective and shall result in a net gain to the state.

“Funding commitment” means commission approval of the use of RISE funds for a project.

“Grant” means funds received for a RISE project with no provision for applicant repayment of principal.

“Immediate opportunity project,” one of the two types of RISE projects, is a roadway project that needs a funding commitment within a short time period and meets the threshold criteria in subrule 163.10(6). The project primarily provides improved access to a single economic unit, such as a county, a city, an industrial park, a plant or other business, a development site or a tourist attraction.

“Import substitution” means replacing inputs, products or services from out-of-state firms or locations with Iowa inputs, products or services.

“Jurisdiction” means the state, county, or city having legal authority over a road or street.

“Loan” means funds received for a RISE project with provision for applicant repayment of principal. A loan may or may not involve the payment of interest charges.

“Local development project,” one of the two types of RISE projects, is a roadway project which is programmed through a semiannual competitive rating procedure. The project primarily provides improved access to either a single economic unit, such as a county, a city, an industrial park, a plant or other business, a development site or a tourist attraction, or to a portion of a metropolitan area.

“Project” means an eligible activity or cost or set of eligible activities or costs funded with RISE program funds. The two types of projects which may be funded under the RISE program are immediate opportunity projects and local development projects.

“RISE” means revitalize Iowa’s sound economy.

“RISE fund” means the fund created in Iowa Code section 315.2.

“Total capital investment” means the economic value of all permanent purchases, donations, or improvements directly associated with an economic development activity but not funded with RISE moneys, including land; improvements to land; buildings; equipment; furnishings; electric, gas, telephone, and other utilities; sanitary sewer and storm sewer extensions and hookups; and railroad spurs, access roads, parking lots, and other transportation facilities.

“Traffic impact analysis” means an analysis identifying system and immediate impacts associated with a proposed development to allow an assessment of the existing and future highway system’s safety, performance, maintenance, and capacity needs and includes all necessary information as required by the department.

“Transportation justification” means the reasons given for a project from a transportation planning and engineering standpoint. The justification should address the current condition of existing roadways or bridges, the relationship of the project to connecting roads, anticipated total traffic, anticipated large truck traffic, proposed major design features, roadway function, and the reasons the proposed alternative was selected over other available alternatives.

“*Value-adding activities*” means activities which, through the employment of knowledge or labor, add value to a product, process or service that results in the creation of new wealth to the state.
[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.2(315) Information and forms. Information, instructions and application forms may be obtained from the Systems Planning Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; by telephone at (515)239-1664; or through the department’s website at www.iowadot.gov.
[ARC 3299C, IAB 8/30/17, effective 10/4/17; Editorial change: IAC Supplement 8/11/21; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.3(315) Purpose of RISE program. The purpose of the RISE program is to promote economic development in Iowa through the establishment, construction, improvement, and maintenance of roads and streets. The RISE program shall be targeted toward value-adding activities to provide maximum economic impact to the state. Value-adding activities feed new dollars into the economy. As these dollars are circulated, the state experiences economic growth. Tourism activities that result in the attraction of out-of-state dollars to the state economy may also be targeted by the program. Residential development, local government facilities, local public schools, locally oriented business services and personal services are generally not value-adding activities and will rarely meet the intent of the program.

The RISE program shall also be administered to encourage economic diversification, new business opportunities, small business development, exporting, import substitution and tourism in Iowa.
[ARC 3299C, IAB 8/30/17, effective 10/4/17]

761—163.4(315) Administration of RISE program.

163.4(1) The RISE program shall be administered by the department as a statewide program, with projects evaluated primarily on the basis of economic development criteria rather than solely on the basis of transportation criteria. In carrying out its program responsibilities, the department shall:

a. Involve local officials in program development and periodic program review and evaluation, including evaluation of the accomplishments and effectiveness of the RISE program. However, all project funding decisions shall be the responsibility of the commission.

b. Simplify application processes and administrative procedures to the maximum practicable extent.

c. Design the RISE program administrative procedures so that they are flexible enough to meet county and city needs.

d. Ensure neutrality and fairness in the treatment of all applications submitted for funding under the RISE program.

e. Promote intergovernmental cooperation on economic development.

f. Promote the use of innovative financing mechanisms for RISE projects.

163.4(2) The commission shall be responsible for all RISE project funding commitments. All project funding commitments are made subject to the availability of RISE funds.

163.4(3) The department shall annually prepare a written report indicating the amount and percentage of funds committed during the previous year on primary roads, secondary roads, city streets, state park roads and county conservation parkways.

[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.5(315) Source, allocation, and use of RISE funds.

163.5(1) Source. The RISE program is funded with dedicated state motor fuel and special fuel tax revenues as set out in Iowa Code section 312.2 and chapter 315.

163.5(2) Allocation and use.

a. Allocation among roadway jurisdictions. The RISE fund shall be allocated as specified in Iowa Code section 315.4.

b. Funding restricted to public roads. The use of RISE funds is restricted to construction or improvement of primary roads, secondary roads, city streets, state park roads and county conservation parkways presently open to public use or ones which will be dedicated and open to public use in the

future. RISE funds may not be used for private road projects or for any other private purpose. Project activities which may and may not be funded under the RISE program are listed in rule 163.7(315).

c. Use of county or city RISE funds on primary road projects. Counties or cities may at their option make application to the department to apply RISE funds allocated for use on secondary road or city street projects toward primary road projects. Use of county or city RISE funds on primary road projects shall be approved by the commission.

d. Type of projects. The two types of projects which may be funded under the RISE program are immediate opportunity projects and local development projects. The requirements and procedures specifically applicable to the two project types are located in the following rules of this chapter:

- (1) Immediate opportunity projects: Rule 761—163.10(315).
- (2) Local development projects: Rule 761—163.11(315).

e. Relationship of project. The demonstrated relationship of a project to economic development shall generally be the main criterion employed in determining the priority for funding. The department is required to assign the lowest priority to a project if it involves a business with wages substantially below other area businesses or with a consistent record of law violations. In terms of project type, an immediate opportunity project shall have first priority for all available RISE funds.

f. Use of repaid funds. RISE funds repaid to the department for any reason may be used for other projects or carried over to the next programming cycle. RISE funds repaid shall be credited to the share of the fund from which the project was originally funded.

g. Carryover of funds. The commission need not commit the spending of all RISE funds available during a programming cycle. Uncommitted city funds may be carried over to the next programming cycle or used for immediate opportunity projects. On June 30 of each year, all uncommitted county funds shall be credited to the secondary road fund.

h. Reserve for future needs and contingencies. The commission shall monitor RISE fund commitments and expected RISE fund cash flow and take actions necessary to ensure that funds remain available for anticipated present and future immediate opportunity project needs and other contingencies. Such actions may include placing a moratorium on the receipt and award of local development RISE applications, placing a limit on RISE dollars awarded to each project, or taking other actions at the discretion of the commission.

[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.6(315) Project financing and funding shares.

163.6(1) Financing. Applicants may choose to propose grant financing for any RISE project. Applicants are encouraged but not required to propose below market rate interest loan, no interest loan, or partial principal payback rather than grant financing for RISE projects. The extent to which a project will return moneys to the RISE fund shall be considered in project evaluation processes. Final financial terms for all RISE projects are subject to negotiation between the department and the applicant and approval by the commission.

163.6(2) Funding shares. Applicants may propose the proportions and sources of RISE and non-RISE funds to be used for a project. Use of RISE funds is subject to commission approval.

[ARC 3299C, IAB 8/30/17, effective 10/4/17]

761—163.7(315) Eligibility of applicants and joint applications.

163.7(1) Applicant eligibility. All incorporated cities and all counties in the state of Iowa are eligible to apply for and receive funds under the RISE program. The department is also eligible to initiate projects and receive funds under this program but need not formally apply for funds. Private firms or developers or other agencies may not apply directly for funds but are encouraged to work with county or city governments in seeking funding for projects. In any case, all projects must be let by the applicant or through the department's office of contracts and in accordance with all applicable laws and rules.

163.7(2) Joint applications. Joint applications from two or more counties or cities are encouraged when mutual action is required to support economic development. Joint applications shall designate a lead county or city to serve as a principal contact point for the department.

[ARC 3299C, IAB 8/30/17, effective 10/4/17]

761—163.8(315) Project activities eligible and ineligible for RISE funds.

163.8(1) Eligible activities. Project activities or costs eligible for RISE funding, and which may be counted as part of the non-RISE participation in immediate opportunity and local development roadway projects, include only the following:

a. Roadway resurfacing, rehabilitation, modernization, upgrading, reconstruction or initial construction, including grading and drainage, paving, erosion control, pavement overlays, and shoulder widening and stabilization.

b. Bridge and culvert repair, modernization, replacement or initial construction.

c. Roadway intersection and interchange improvements including warranted traffic signalization when it is integral to the improvement.

d. Public transportation system improvements, including but not limited to bus shelters, bus turnouts, and passenger information signage, when they are integral to the roadway improvement.

e. Bicycle and pedestrian infrastructure improvements, including but not limited to sidewalks, at-grade pedestrian crossings, bike lanes, and separated bike lanes, when they are integral to the roadway improvement.

f. Right-of-way acquisition costs, including but not limited to appraisals, negotiation, compensation, and cultural resources surveys necessary to comply with applicable local, state and federal laws, rules and regulations.

g. Construction or improvement of motorist rest areas, welcome centers, and information centers.

h. Design engineering costs leading to construction plan development and construction inspection costs associated with RISE-financed projects.

i. County and city bond principal and interest payments associated only with RISE projects. No financing expenses incurred prior to funding commitment shall be eligible, and no administrative or legal expenses may be reimbursed. The bond term may not exceed the expected useful life of the roadway.

j. Storm drainage and storm sewer costs to the extent needed for draining the roadway.

k. Reconstruction or adjustment of utilities, including but not limited to water, sanitary sewer, electric, telephone, and natural gas, when utilities are located on private property and require replacement or relocation due to project construction; or said utilities are located in the public right-of-way and the utility is not required to relocate at its own expense.

l. Costs associated with the acquisition of local, state and federal permits required for roadway construction.

m. Costs of modifications to railroad facilities required to construct the RISE roadway, including but not limited to construction, hiring flaggers, and engineering performed by the railroad or the railroad's contractor, that are consistent with an executed agreement between the railroad and the roadway jurisdiction.

163.8(2) Ineligible activities. Activities or costs ineligible for RISE funding, and which may not be counted as part of the non-RISE participation in immediate opportunity or local development roadway projects, include but are not limited to the following:

a. Any and all costs incurred prior to a funding commitment by the commission notwithstanding rule 761—163.9(315).

b. Routine roadway, bridge and culvert maintenance, including but not limited to pothole filling, crack sealing, seal coating, patching, shoulder maintenance, gravel or earth roadway maintenance, and bridge painting.

c. Winter roadway and bridge maintenance, including but not limited to snow plowing, sanding, and salting.

d. Overhead and operating costs associated with eligible project activities, including auditing.

e. Expenses associated with the preparation and submission of applications for RISE funding.

f. Predesign engineering, feasibility or alignment studies, and other planning expenses.

g. Traffic signalization, except as an integral part of a roadway project.

h. Pavement marking and traffic signs, except as an integral part of a roadway project.

i. Utility construction, reconstruction or adjustment except for those activities or costs described in subrule 163.8(1).

- j.* Safety appurtenances, except as an integral part of a roadway project.
- k.* Lighting, except as an integral part of a roadway project.
- l.* Lighting energy and maintenance costs.
- m.* Sidewalks, bicycle paths, and railroad-highway crossings, except when replacing those facilities in service and affected by the project, or as an integral part of a roadway project.
- n.* Parking expenditures, including those for structures, lots, meters, paving, and marking whether for on-street or off-street parking.
- o.* Nonroadway transportation expenditures, including those for railway, aviation, public transportation, and inland waterway facilities and equipment.
- p.* Purchase of furnishings, construction equipment, and personal property.
- q.* General government expenses and expenses associated with the provision of any public service which are not eligible for RISE program assistance.
- r.* Donated right-of-way.

[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.9(315) Advance eligibility of land acquisition and preliminary design costs incurred prior to funding commitment by commission.

163.9(1) *Need for advance eligibility.* If there is extreme urgency involving land acquisition or preliminary design and a necessity to protect or preserve a project corridor or to proceed with the preparation of project construction plans prior to a RISE funding commitment, a potential applicant may submit a written request to the department for a determination of advance eligibility to incur costs for land acquisition or preliminary design immediately. A determination of advance eligibility by the department will allow specified costs incurred prior to a funding commitment by the commission to be eligible for reimbursement with RISE funding without jeopardizing the project's eligibility for funding approval, but does not imply or guarantee that the commission will commit RISE funding to a subsequent application.

163.9(2) *Request, justification and review.* The request must be received by the department prior to the expenditure and must include justification regarding the extreme urgency and necessity to incur costs prior to a RISE funding commitment. A request for land acquisition must also include a description of the land to be acquired, a summary of the estimated costs, and a map showing the parcels to be acquired. Preliminary design requests must include a description of the project scope, location map, and proposed cross section. If the request will include consultant design costs, a draft agreement between the jurisdiction and the consultant must be submitted which includes the scope of services to be rendered. Costs for RISE application preparation and submission or project feasibility, route alignment studies or other planning expenses as cited in paragraphs 163.8(2) "e" and "f" remain ineligible for RISE funding and shall not be included in a request for determination of advance eligibility. The department will review the submittal. If the requirements of this rule are met, the department will provide written confirmation of the determination of advance eligibility.

163.9(3) *Requirements.* Any cost incurred before the request is received by the department will be ineligible for reimbursement. Costs receiving a determination of advance eligibility must be noted in the subsequent RISE funding application submitted to the department. Land acquired or design work completed following a determination of advance eligibility will not be eligible for reimbursement with RISE funds if the property acquired or design work completed is not necessary to construct the proposed RISE project included in the subsequent application. Design costs receiving a determination of advance eligibility may not exceed 10 percent of the total construction costs for the project. An application for funding which includes the expenditure must be received by the department within two years following the determination of advance eligibility, or the costs may become ineligible for RISE funding.

[ARC 3299C, IAB 8/30/17, effective 10/4/17]

761—163.10(315) Immediate opportunity projects.

163.10(1) *General provisions.* The following provisions are applicable to immediate opportunity projects:

a. Immediate opportunity projects may be located on primary roads, secondary roads, city streets, state park roads or county conservation parkways.

b. There is no restriction on the number of applications per county or city that will be considered for RISE funding.

c. Counties and cities may apply for single-year or multiyear funding. Multiyear funding shall be limited to funding commitments from no more than three program years' allocations.

d. Applicants may use staff from other counties or cities, areawide planning organizations, areawide economic development organizations, or other jurisdictions to prepare application materials or administer projects.

e. There must be an adequate transportation justification for the roadway project. The proposed improvement need not be designed prior to project application, but the concept must generally be reasonable from a transportation planning and engineering standpoint and detailed enough to enable project cost estimates to be developed.

163.10(2) Contents of applications. Each application for an immediate opportunity project must contain the following:

a. General information, including the applicant's name, contact person, mailing address, telephone number, local economic development area and history of efforts in the area, and other information of a general nature about the project proposal and the associated economic development activity.

b. Cost information, including the estimated total capital investment involved with the associated economic development activity, the estimated total cost of the roadway project, the amount of RISE funds requested for the roadway project, and the amount of non-RISE funds to be used to match or supplement RISE funding. Itemized breakdowns (showing the item, cost, and funding source) must be included for the total capital investment, the total roadway project cost, the RISE funds requested, and the non-RISE funds to be used to match or supplement RISE funding.

c. Data showing the impact of the associated economic development activity, including the number of direct jobs created or retained. Jobs created as a result of jobs being displaced elsewhere in the state shall not be considered direct jobs created for the purpose of evaluating the application.

(1) To expedite the review, the applicant shall provide the following data for each business included in the project justification: a list of in-state competitors; a list of in-state suppliers; the percentage of out-of-state sales; the effect on import substitution; long-range growth potential; and a list of all current and anticipated employment positions, both full- and part-time, the hourly wage for each, and the turnover rate.

(2) The applicant shall certify that each business will give hiring preference to residents of the state or local area, except for out-of-state employees offered a transfer to Iowa.

d. A preliminary project concept statement for the roadway project, including maps showing site characteristics, such as zoning, platting, subdivision boundaries, and corporate limits; a sketch plan; and a justification for the transportation improvement. In most cases, a sketch plan should include a simple plan and profile defining the horizontal and vertical geometrics and a typical roadway cross section defining pavement, shoulders, foreslope, and backslope or border treatment. The transportation justification should address topics such as the current condition of existing roadways or bridges, the relationship of the project to connecting roads, and ingress to and egress from the site, as well as the current flow of traffic on the development site, anticipated total traffic and large truck traffic, proposed major design features of the proposed improvement, the intended roadway function, how the proposed improvement is consistent with other local plans, and the reason the proposed alternative was selected over other alternatives. In consultation with the department, a traffic impact analysis may be required to supplement the transportation justification.

e. A time schedule for the total development, including the roadway project and the associated economic development activity.

f. A formal resolution passed by the governing body of the jurisdiction responsible or to be responsible for the road or street to be constructed or improved. The resolution shall state that the project will be adequately maintained and dedicated to public use for a minimum of 20 years after completion of the project and that land provided access by the proposed improvement will be developed

according to rule 761—163.3(315). The resolution must also certify that the project meets the threshold criteria cited in paragraph 163.10(6)“a” and that any business assisted by the project which acquires or merges with an Iowa corporation within three years following the RISE application shall make a good-faith effort to hire the workers of the merged or acquired company.

g. Documentation showing that the threshold criteria of subrule 163.10(6) have been met.

163.10(3) *Submission of applications.* Applications shall be submitted on a form provided by the department. Applications may be submitted at any time.

Once an application has been submitted, no further information concerning that application shall be accepted by the department from the applicant unless specifically requested by the department. Applications may be withdrawn by the applicant and resubmitted at any time. Resubmitted applications shall be dated accordingly.

163.10(4) *Incomplete applications.* An applicant must satisfy the application requirements outlined in this chapter and must fully complete the official application form before the application will be considered by the commission.

163.10(5) *Verification of application materials.* Complete applications shall be reviewed to verify the figures or statements in the applications. This may include site visits. If inaccuracies, omissions, or errors are found, the commission may rescind the commitment of funds or reevaluate the application based on the correct information. If an applicant loses funding through this process, the commission shall have complete discretion concerning the disposition of those funds, including awarding them to other applicants or carrying them over to the next programming cycle.

163.10(6) *Threshold criteria.* Funding commitment decisions for immediate opportunity projects shall be made on an individual basis. There is no competitive ranking of project applications. In order to gain a funding commitment, an application must meet all of the following threshold criteria:

a. The project must be related to an immediate, nonspeculative opportunity for permanent job creation or retention. The applicant county or city (or its agent) should be in the process of negotiating a location or retention decision with a developer or firm.

b. The applicant must demonstrate that an immediate funding commitment is essential to influence the job location or retention decision.

c. The applicant must demonstrate that necessary arrangements have been made for nonroadway factors (e.g., labor force training, zoning, sewer, water, police and fire protection, financing, and permits) essential for the proposed job creation or job retention activity.

d. There must be at least 20 percent non-RISE financial participation in the roadway project, except the commission may approve a participation amount that is less than 20 percent if it determines that the applicant city or county is economically distressed.

e. There must be a strong likelihood that the total development, including the roadway project, can be completed in a timely manner. It is up to the applicant to identify a time schedule and maintain it. This time schedule may be adjusted for such reasons including but not limited to the project involves unusually complex engineering studies, extensive real estate negotiations, extensive analysis for environmental clearances, or unusually complex planning for associated development. The commission may withdraw funding if time schedules have been misrepresented or have not been maintained.

163.10(7) *Review and funding of applications.*

a. The staff of the department shall review complete immediate opportunity project applications and may consult with other organizations with economic development responsibilities. As part of the review, the staff shall evaluate the effect of the proposed project on the state economy using the following factors: consistency with the state economic development plan; diversification of the state economy; the impact on in-state suppliers, competitors, and import substitution; percentage of out-of-state sales; the quality of employment positions; and the record of law violations. This review shall be performed within a reasonable period of time after receipt of the application. Following this review, complete applications meeting the threshold criteria of subrule 163.10(6) shall be forwarded to the commission for action at its next meeting.

b. The commission may fund all or any part of an application and may make a conditional funding commitment. In making its decision, the commission will consider the amount of total capital investment per RISE dollar requested, and the amount of RISE dollars requested per job created or retained.

c. The commission may deny funding for projects which will not result in net job creation or job retention from a statewide point of view, for instance, projects which simply involve the relocation of jobs or other economic activity within Iowa.

d. Immediate opportunity project applications may, at the discretion of the commission, be considered as applications for local development projects. These applications shall be included in the current round of local development project programming, regardless of the deadlines stated in subrule 163.11(3). However, immediate opportunity project applications submitted solely to circumvent the deadlines for local development project applications shall not be considered in this manner.

[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.11(315) Local development projects.

163.11(1) *General provisions.* The following provisions are applicable to local development projects:

a. Local development projects may be located on primary roads, secondary roads, city streets, state park roads or county conservation parkways.

b. There is no restriction on the number of applications per county or city that will be considered for RISE funding.

c. Counties and cities may apply for single-year or multiyear funding. Multiyear funding shall be limited to funding commitments from no more than three program years' allocations.

d. Applicants may use staff from other counties or cities, areawide planning organizations, areawide economic development organizations, or other jurisdictions to prepare application materials or administer projects.

e. There must be an adequate transportation justification for the roadway project. The proposed improvement need not be designed prior to project application, but the concept must generally be reasonable from a transportation planning and engineering standpoint and detailed enough to enable project cost estimates to be developed.

163.11(2) *Contents of applications.* Each application for a local development project must contain the following:

a. General information, including the applicant's name, contact person, mailing address, telephone number, local economic development program and history of efforts in the area, and other information of a general nature about the project proposal and the associated economic development activity.

b. Cost information, including the estimated total capital investment involved with the associated economic development activity, the estimated total cost of the roadway project, the amount of RISE funds requested for the roadway project, and the amount of non-RISE funds to be used to match or supplement RISE funding. Itemized breakdowns (showing the item, cost and funding source) must be included for the total capital investment, the total roadway project cost, the RISE funds requested, and the non-RISE funds to be used to match or supplement RISE funding.

c. Data showing the impact of the associated economic development activity, including the number of direct jobs created or retained. Jobs created as a result of jobs being displaced elsewhere in the state shall not be considered direct jobs created for the purpose of evaluating the application.

(1) To expedite the review, the applicant shall provide the following data for each business included in the project justification: a list of in-state competitors; a list of in-state suppliers; the percentage of out-of-state sales; the effect on import substitution; long-range growth potential; and a list of all current and anticipated employment positions, both full- and part-time, the hourly wage for each, and the turnover rate.

(2) The applicant shall certify that each business will give hiring preference to residents of the state or local area, except for out-of-state employees offered a transfer to Iowa.

d. A preliminary project concept statement for the roadway project, including maps showing site characteristics such as zoning, platting, subdivision boundaries, and corporate limits; a sketch plan;

and a justification for the transportation improvement. In most cases, a sketch plan should include a simple plan and profile defining the horizontal and vertical geometrics and a typical roadway cross section defining pavement, shoulders, foreslope, and backslope or border treatment. The transportation justification should address topics such as the current condition of existing roadways or bridges, the relationship of the project to connecting roads, and ingress to and egress from the site, as well as the current flow of traffic on the development site, anticipated total traffic and large truck traffic, proposed major design features of the proposed improvement, the intended roadway function, how the proposed improvement is consistent with other local plans, and the reason the proposed alternative was selected over other alternatives. In consultation with the department, a traffic impact analysis may be required to supplement the transportation justification.

e. A time schedule for the total development, including the roadway project and the associated economic development activity.

f. A formal resolution passed by the governing body of the jurisdiction responsible or to be responsible for the road or street to be constructed or improved. The resolution shall state that the project will be adequately maintained and dedicated to public use for a minimum of 20 years after completion of the project and that land provided access by the proposed improvement will be developed according to rule 761—163.3(315). The resolution must also certify that any business assisted by the project which acquires or merges with an Iowa corporation within three years following the RISE application shall make a good-faith effort to hire the workers of the merged or acquired company.

g. A summary showing that necessary arrangements have been made for nonroadway factors (e.g., zoning, sewer, water, police and fire protection, financing, and permits) essential for the proposed economic development activity.

163.11(3) *Submission of applications.* Applications shall be submitted on a form provided by the department.

a. Applications may be submitted at any time. However, in order to be considered in the current round of programming, complete applications must be received by the department or postmarked no later than February 1 or September 1.

b. Once an application has been submitted, no further information concerning that application shall be accepted by the department from the applicant unless specifically requested by the department. Applications may be withdrawn by the applicant and resubmitted at any time. Resubmitted applications shall be dated accordingly.

163.11(4) *Incomplete applications.* An applicant must satisfy the application requirements outlined in this chapter and must fully complete the official application form before the application will be considered by the commission. An applicant shall be notified if an application is incomplete.

163.11(5) *Verification of application materials.* Complete applications shall be reviewed to verify the figures or statements in the applications. This may include site visits. If inaccuracies, omissions, or errors are found, the commission may rescind the commitment of funds or reevaluate the application based on the correct information. If an applicant loses funding through this process, the commission shall have complete discretion concerning the disposition of those funds, including awarding them to other applicants or carrying them over to the next programming cycle.

163.11(6) *Rating factors.* The following factors and potential rating points shall be used in assessing applications for local development projects. Assessment of these factors shall be the responsibility of the department.

a. Development potential. This factor measures the degree of certainty involved in the economic development activity to be supported by the proposed RISE project and the potential for future job growth. Maximum points: 35.

b. Economic impact. This factor measures the economic impact of the development activity to be supported by the proposed RISE project, including the number of direct jobs assisted, investment leveraging, the percentage of out-of-state sales and in-state suppliers, the impact on competition and diversification, and the quality of job factors. Maximum points: 20.

c. Local commitment and initiative. This factor measures the level of effort being put forth by the applicant to attract economic development and the adequacy of the supporting infrastructure. Maximum points: 35 (includes 5 points for the remediation or redevelopment of a brownfield site).

d. Transportation need. This factor measures the condition and quality of existing road or street service. Maximum points: 4.

e. Area economic need. This factor measures the economic condition of the area. Maximum points: 6.

163.11(7) Review and funding of applications.

a. The staff of the department shall review and rate complete local development project applications and may consult with other organizations with economic development responsibilities. As part of the review, the staff shall evaluate the effect of the proposed project on the state economy using the following factors: consistency with the state economic development plan; diversification of the state economy; the impact on in-state suppliers, competitors, and import substitution; percentage of out-of-state sales; the quality of employment positions; and the record of law violations. Complete applications shall be forwarded to the commission for a funding commitment action within a reasonable period of time after the application deadline. An application considered but not funded in one programming cycle must be resubmitted by the applicant if it is to be considered in a subsequent cycle.

b. The commission may fund all or any part of an application and may make a funding commitment conditional upon adherence to a specific time schedule, realization of a development prospect, or fulfillment of other agreements.

[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

761—163.12(315) Project administration.

163.12(1) Agreement. After a funding commitment has been made for a project, the department shall enter into a project agreement with the applicant. The agreement shall delineate responsibilities for project planning, design, right-of-way, contracting, construction and materials inspection, and documentation. The agreement shall identify any additional requirements for the project relating to specific jobs to be created or retained and land identified as being required to be developed consistent with rule 761—163.3(315). Procedures for documenting compliance with these requirements will also be identified in the agreement. The agreement shall require the applicant to comply with all local, state, and federal laws, and rules and regulations that may apply to the project.

163.12(2) Project payments. Payments from the RISE fund to counties or cities shall be made on a cost reimbursement basis, and financial participation shall be limited to the maximum percentage allowed by the funding commitment. The non-RISE financial participation shall include only those items listed as eligible for RISE funding and may be in the form of cash, the value of design engineering and construction inspection services, or the cost of eligible advance right-of-way acquisitions or preliminary design pursuant to rule 761—163.9(315). Grants from other state agencies or programs may also contribute to the non-RISE financial participation if their laws and rules allow. The applicant shall provide documentation to the department supporting the value of any noncash contribution to the project. The department has the sole authority to determine the value of noncash contributions. Contributions made by a third party may be allowed.

163.12(3) Project expenditures incurred prior to agreement. Project expenditures incurred after the commission has made a funding commitment, but before execution of the agreement, are eligible for reimbursement if a project agreement is subsequently executed. However, under no circumstances shall any reimbursement be paid until the agreement has been executed.

163.12(4) Remedies for noncompliance with project agreement. The commission may revoke funding commitments, require repayment of RISE funds loaned or granted, or take both actions when the county or city has not fulfilled the terms of the project agreement.

163.12(5) Cost overruns. RISE funds committed for projects are for a maximum dollar amount. Cost overruns shall be the responsibility of the administering jurisdiction.

163.12(6) *Audit.* The department may audit all project costs incurred for compliance with the agreement, including costs that are part of the matching contribution. All force account work performed by a county or city on the project shall be audited.

[ARC 3299C, IAB 8/30/17, effective 10/4/17; ARC 6930C, IAB 3/8/23, effective 4/12/23]

These rules are intended to implement Iowa Code section 312.2 and chapter 315.

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VEHICLES

CHAPTER 400

VEHICLE REGISTRATION AND CERTIFICATE OF TITLE

[Prior to 6/3/87, Transportation Department[820]—(07.D)Ch 11]

761—400.1(321,322,544) Definitions. The definitions in Iowa Code section 321.1 are hereby made part of this chapter. In addition, the following words and phrases, when used in Iowa Code chapter 321 or this chapter, shall have the meanings respectively ascribed to them, except when the context otherwise requires.

“Certificate of title” means a document issued by the appropriate official which contains a statement of the owner’s title, the name and address of the owner, a description of the vehicle, a statement of all security interests and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms “title certificate,” “title only,” and “title” shall be synonymous with the term “Certificate of title.”

“Contiguous county” means any county in Iowa that directly borders an adjacent Iowa county, including sharing a common corner or corners.

“Dealer’s or manufacturer’s stock or inventory” means a vehicle owned by a dealer which is being held for sale or trade and for which the dealer has a duly assigned ownership document as required by Iowa Code section 321.45.

“Driverless-capable vehicle” means the same as defined in rule 761—380.2(321).

“Electric vehicle annual registration fee” means an annual registration fee for a battery electric or plug-in hybrid electric motor vehicle as provided in Iowa Code sections 321.116 and 321.117. Unless otherwise provided, for purposes of this chapter, any reference to a registration fee shall also include an annual registration fee for a battery electric or plug-in hybrid electric motor vehicle if that vehicle is a battery electric or plug-in hybrid electric motor vehicle as defined in Iowa Code sections 321.116 and 321.117.

“Electronic” means as defined in Iowa Code section 554D.103.

“Electronic lien and title” or *“ELT”* means an information technology system authorized by the department for the purpose of providing an electronic record of the certificate of title to a security interest holder in order to subject a vehicle to an electronic lien and to allow for the submission and receipt of forms related to security interests through electronic means as described in Iowa Code section 321.50.

“Electronic record” means as defined in Iowa Code section 554D.103.

“Electronic signature” means as defined in Iowa Code section 554D.103.

“End user” means a person or entity that directly uses the services of an electronic registration and titling (ERT) service provider to submit an electronic application for certificate of title or registration of a vehicle.

“ERT service provider” means a person or entity authorized by the department under subrule 400.3(17) to submit electronic applications for certificate of title or registration of a vehicle on behalf of an end user to a county treasurer.

“Farm trailer” means a trailer used exclusively by a farmer in the conduct of the farmer’s agricultural operation. The term shall not include a “semitrailer.”

“Final-stage manufacturer” means as defined in Iowa Code section 322.2.

“Half-year fee” means the first semiannual installment of an annual registration fee but does not include an electric vehicle annual registration fee. The term “half-year registration” shall be synonymous with the term “half-year fee.”

“Hearse” means a motor vehicle used exclusively to transport a deceased person.

“Lien” means an interest in a vehicle which secures payment or performance of an obligation. The term “security interest” shall be synonymous with the term “lien.”

“Manufacturer’s certificate of origin” means a certification signed by the manufacturer, distributor or importer that the vehicle described has been transferred to the person or dealer named and that the transfer is the first transfer of the vehicle in ordinary trade and commerce.

1. The terms “manufacturer’s statement,” “importer’s statement or certificate,” “MSO” and “MCO” shall be synonymous with the term “manufacturer’s certificate of origin.”

2. In addition to the requirements of Iowa Code subsection 321.45(1), the certificate shall contain a description of the vehicle which includes the make, model, style and vehicle identification number. The description of a motorized bicycle shall also specify the maximum speed.

3. For 1992 and subsequent model year vehicles, the form used for manufacturers’ certificates of origin shall be the universal form adopted in 1990 by the American Association of Motor Vehicle Administrators (AAMVA). This requirement does not apply to trailer-type vehicles. A copy of this universal form may be obtained from the motor vehicle division at the address in subrule 400.6(1).

“*Model year*,” except where otherwise specified, means the year of original manufacture or the year certified by the manufacturer. For purposes of titling and registration, the model year shall advance one year each January 1.

“*Registered*” means that the appropriate registration fee has been paid for a vehicle and a registration card evidencing payment has been issued to the owner.

“*Registration card*” means a document issued to the owner of a vehicle by the appropriate agency whose duty it is to register vehicles, which contains the name and address of the owner and a description of the vehicle, and which is issued to the owner when the vehicle has been registered. The terms “registration certificate,” “registration receipt” and “registration renewal receipt” are synonymous with the term “registration card.”

“*Security interest*” means an interest in a vehicle which secures payment or performance of an obligation. The term “lien” shall be synonymous with the term “security interest.”

“*Signature*,” unless otherwise specified, shall include a signature in ink or an electronic signature as provided in Iowa Code section 554D.103(9). A requirement to sign a document unless otherwise specified shall allow for a signature in ink or an electronic signature.

“*Social security number*” means a social security number issued by the United States government.

This rule is intended to implement Iowa Code chapter 554D and sections 321.1, 321.8, 321.20, 321.23, 321.24, 321.40, 321.45, 321.50, 321.116, 321.117, 321.123, 321.134, 321.157 and 322.2.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 5178C, IAB 9/9/20, effective 10/14/20; ARC 5893C, IAB 9/8/21, effective 10/13/21; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.2(321,322) Vehicle registration, certificate of title, receipt, validation sticker and registration plates—general provisions.

400.2(1) *Vehicles subject to registration.* A vehicle subject to registration under the laws of Iowa shall be required to be registered at the time the vehicle is first operated or moved upon a highway in this state.

400.2(2) *Vehicles exempt from titling or registration.* A certificate of title shall not be issued for a vehicle which is exempt from the titling or registration provisions of Iowa Code chapter 321, unless issuance of a certificate of title is specifically authorized in Iowa Code chapter 321 or as provided in 761—Chapter 410.

400.2(3) *Issuance of a certificate of title, receipt, validation sticker and registration plates upon payment of registration fees.* Except as otherwise provided in Iowa Code chapter 321 or this chapter, the current year registration fee and any delinquent registration fees and penalties, if any, shall be paid prior to issuance of a certificate of title, receipt, validation sticker and registration plates.

400.2(4) *Trailers with an empty weight of 2000 pounds or less.* Certificates of title shall not be issued for trailers with an empty weight of 2000 pounds or less. However, these trailers shall be subject to the registration fees provided in Iowa Code section 321.123.

400.2(5) *Vehicles owned by the government.* A certificate of title shall be issued for a vehicle owned by the government when the vehicle is first registered. However, vehicles owned by the government shall be exempted from registration and titling fees. Also, a certificate of title shall not be issued for a government-owned vehicle if a certificate of title would not be issued if the vehicle were owned by someone other than the government.

400.2(6) *Vehicles leased by the government.* Vehicles leased by the government for a period of 60 days or more are exempted from payment of registration fees. A copy of the lease agreement, certificate of lease, or other evidence that the vehicle is being leased by the government shall be required in order to obtain this exemption. However, the lessor is not exempted from the requirements for obtaining a certificate of title as set out in Iowa Code chapter 321 and these rules, including payment of the appropriate certificate of title fee.

400.2(7) *Special mobile equipment.* Rescinded IAB 3/7/90, effective 4/11/90.

400.2(8) *Private school buses, fire trucks, authorized emergency vehicles, and transit buses.* In accordance with Iowa Code sections 321.18, 321.19 and 321.22, private school buses, fire trucks not owned or operated for a pecuniary profit, certain authorized emergency vehicles owned and operated by nonprofit organizations, and urban and regional transit system buses are exempt from the payment of registration fees. However, these vehicles are not exempt from the requirements for obtaining a certificate of title as set out in Iowa Code chapter 321, including payment of the appropriate certificate of title fee.

400.2(9) *Towable recreational vehicles.* For purposes of registration and titling under Iowa Code chapter 321 and this chapter, a towable recreational vehicle as defined in Iowa Code section 322C.2 shall be considered a travel trailer or fifth-wheel travel trailer, as those terms are defined in Iowa Code section 321.1, as applicable.

400.2(10) *Plates for exempted vehicles.* Upon application, the department shall issue plates for exempted vehicles under subrules 400.2(5), 400.2(6) and 400.2(8) in accordance with the requirements in Iowa Code sections 321.18, 321.19, 321.22 and 321.170, as applicable, and this chapter. As authorized by Iowa Code sections 8A.361 and 8A.362(7), the Iowa department of administrative services may order the issuance of regular registration plates for exempted vehicles assigned to the Iowa department of administrative services. The following process applies to regular registration plates issued to an exempted vehicle under Iowa Code section 321.19(1)“c”:

a. The requesting agency under Iowa Code section 321.19(1)“c,” other than the Iowa department of administrative services, shall file an application with the department in the form and manner prescribed by the department and shall certify the authorized purpose for which issuance of the registration plates for an exempted vehicle is requested.

b. The Iowa department of administrative services or the department may order the issuance of regular registration plates for exempted vehicles as authorized by Iowa Code section 321.19(1)“c.” The plates shall be assigned to a specific vehicle. The requesting agency shall notify the department within ten days of assigning the plate to another vehicle.

c. In accordance with Iowa Code section 321.19, the department shall maintain separate records of regular registration plates issued to exempted vehicles, which shall be available in a manner that allows law enforcement and other persons authorized by Iowa Code section 321.11(3) to query vehicle and owner information by the registration plate number.

d. If a vehicle to which regular registration plates are assigned under this subrule is no longer used for an exempted purpose, the requesting agency shall surrender the plates to the department and the department shall cancel the plates. The department may revoke the plates and require the agency to surrender the plates pursuant to Iowa Code section 321.103 if the department determines use of the plates is no longer authorized.

This rule is intended to implement Iowa Code sections 321.18 through 321.22, 321.24, 321.34, 321.103, 321.123, 321.170 and 322C.2(19).

[ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.3(321) Application for certificate of title or registration for a vehicle.

400.3(1) *Application form.* To apply for a certificate of title or registration for a vehicle, the owner of the vehicle shall complete an application form prescribed by the department, which may be electronic. Application shall be made in accordance with Iowa Code chapter 321, these rules, and other applicable provisions of law.

400.3(2) Full legal name. Full legal names shall be given on the application. Civilian or military titles and nicknames shall not be used.

400.3(3) Information about owner, lessee and primary user.

a. Iowa Code sections 321.20 and 321.109 list the information that must be disclosed by the owner, lessee and primary user on the application.

b. A firm, association, corporation, or trust that is not required to have a federal employer identification number shall disclose the social security number, Iowa driver's license number or Iowa nonoperator's identification card number of an authorized representative of the firm, association, corporation, or trust. The authorized representative of a trust is the trustee unless otherwise specified in the trust agreement or the certification of trust as defined in Iowa Code section 633A.4604.

400.3(4) Plate number and validation number. If the owner has registration plates that have been assigned to the owner and affixed to the vehicle, the owner shall list the plate number on the application form. The validation number from the validation sticker shall also be listed.

400.3(5) Birth or registration month. If the vehicle is owned by one individual, the individual's month of birth shall be listed on the application form and shall determine the registration year. If the vehicle is owned by two or three individuals, the month of birth of one of the individuals shall be listed and shall determine the registration year. If the vehicle is owned by a partnership, corporation, association, or governmental subdivision, the birth or registration month shall be left blank on the application; the county treasurer shall determine the month of registration.

400.3(6) Model year. The application shall include the model year of the vehicle.

400.3(7) Purchase information. The application shall include the date of purchase or acquisition and, if the vehicle was not purchased from a dealer, the purchase price.

400.3(8) Vehicle color. The application shall include the vehicle color.

400.3(9) Foreign registered vehicle. If the vehicle is registered in a foreign jurisdiction, the application shall include the date the vehicle was brought into Iowa.

400.3(10) Signature of applicant. The owner shall sign the application form. If there are two or more owners, all owner signatures are necessary.

400.3(11) Dealer certification.

a. If the vehicle is a new vehicle which has been sold to the owner by a dealer, as defined in Iowa Code section 321.1, the dealer shall certify the following on the application form: sale price of the vehicle, the amounts allowed for property traded in, nontaxable charges and rebates, the tax price of the vehicle, the date that a "Registration Applied For" card was issued, and the registration fee collected.

b. The certification shall include the dealer's number and name and shall be signed by the dealer or an authorized representative of the dealer. The signature may be electronic when the application form is submitted electronically in a manner approved by the department.

400.3(12) Weigh ticket. If application is being made to lower the tonnage on any motor truck, bus or truck tractor, the county treasurer may require a copy of a stamped weigh ticket issued by any public scale.

400.3(13) Credits. See rule 761—400.60(321) for:

Credit for unexpired registration fee.

Credit for transfer to spouse, parent or child.

Credit from/to apportioned registration.

Assignment of credit and registration plates from lessor to lessee.

400.3(14) Leased vehicle. As required by Iowa Code section 423.26, the lessor shall list the lease price of the vehicle and the lessor's leasing number, if applicable, on the application form.

400.3(15) Affidavit of correction. As provided in Iowa Code section 321.23A, the county treasurer or the department may accept an affidavit of correction on a form prescribed by the department.

a. The affidavit may be used only to correct those errors, erasures or alterations listed on the affidavit.

b. The affidavit must contain the signatures of all parties to the original error, erasure or alteration.

c. Only an original, notarized affidavit shall be accepted.

d. The affidavit must be surrendered with the document that contains the error, erasure or alteration to be corrected.

e. The affidavit may be accepted to correct errors, erasures or alterations on either an Iowa title or a foreign title.

400.3(16) *Driverless-capable vehicle.* As provided in Iowa Code sections 321.20 and 321.515 and rule 761—400.21(321), the applicant shall indicate on the application whether the vehicle is a driverless-capable vehicle as defined in rule 761—380.2(321).

400.3(17) *Electronic applications.*

a. Applications for certificate of title or registration of a vehicle may be submitted electronically via web-based services offered and maintained by ERT service providers authorized by the department. To be authorized to serve as an ERT service provider, the ERT service provider must establish to the satisfaction of the department that the ERT service provider has the technical, financial, legal, and administrative capacity to meet the department's requirements for submission of electronic applications and must execute an agreement, in a form and content determined by the department, that authorizes and permits the ERT service provider to interact with the department's vehicle title and registration system via an application program interface established by the department and to submit electronic applications on behalf of end users that choose to use the ERT service provider's services to submit an application electronically. Agreements executed by ERT service providers under this paragraph shall include provisions that address security, financial responsibility, privacy, termination, and any other matters deemed appropriate by the department.

b. An agreement executed by an ERT service provider is a condition of authorization and permission only. An ERT service provider authorized by the department is not a contractor, vendor, employee, or agent for the department, the state of Iowa, or any county treasurer accepting electronic applications, and shall not be entitled to compensation from the department, the state of Iowa, or any county treasurer for any service, transaction, or other act rendered as an ERT service provider. The ERT service provider remains solely liable and responsible for the ERT service provider's services and activities as an ERT service provider and shall defend, indemnify and hold harmless the department, any county treasurer, the state of Iowa, and its, or their agents, officers, heirs, assigns, and employees of and from any and all damages, claims, penalties, debts owed, or any other form of liability arising from or related to the ERT service provider's service, performance, errors, acts, or omissions. An ERT service provider that chooses to provide service under the department's permission and authorization does so at the ERT service provider's sole risk and has no claim or right against the department, any county treasurer, or the state of Iowa for fees, costs, profits, loss of profits, interruption of business, or any other form of compensation, remuneration, liability, or damages arising from or related to the ERT service provider's activity as an ERT service provider or inability to serve as an ERT service provider.

c. An ERT service provider authorized by the department may establish web-based services to allow end users to submit applications via an electronic interface established and maintained by the ERT service provider and to submit the applications on behalf of the end user to county treasurers via the department's vehicle title and registration system and application program interface established by the department. In doing so, the ERT service provider is acting as a contractor or vendor for the end user and not the department, any county treasurer, or the state of Iowa, and remains solely responsible to the end user for any failure to perform or breach of performance or agreement. When the end user is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C, "end user" includes the motor vehicle dealer and any person with an interest in the vehicle that is the subject of the application. The ERT service provider may charge the end user a fee for services rendered as an ERT service provider.

d. In addition to the documentary fee authorized under Iowa Code section 322.19A, an end user that is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C may pass and charge to a customer the fees or costs incurred by the motor vehicle dealer to submit the customer's application through an ERT service provider's services as a third-party cost or fee, provided that the motor vehicle dealer discloses the charge to the customer before submitting the application. The documentary fee charged by the motor vehicle dealer shall not exceed the amount authorized by Iowa Code section

322.19A. Neither the ERT service provider nor the motor vehicle dealer shall charge a customer for creation or delivery of a “registration applied for” card.

e. An ERT service provider authorized by the department has no authority to approve or deny applications. Acceptance of an application by an ERT service provider is not approval of the application. An application is not considered to be formally submitted until it is electronically transmitted by the ERT service provider to the county treasurer via the department’s vehicle title and registration system and the application program interface established by the department. The county treasurer remains responsible for approving or denying the application and may reject the application for any reason permitted or required by state or federal law or regulation.

f. An authorized ERT service provider is responsible for the ERT service provider’s payment solution and for all payment transaction security and compliance with all applicable standards associated with the payment solution or solutions offered by the ERT service provider. The ERT service provider shall transfer title and registration fees collected by the ERT service provider directly to an account designated by the county treasurer responsible for the transaction via automated clearing house (ACH) transfer and the fees shall be available to the county treasurer no later than three business days following the submission of a transaction for which the fees were paid. Funds received by the ERT service provider shall be held until transfer to the county treasurer’s account in a bank insured by the Federal Deposit Insurance Corporation. The ERT service provider shall be responsible for reconciling insufficient funds from an end user.

g. Fees submitted electronically are not deemed to be received until deposited into the county treasurer’s account via completion of the ACH transfer. The end user remains responsible for fees submitted via an ERT service provider and the end user’s responsibility for payment of any required fees is not waived or excused by the ERT service provider’s failure to complete the transfer. As a condition of authorization and permission to serve as an ERT service provider and before the ERT service provider may offer services, the ERT service provider shall furnish a surety bond executed by the ERT service provider as principal and executed by a corporate surety company, licensed and qualified to do business within the state of Iowa. The bond shall run to the state of Iowa, be in the amount of \$150,000 and be conditioned upon the faithful compliance by the ERT service provider of all obligations imposed upon the ERT service provider by any applicable state or federal law or regulation, including the terms of this chapter, the authorizing agreement executed by the ERT service provider under this chapter, and any terms or conditions existing between the ERT service provider and any end user using the ERT service provider’s services. The ERT service provider shall indemnify any end user that uses the ERT service provider’s services of and from any loss or damage occasioned by the failure of the ERT service provider to so comply, including but not limited to the complete and timely submission to the county treasurer of the title and registration fees required for a given transaction. The bond shall be filed with the department before the ERT service provider may begin or offer services as an ERT service provider. The aggregate liability of the surety shall not exceed the amount of the bond.

h. The ERT service provider shall provide accounting reports of all fees received and transferred to each respective county treasurer, in a manner determined by the department.

i. The ERT service provider shall submit to audits by the department and the state auditor, which shall be at least yearly but may be more frequently if determined necessary by the department or the state auditor.

j. An application submitted electronically must meet all legal requirements for the transaction in question, and no requirement shall be excused or waived as a result of submitting the transaction electronically. However, wherever a signature is required, the signature may be an electronic signature, as determined by the department and according to methods approved by the department. Wherever an electronic solution approved by the department requires the submission of scanned documents, the scanned documents shall be of a quality and resolution determined by the department, which shall at a minimum meet any applicable state or federal standard or requirement, and shall completely capture and represent the original document. The department and any county treasurer processing an application retain the right under Iowa Code section 321.13 to determine the genuineness, regularity, and legality of the application and any scanned document submitted as part of the application and may withhold approval

of the application and require presentation of the original document whenever the scanned document is of insufficient quality, content, or appearance to determine the same. An end user that submits a scan of an original document as part of an electronic application shall retain the original document for a period of six months. An end user shall make all such original documents available for inspection by the department at the department's request. An end user that is a business entity shall retain the documents at the end user's principal place of business in Iowa. Anything in this paragraph notwithstanding, lessors required to retain a damage disclosure statement under Iowa Code section 321.69(4), and authorized vehicle recyclers licensed under Iowa Code chapter 321H and motor vehicle dealers licensed under Iowa Code chapter 322 required to retain damage disclosure statements under Iowa Code section 321.69(6) shall retain the original document for a period of five years from the date of the statement, as required therein.

k. An end user that is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C and that electronically submits an application on behalf of the owner or owners to whom the dealer is transferring or delivering the vehicle shall disclose to all owners or, if there is more than one owner and the title application uses "or" between the names of the owners, at least one owner, that the application will be submitted electronically and shall obtain written authorization from all owners, or if there is more than one owner and the title application uses "or" between the names of the owners, written authorization from at least one owner, to submit the application on the owner's behalf. The written authorization shall be retained at the motor vehicle dealer's principal place of business for a period of six months from the date of application and shall be available for inspection by the department at the department's request. The motor vehicle dealer shall also review with and disclose to the owner or owners all details of the application, before submitting the application, and shall provide a complete, true, and accurate copy of the application to the owner or owners immediately after submitting the application. The written authorization shall be submitted in the form and manner required by the department.

l. An authorized ERT service provider shall retain all data, information, records, and electronic records associated with an electronic application or transaction submitted or transacted through the ERT service provider for a period of at least six months, or longer as required by applicable state or federal law or regulation, and shall make all such data, information, and records available to the department at the department's request. This includes but is not limited to the identity of the end user that initiated the electronic application or transaction. Identity information for end users shall be maintained at the entity and individual level, meaning that the ERT service provider must implement and maintain secure profile management that is capable of authenticating and verifying the identity of any entity that initiated the application or transaction and the individual officer, employee, or agent within the entity that was authorized by the entity to initiate the application or transaction.

m. The ERT service provider shall hold and protect all personal information as required by Iowa Code section 321.11 and the federal Driver's Privacy Protection Act, 18 U.S.C. §2721 et seq. (the DPPA), shall only use or release such personal information for purposes necessary to perform services as an ERT service provider, and shall release such personal information for no other purposes or use except as required to comply with legal or administrative matters as permitted under the DPPA. The ERT service provider shall immediately advise the department of any suspected or actual unauthorized release of personal information or highly restricted personal information and shall notify the entity and individual whose personal information or highly restricted personal information was released in an unauthorized manner.

This rule is intended to implement Iowa Code sections 321.1, 321.8, 321.20, 321.23 to 321.26, 321.31, 321.34, 321.46, 321.105A, 321.109, 321.122, 321.515, 321.519, 322.19A and 423.26.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5893C, IAB 9/8/21, effective 10/13/21; ARC 6219C, IAB 3/9/22, effective 4/13/22; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.4(321) Supporting documents required. This rule describes the basic supporting documents to be submitted by an applicant for a certificate of title or registration.

400.4(1) New vehicle. If application is made for a new vehicle, a manufacturer's certificate of origin, properly assigned to the applicant, shall be submitted. A manufacturer's certificate of origin shall not be accepted if the assignment to the applicant is made by any person other than the manufacturer, importer

or distributor, a licensed motor vehicle dealer franchised to sell that line-make of vehicle, or a final-stage manufacturer motor vehicle dealer licensed under rule 761—425.11(322).

a. The first person, including a dealer not franchised to sell that line-make of vehicle, who is assigned the manufacturer's certificate of origin shall obtain a certificate of title and register the vehicle.

b. An uncanceled security interest noted on the reverse side of a manufacturer's certificate of origin (MCO) shall be noted as a separate security interest on the certificate of title, in addition to any security interest acknowledged by the applicant, unless the security interest acknowledged by the applicant is the same as the one noted on the reverse side of the MCO.

c. If a 1980 or subsequent model year vehicle is manufactured by a person other than the original manufacturer, both the original manufacturer's certificate of origin and the final-stage manufacturer's certificate of origin shall be submitted if the vehicle's original line-make is changed by the final-stage manufacturer. All assignments or reassignments of ownership of the vehicle shall be made on the final-stage manufacturer's certificate of origin. The face of the original manufacturer's certificate of origin shall be stamped in bold type with the statement: "Final-stage manufacturer's MCO has been issued on this vehicle." The original manufacturer's vehicle identification number shall be listed on the final-stage manufacturer's certificate of origin.

d. If a final-stage manufacturer is a motor vehicle dealer licensed under rule 761—425.11(322), the final-stage manufacturer may reassign the original manufacturer's certificate of origin or an incomplete or intermediate MCO to the retail buyer.

400.4(2) *Used vehicle registered or titled in this state.* The last issued certificate of title, properly assigned to the applicant, shall be submitted, unless the applicant is an insurer applying for a salvage certificate of title under Iowa Code section 321.52(4). An uncanceled security interest noted on the face of the certificate of title shall be noted on the face of the certificate of title issued to the applicant, in addition to any security interest acknowledged by the applicant. If the vehicle is not subject to titling provisions, the last issued registration receipt or bill of sale, properly assigned to the applicant, shall be submitted.

400.4(3) *Used vehicle from a foreign jurisdiction.* If the vehicle was subject to the issuance of a certificate of title in the foreign jurisdiction, the certificate of title issued by the foreign jurisdiction to the applicant or properly assigned to the applicant shall be submitted, unless the applicant is an insurer applying for a salvage certificate of title under Iowa Code section 321.52(4).

a. A security interest, noted on the face of the foreign certificate of title, which has not been canceled, shall be noted on the face of the certificate of title issued to the applicant, in addition to any security interest acknowledged by the applicant.

b. A certificate of title issued in a foreign jurisdiction may be assigned to a motor vehicle dealer in another jurisdiction, and the dealer may reassign the certificate of title to the applicant. An assignment or reassignment form issued by a foreign jurisdiction may be used with a foreign title to complete an assignment or reassignment of ownership from a foreign motor vehicle dealer to the applicant, provided the ownership chain is complete.

c. An Iowa licensed motor vehicle dealer who acquires a vehicle registered in another state or country may reassign the foreign certificate of title to the applicant, as provided in Iowa Code subsection 321.48(2) and rule 761—400.27(321,322).

d. A person who registers a foreign vehicle under Iowa Code section 321.23(3) shall be issued a nontransferable-nonnegotiable registration. To transfer ownership of the vehicle, the owner must first obtain an Iowa certificate of title except as follows: If ownership is transferred to an Iowa licensed motor vehicle dealer or an insurance carrier authorized to do business in Iowa as provided in Iowa Code section 321.23(3), the foreign certificate of title may be assigned to the dealer or the insurance carrier; the owner is not required to obtain an Iowa title. The dealer may then reassign the foreign title, as provided in Iowa Code section 321.48(2) and rule 761—400.27(321,322).

e. If the vehicle was not subject to the issuance of a certificate of title in the foreign jurisdiction, the registration document issued by the foreign jurisdiction to the applicant or properly assigned to the applicant shall be submitted.

(1) If the foreign registration document is not issued in the applicant's name and does not contain an assignment of ownership form, a bill of sale conveying ownership from the owner as listed on the foreign registration document to the applicant shall be submitted with the foreign registration document.

(2) Upon receipt of the foreign registration document, the county treasurer shall issue a nontransferable—nonnegotiable registration unless the foreign registration document has been approved by the department.

(3) Acceptance of the foreign registration document shall be determined by the department on an individual basis, if the county treasurer of the county where the certificate of title is to be issued cannot determine whether the document is acceptable.

f. If a trailer weighing 2000 lbs. or less is exempt from the issuance of a certificate of title and registration in the foreign jurisdiction, a bill of sale conveying ownership to the applicant, if acquired by a resident from a nonresident, or an affidavit of ownership signed by the applicant, if the applicant is establishing residence in this state, shall be submitted.

g. If a motor vehicle is exempt from the issuance of a certificate of title and registration in the foreign jurisdiction, the bonding procedures as provided in Iowa Code section 321.24 shall be followed.

400.4(4) *Used vehicle acquired by a resident of this state from a government agency.* If the vehicle was acquired from an agency of the federal government, the applicant shall surrender the government bill of sale, General Services Administration Form 97, or Internal Revenue Service Form 2435, properly assigned to the applicant. If the vehicle was acquired from the state of Iowa or a subdivision of government, the applicant shall surrender the Iowa certificate of title issued in the name of the agency, properly assigned to the applicant.

400.4(5) *Manufactured or mobile home.* If the vehicle described on the application is a manufactured or mobile home with an Iowa title, the applicant shall submit a tax clearance form to show that no taxes are owing, unless the title has been issued to a manufactured or mobile home retailer licensed under Iowa Code chapter 103A. The form may be obtained by any owner of record of the manufactured or mobile home from the county treasurer.

400.4(6) *Vehicle acquired by a resident of this state by operation of law.* If the vehicle was acquired by the applicant by operation of law as specified in Iowa Code section 321.47, the last issued certificate of title shall be submitted by the applicant, or when that is not possible, presentation of satisfactory proof of the applicant's ownership and right of possession to the vehicle shall be submitted by the applicant. Proof of ownership may consist of a foreclosure sale affidavit, artisan's or storage lien affidavit, affidavit of death intestate, abandoned vehicle sales receipt, peace officers bill of sale or court order. See also subrules 400.14(4) and 400.14(5).

400.4(7) *Foreign ownership document issued in a language other than English.* A foreign ownership document issued in a language other than English may be required to be reproduced in writing in English and certified to be a correct translation by a person qualified to translate that particular language. The English translation and certification shall be submitted with the foreign ownership document.

400.4(8) *Titles from foreign jurisdictions.*

a. Except as provided in paragraph "b" of this subrule, a certificate of title issued by a foreign jurisdiction shall not be accepted if the title contains an alteration or erasure.

b. An affidavit of correction form issued by a foreign jurisdiction that corrects the certificate of title issued by the foreign jurisdiction shall be accepted only for the reason listed on the affidavit of correction form. However, acceptance of an affidavit of correction form that corrects an odometer statement or a designation shall be determined by the department on an individual basis.

400.4(9) *Applications in the name of trusts.* An application in the name of a trust shall be accompanied by a copy of all documents creating or otherwise affecting the trust or by the certification of trust as defined in Iowa Code section 633A.4604.

a. The certification of trust may be signed by any trustee or the attorney for any trustee.

b. The application shall be signed by the number of trustees as specified in the trust agreement, and the applicant shall provide the department with the document or the certification of trust specifying the required signatories for the trust.

c. If a certification of trust is provided, one of the following shall apply:

(1) Any currently acting trustee may sign the application if the certification of trust states that such trustee may act individually.

(2) A majority of the trustees must sign the application if the certification of trust states that the trustees must act by majority decision.

(3) All currently acting trustees must sign the application if the certification of trust states that the trustees must act by unanimous decision.

d. A certification of trust must meet the requirements of Iowa Code section 633A.4604, including but not limited to providing the names of all the currently acting trustees. If there are two or more currently acting trustees, the certification of trust must state whether the trustees may act individually, whether the trustees must act by majority decision or whether the trustees must act by unanimous decision. If the certification of trust does not meet said requirements, the certification of trust will be considered invalid for the purposes of the application.

e. Each signature on the application shall be followed by the words “as trustee.”

400.4(10) *Driverless-capable vehicles.* If an application is made for a driverless-capable vehicle, the department may require the application to be accompanied by the operational design domain.

400.4(11) *Supporting document retained by county treasurer.* All supporting documents, except those submitted pursuant to subrule 400.3(17), shall be retained by the county treasurer.

This rule is intended to implement Iowa Code sections 321.20, 321.23, 321.24, 321.30, 321.31, 321.45 to 321.50, 321.67, 321.515, 321.519, 322.3 and 633A.4604.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 5893C, IAB 9/8/21, effective 10/13/21; ARC 6219C, IAB 3/9/22, effective 4/13/22; ARC 6287C, IAB 4/6/22, effective 5/11/22; ARC 6932C, IAB 3/8/23, effective 4/12/23]

761—400.5(321) Where to apply for registration or certificate of title.

400.5(1) Except as otherwise provided, application for the registration of a vehicle or a certificate of title for a vehicle, or transfers thereof, shall be made to the county treasurer as described in Iowa Code chapter 321, including, when applicable, the county treasurer of a contiguous county to the county designated for the owner under Iowa Code section 321.20(1) for registration and issuance of a certificate of title. When none of the primary users of a non-resident-owned vehicle are located in Iowa, the vehicle may be registered by the county treasurer of any county.

400.5(2) Application shall be made to the department’s motor vehicle division for the following:

a. Titling and registration of vehicles owned by the government. This requirement does not apply to manufactured or mobile homes subject to a public bidder sale as explained in Iowa Code subsection 321.46(2).

b. Registration of vehicles leased by the government for a period of 60 days or more.

c. Registration of urban and regional transit system buses.

d. Registration of fire trucks not owned and operated for a pecuniary profit.

e. Registration of certain authorized emergency vehicles owned and operated by nonprofit organizations.

f. Registration of private school buses.

g. Registration of vehicles under the provisions of Iowa Code subsection 321.23(4), relating to restricted-use vehicles.

400.5(3) Application for a certificate of title for a vehicle subject to apportioned registration under Iowa Code chapter 326 may be made to either the county treasurer or to the department’s motor vehicle division.

400.5(4) Application for apportioned registration shall be made to the department’s motor vehicle division. See 761—Chapter 500.

This rule is intended to implement Iowa Code sections 321.18 through 321.23, 321.46(2), and 321.170.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.6(17A) Addresses, information and forms. Assistance under this chapter is available as follows:

400.6(1) Information and forms for vehicle registration, certificate of title, or other procedures covered under Iowa Code sections 321.18 through 321.173 may be obtained from the county treasurer or by mail from the Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3110; or on the department's website at www.iowadot.gov.

400.6(2) Information for investigations under this chapter may be obtained from the Bureau of Investigation and Identity Protection, Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3050; or on the department's website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.7(321) Information appearing on title or registration. In addition to the requirements of Iowa Code sections 321.24, 321.52, 321.69, 321.71 and 322G.12, a certificate of title or registration receipt or both shall contain the following information when applicable:

400.7(1) Registration expiration date.

400.7(2) Registration month, as explained in rule 761—400.3(321).

400.7(3) Name and address of last titled owner.

400.7(4) Description of the vehicle, including the following items. These items may be represented on the title and registration by code letters or numbers.

a. Vehicle identification number.

b. Type, such as automobile, trailer, truck, etc.

c. Style.

d. Make, model, and model year.

e. Number of engine cylinders.

f. Color.

g. Weight and registered gross weight.

h. The square footage of floor space of a manufactured or mobile home or travel trailer, as determined by measuring the exterior.

i. The odometer mileage and whether the mileage is “actual,” “not actual,” or “exceeds mechanical limits.”

400.7(5) Previous Iowa title number or the name of the foreign jurisdiction if the previous title is a foreign title.

400.7(6) Plate number and previous registration number.

400.7(7) List price or value.

400.7(8) Penalties and title, registration and security interest receipt numbers.

400.7(9) The following phrase stamped on the reassignment portion of a manufactured or mobile home title: “Dealer reassignment not authorized on this certificate of title.”

400.7(10) The designation required by 761—Chapter 405. A vehicle may have no more than one designation. The referenced rules explain which designation takes precedence when more than one designation could apply.

400.7(11) Full legal name of owner.

a. When the name of an owner changes from that which is printed on the title or registration issued to the owner, the owner shall submit to the county treasurer one of the following documents:

(1) Court order for a name change. The court order must contain the full name, date of birth, and court seal.

(2) Divorce decree.

(3) Marriage certificate.

b. This subrule does not apply to owners that are firms, associations, corporations, or trusts.

c. When the name of an owner changes from that which is printed on the registration card, the owner shall apply for a replacement registration card.

400.7(12) Driverless-capable vehicle indicator, which may also indicate whether operational restrictions exist.

This rule is intended to implement Iowa Code sections 321.24, 321.31, 321.40, 321.45, 321.52, 321.69, 321.71, 321.124, 321.515, 321.519 and 322G.12.

[ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5893C, IAB 9/8/21, effective 10/13/21]

761—400.8(321) Release form for cancellation of security interest.

400.8(1) A secured party may use a form prescribed by the department to note the cancellation of a security interest.

400.8(2) The secured party may also note the cancellation in a statement written on the secured party's letterhead if the statement is notarized and contains the following information: county that issued the title; title number; security interest number; vehicle identification number; vehicle owner's name; secured party's name, street address, city, state and ZIP code; date the security interest was canceled; and signature of an authorized representative of the secured party.

400.8(3) The secured party shall forward the original cancellation form or statement to the department or to the county treasurer of the county where the title was issued. Facsimiles and photocopies are not acceptable.

400.8(4) The secured party shall note the cancellation on the face of the title, attach a copy of the release form to the title as evidence of cancellation, and forward the title to the next secured party or, if there is no other secured party, to the person designated by the owner or, if there is no person designated, to the owner.

This rule is intended to implement Iowa Code section 321.50.

[ARC 4343C, IAB 3/13/19, effective 4/17/19]

761—400.9(321) Security interest notation, 30-day limit. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.10(321) Assignment of security interest. A security interest noted on a certificate of title may be assigned to another secured party without losing the seniority of the security interest by complying with the procedure in Iowa Code section 321.50 or with the following procedure:

400.10(1) *Notice of assignment.* The secured party listed on the title certificate shall make the following notation in the cancellation portion of the certificate of title where security interest is noted "Assigned to (name of assignee)." The date, name of secured party and signature of the person noting the assignment shall be completed in the cancellation portion pertaining to the security interest.

400.10(2) *Application for notation of security interest.* The assignee shall complete an application for notation of a security interest on the form provided by the department. The application form shall be signed by the assignee in the space where the signature of the owner is ordinarily required. The signature of the owner shall not be required on an assignment of a security interest.

400.10(3) *Submission of documents to county treasurer.* The certificate of title, application for notation of security interest and appropriate notation fee shall be submitted to the county treasurer of the county where the certificate of title was issued or will be issued.

a. If there are additional security interests noted on the certificate of title, the seniority of the assignee's security interest may be preserved by issuance of a certificate of title in lieu of the original, on which the assignee's security interest shall be noted in the same seniority as the assignor's.

b. A receipt for notation of security interest form shall be processed and the new receipt number shall be listed in the appropriate space provided. The original notation date shall also be listed and the words "by assignment" shall be listed following the name of the assignee.

This rule is intended to implement Iowa Code section 321.50.

761—400.11(321) Sheriff's levy, restitution lien, and forfeiture lien noted as security interests.

400.11(1) A sheriff's levy may be noted as a security interest on a certificate of title if the sheriff so desires. To apply for a notation of a security interest, the sheriff or the sheriff's deputy shall complete an application form prescribed by the department. The sheriff or sheriff's deputy shall sign the application in the space where the signature of the owner is ordinarily required. The signature of the owner is not required. The appropriate notation fee shall be submitted with the application form to the county treasurer of the county where the certificate of title was issued. If the certificate of title is not surrendered with the application, the county treasurer shall notify the holder of the certificate of title in the manner prescribed in Iowa Code section 321.50.

400.11(2) A restitution or forfeiture lien may be noted as a security interest on a certificate of title if the county attorney so desires. To apply for a notation of a security interest, the county attorney or designee shall complete an application form prescribed by the department. The county attorney or designee shall sign the application in the space where the signature of the owner is ordinarily required. The signature of the owner is not required. A lien notation fee is not required. If the certificate of title is not surrendered with the application, the county treasurer shall notify the holder of the certificate of title in the manner prescribed in Iowa Code section 321.50.

This rule is intended to implement Iowa Code section 321.50 and chapter 809A.
[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.12(321) Replacement certificate of title.

400.12(1) When a certificate of title is lost, destroyed or altered, the owner or lienholder shall apply for a replacement certificate of title. If a security interest noted on the certificate of title was released by the secured party on a separate form, but the secured party has not delivered the original certificate of title to the appropriate party, the owner may apply for a replacement certificate of title as provided in Iowa Code section 321.42.

400.12(2) Application for a replacement certificate of title shall be made on a form prescribed by the department. All owners of the vehicle as listed on the certificate of title shall sign the application form. If an owner is deceased, the signatures and documents specified in subrules 400.14(4) and 400.14(5) shall be required in lieu of the deceased owner's signature. A person entitled to vehicle ownership under the laws of descent and distribution shall sign the required forms and shall insert the words "heir at law" following the signature.

This rule is intended to implement Iowa Code section 321.42.

761—400.13(321) Bond required before title issued. An applicant for a certificate of title who cannot provide the supporting documents required in rule 761—400.4(321) shall be required to file a bond as a condition to obtaining a title and registration plates.

400.13(1) Procedures. This subrule describes the procedures to be followed to obtain a "bonded" certificate of title. The procedures described are in addition to the regular procedures for titling and registering a vehicle.

a. The applicant shall submit a bond application to the motor vehicle division on a form prescribed by the department. The application shall be accompanied by evidence of ownership of the vehicle.

b. The department shall search the state files to determine if there is an owner of record or security interest for the vehicle and if the vehicle has been reported stolen or embezzled.

(1) If an owner of record is found, the department shall mail a release letter by first-class mail to the owner of record at the owner's last-known address. The release letter shall notify the owner of the right to claim ownership of the vehicle or to waive all rights or claims.

(2) If the owner of record makes a claim, a motor vehicle investigator shall review the claim.

(3) If the department receives no response from the owner of record within ten days after the date of mailing, the owner of record waives all rights or claims; or if the letter is returned as undeliverable, the department shall continue processing the bond application.

(4) If one or more security interests are found and can be identified, the department shall send a certified letter and application for cancellation of security interest to a lienholder to the last-known

address of that lienholder. If a lienholder releases the lien, the department shall continue to process the application. If a lienholder responds with a request to claim the vehicle, the department will review the claim. If the certified letter is returned as undeliverable, the department shall continue to process the application.

(5) If one or more security interests is found but a lienholder cannot be identified because the record is held by another jurisdiction, the department shall return the application to the applicant and inform the applicant which jurisdiction holds the record(s) to the vehicle.

c. If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall determine the current value of the vehicle and notify the applicant to deposit cash or file a surety bond with the department in an amount equal to one and one-half times the current value of the vehicle.

d. After the cash deposit or surety bond has been deposited, a motor vehicle investigator of the department may examine the vehicle to verify the information submitted on the application is correct. The owner of the vehicle may drive or tow the vehicle to and from the examination location after completing an affidavit to drive on a form provided by the department. The form shall state that the vehicle is reasonably safe for operation, and the form must be signed by the owner. After verifying the information, the investigator shall authorize the county treasurer to issue a title for and register the vehicle. Should the vehicle not meet the equipment requirements of Iowa Code chapter 321, the investigator shall authorize the county treasurer to issue a title and registration but instruct the county treasurer to immediately suspend the registration until such time as the vehicle meets these equipment requirements. If applicable, the investigator shall also affix an assigned vehicle identification number to the vehicle.

e. The applicant shall then make application for a certificate of title and registration.

400.13(2) Disapproval. If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, or that there is an unsatisfied security interest, then the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

400.13(3) Junked vehicle. A certificate of title shall not be reinstated for a vehicle that has been issued a junking certificate unless the junking certificate was issued in error, as explained in rule 761—400.23(321), or the vehicle qualifies as an antique vehicle under Iowa Code subsection 321.115(1).

This rule is intended to implement Iowa Code sections 321.24 and 321.52.
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.14(321) Transfer of ownership. The following procedures shall apply for all titling and registration purposes:

400.14(1) Transfer of vehicle owned by two or three persons.

a. If the names of the owners of a vehicle on the certificate of title or on the manufacturer's certificate of origin are joined by the word "or," as in "John Doe, Jane Doe or Mary Doe," then the signature of any of these owners is sufficient to transfer title or to junk the vehicle.

b. If ownership of a vehicle is stated as a name or names followed by the words "Doing Business As" or the initials "DBA" and another name, only the name of an owner followed by the signature of an authorized representative of an owner is required to transfer title or to junk the vehicle.

EXAMPLE: Ownership is stated as "John Smith and Mary Smith DBA Smith Repair." Jane Doe is an authorized representative of John Smith and Mary Smith. To transfer ownership, Jane Doe may sign as "John Smith and Mary Smith DBA Smith Repair, by Jane Doe," "John Smith and Mary Smith by Jane Doe," or Smith Repair by Jane Doe."

c. In all other cases the signature of each named owner is required.

400.14(2) Assignment of title to two or three persons. If a certificate of title or a manufacturer's certificate of origin is assigned to two or three persons with their names joined by the word "or," as in

“John Doe, Jane Doe or Mary Doe,” then a certificate of title may be issued to any one of these persons, or to any two or all three of these persons with their names joined by the word “or.” However, a certificate of title shall only be issued to persons who have signed the application for title.

400.14(3) Organizational ownership.

a. When a vehicle is owned by a partnership, corporation, association, governmental unit, or private organization, the signature of its authorized representative is required.

b. When a vehicle is owned by a trust, the title shall be accompanied by a copy of all documents creating or otherwise affecting the trust or by the certification of trust as defined in Iowa Code section 633A.4604.

(1) The certification of trust may be signed by any trustee or the attorney for any trustee.

(2) The title shall be signed by the number of trustees as specified in the trust agreement, and the transferor shall provide the department with the document or the certification of trust specifying the required signatories for the trust.

(3) If a certification of trust is provided, one of the following shall apply:

1. Any currently acting trustee may sign the title if the certification of trust states that such trustee may act individually.

2. A majority of the trustees must sign the title if the certification of trust states that the trustees must act by majority decision.

3. All currently acting trustees must sign the title if the certification of trust states that the trustees must act by unanimous decision.

(4) A certification of trust must meet the requirements of Iowa Code section 633A.4604, including but not limited to providing the names of all the currently acting trustees. If there are two or more currently acting trustees, the certification of trust must state whether the trustees may act individually, whether the trustees must act by majority decision or whether the trustees must act by unanimous decision. If the certification of trust does not meet said requirement, the certification of trust will be considered invalid for the purposes of the transfer.

(5) Each signature on the title shall be followed by the words “as trustee.”

400.14(4) Death with a will. When ownership is transferred according to a decedent’s will, a certified copy of the court order or the letter of appointment appointing the person assigning the title as executor of the will shall be required.

400.14(5) Death without a will. When ownership is transferred from a decedent without a will and there is no administration of the estate, an affidavit of death intestate form signed by the clerk of court shall be required. When ownership is transferred from a decedent without a will but there is an administration of the estate, a copy of the court order or the letter of appointment appointing the person assigning the title as administrator shall be required.

400.14(6) Power of attorney. An attorney in fact may act for the owner(s) if the appointment is shown on a power of attorney form. Power of attorney forms are available from the department but other forms may be accepted if they contain all necessary information. The power of attorney form or a certified true copy shall be kept by the county treasurer and attached to the document to which it applies.

This rule is intended to implement Iowa Code sections 321.20, 321.24, 321.45, 321.47, 321.49, 321.67 and 633A.4604.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6219C, IAB 3/9/22, effective 4/13/22]

761—400.15(321) Cancellation of a certificate of title.

400.15(1) The department shall cancel a certificate of title when authorized by any provision of law or when it has reasonable grounds to believe that the title has not been surrendered to the county treasurer as provided in Iowa Code section 321.52 or when the vehicle has been stolen or embezzled from the rightful owner or seized under the provisions of Iowa Code section 321.84, and the person holding the certificate of title, purportedly issued for the vehicle, has no immediate right to possession of the vehicle.

400.15(2) The decision to issue a new certificate of title or to allow the previous title to be reinstated through a replacement title application process or to take any other action regarding ownership of the

vehicle for which the current title has been canceled shall be determined after an investigation and recommendation by a motor vehicle investigator of the department.

This rule is intended to implement Iowa Code section 321.101.

761—400.16(321) Application for certificate of title or original registration for a specially constructed, reconstructed, street rod or replica motor vehicle.

400.16(1) Definitions applicable to this rule.

a. “Ownership document for the vehicle” means the certificate of title, the manufacturer’s certificate of origin, the junking certificate, or other evidence of ownership acceptable to the department.

b. “Ownership documents for essential parts” means bills of sale for all essential parts used to construct or reconstruct the vehicle. Each bill of sale shall contain a description of the part, the manufacturer’s identification number of the part, if any, and the name, address, and telephone number of the seller.

400.16(2) Procedures. This subrule describes the procedures for obtaining department approval to title and register a specially constructed, reconstructed, street rod or replica motor vehicle. The procedures described are in addition to the regular procedures for titling and registering a vehicle.

a. The applicant shall apply to the county treasurer for a certificate of title and registration, including, when applicable, the county treasurer of a contiguous county to the county designated for the owner under Iowa Code section 321.20(1) for registration and issuance of a certificate of title. The county treasurer, upon receiving an application that indicates the vehicle is a specially constructed, reconstructed, street rod or replica motor vehicle, shall forward the application to a motor vehicle investigator of the department.

b. The investigator shall contact the applicant and schedule a time and place for an examination of the vehicle and the ownership documents. The owner of the vehicle may drive or tow the vehicle to and from the examination location by completing an affidavit to drive on a form provided by the department. The form shall state that the vehicle is reasonably safe for operation and must be signed by the owner. The applicant, when appearing with the vehicle for the examination, shall submit to the investigator the ownership document for the vehicle, the ownership documents for essential parts, and a weigh ticket indicating the weight of the vehicle. However, a weigh ticket is not required for motorcycles, autocycles, trucks, truck tractors, road tractors or trailer-type vehicles.

c. If the investigator determines that the vehicle complies with 761—Chapter 450, that the integral parts and components have been identified as to ownership, and that the application has been completed properly:

(1) The investigator shall approve the application, affix to the vehicle an assigned vehicle identification number, and return the application and ownership documents to the applicant. The investigator shall authorize the county treasurer to issue a title and registration for the vehicle.

(2) If the vehicle is a passenger-type motor vehicle, the department shall determine its weight and value. The department shall also determine if the vehicle is subject to the electric vehicle annual registration fee. The vehicle weight shall be fixed at the next even 100 pounds above the actual weight of the vehicle fully equipped, as provided in Iowa Code section 321.162. The weight and value shall constitute the basis for determining the annual registration fee under Iowa Code section 321.109, except as provided in Iowa Code section 321.113.

(3) The applicant shall then submit the ownership document for the vehicle to the county treasurer and continue with the regular title and registration process.

400.16(3) Disapproval. If the department determines that the vehicle does not comply with 761—Chapter 450, that the integral parts or components have not been identified as to ownership, or that the application has not been completed properly, then the department shall not approve the vehicle for titling and registration.

400.16(4) Model year. The model year of a specially constructed or reconstructed motor vehicle is the year the vehicle is approved by the department as a specially constructed or reconstructed motor vehicle.

This rule is intended to implement Iowa Code sections 321.20, 321.23, 321.24, 321.52, 321.109, 321.116, 321.117 and 321.162.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5178C, IAB 9/9/20, effective 10/14/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.17(321) Remanufactured vehicle. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.18(321) Rescinded IAB 3/26/97, effective 4/30/97.

761—400.19(321) Temporary use of vehicle without plates or registration card.

400.19(1) Temporary use of vehicle without plates. A person who acquires a vehicle which is currently registered or in a dealer's inventory at the time of sale and who does not possess registration plates which may be assigned to and displayed on the vehicle may operate or permit the operation of the vehicle not to exceed 30 days from the date of purchase or transfer without registration plates displayed thereon, if ownership evidence is carried in the vehicle.

400.19(2) Temporary use of vehicle without registration card. A person who acquires a vehicle which is currently registered or in a dealer's inventory at the time of sale and who has possession of plates which may be attached to the vehicle acquired may operate or permit the operation of the vehicle not to exceed 45 days from the date of delivery or transfer without a registration card, if ownership evidence is carried in the vehicle.

400.19(3) Ownership evidence. Ownership evidence under this rule shall consist of the certificate of title or registration receipt, or a photocopy thereof, properly assigned to the person who has acquired the vehicle, or a bill of sale conveying ownership of the vehicle to the person who has acquired the vehicle. The ownership evidence shall be shown to any peace officer upon request.

This rule is intended to implement Iowa Code sections 321.25 and 321.46.
[ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.20(321) Registration of motor vehicle weighing 55,000 pounds or more. When applying for registration or renewal of registration for a motor vehicle weighing 55,000 pounds or more, the owner shall present to the department or to the county treasurer proof of compliance with the federal heavy vehicle use tax required by 26 U.S.C. Section 4481 and 26 CFR Part 41.

400.20(1) If the motor vehicle is used exclusively in the transportation of harvested forest products, the owner may present a written statement certifying that usage and the usage will be recorded.

400.20(2) If the motor vehicle is used primarily for farming purposes, the owner may present a written statement certifying that usage and the usage will be recorded.

This rule is intended to implement Iowa Code sections 307.30 and 321.20.

761—400.21(321) Registration of vehicles on a restricted basis. The department may register a vehicle which does not meet the equipment requirements of Iowa Code chapter 321, due to the particular use for which it is designed or intended, or which is a driverless-capable vehicle as defined in rule 761—380.2(321). Registration may be accomplished upon payment of the appropriate fees and after inspection and certification by the department that the vehicle is not in an unsafe condition.

400.21(1) Operation of the vehicle may be restricted to a roadway to which a specific lawful speed limit applies, as specified in Iowa Code section 321.285, if the maximum speed of the vehicle is such that the operation of the vehicle would impede or block the normal and reasonable movement of traffic.

400.21(2) The department may also restrict the operation of the vehicle to daylight hours if operation of the vehicle during hours other than daylight would create a hazard.

400.21(3) A certificate of restriction shall be issued in conjunction with registration of the vehicle, listing the restrictions that apply to the operation of the vehicle.

a. Registration laws applicable to motor vehicles in general shall also apply to vehicles registered under a restricted registration.

b. The department may approve exceptions to those equipment requirements of Iowa Code chapter 321 which cannot be met due to the particular use for which the vehicle is designed or intended.

400.21(4) The department shall not register an all-terrain vehicle. The department shall not register a vehicle built on or after January 1, 1968, unless it was manufactured primarily for use on public streets, roads and highways except a vehicle operated exclusively by a person with a disability, which may be registered if the department, in its discretion, determines that the vehicle is not in an unsafe condition. This subrule does not apply to a specially constructed, reconstructed, street rod or replica motor vehicle as defined in Iowa Code section 321.1.

400.21(5) When a vehicle registered in this state is modified to make it a driverless-capable vehicle as defined in rule 761—380.2(321), the person in whose name the vehicle is registered shall within 30 days notify the department upon a form prescribed by the department.

400.21(6) As provided in Iowa Code sections 321.515 and 321.519, the department may restrict the operations of a driverless-capable vehicle registered in this state or another state but which operates in this state. The restrictions may include but are not limited to the restrictions provided in subrules 400.21(1) and 400.21(2) and any operational restrictions based on a specific functional highway classification, weather conditions, days of the week, times of day, and other elements of operational design while the automated driving system is engaged. The department may require the vehicle owner to submit to the department the automated driving system's intended operational design domain for the vehicle on a form prescribed by the department. The department may evaluate the automated driving system's intended operational design domain for the vehicle. The department may establish additional operational restrictions to ensure safe operation of the vehicle. The department shall issue a certificate of restriction as provided in subrule 400.21(3) for any restriction established under this subrule, and the certificate shall be carried in the vehicle and made available for inspection by any peace officer upon request.

This rule is intended to implement Iowa Code sections 321.1, 321.23(4), 321.30(2), 321.101(1), 321.234A, 321.515 and 321.519.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 5893C, IAB 9/8/21, effective 10/13/21]

761—400.22(321) Transfers of ownership by operation of law. When ownership of a vehicle is transferred by operation of law under Iowa Code section 321.47, the following, in addition to rule 761—400.4(321), shall apply:

400.22(1) The new certificate of title and registration shall be issued, upon receipt of the proper documentation, by the county treasurer of the county where the transferee resides.

400.22(2) If the vehicle is not currently registered in this state, the registration fee and penalties due shall be computed in accordance with the following:

a. If the vehicle is ordered confiscated or forfeited by a court under a judgment or forfeiture, the fee shall be computed on the remaining unexpired months in the registration year from the date of the court order.

b. If the vehicle is sold on a peace officer's bill of sale as an unclaimed, stolen, embezzled or abandoned vehicle, or as a vehicle seized under Iowa Code section 321.84, the fee shall be computed on the remaining unexpired months in the registration year from the date of the sale.

c. If the vehicle is sold or transferred under a judgment or order entered by a court in a civil action or proceeding, or is transferred under any provision of Iowa Code section 321.47 which is not covered in this subrule, the fee shall include any delinquent fees which have accrued during previous registration periods and accrued penalties. Penalties shall continue to accrue until paid.

d. If the vehicle was last titled or registered in a foreign state, the fee shall be based on the month the vehicle becomes subject to registration in this state, except as provided in paragraphs 400.22(2) "a" and "b" above.

This rule is intended to implement Iowa Code sections 321.47, 321.105, 321.106, 321.134, and 321.135.

761—400.23(321) Junked vehicle.

400.23(1) *Junking certificate.* The owner of a vehicle that is to be junked or dismantled shall obtain a junking certificate when required by Iowa Code section 321.52.

400.23(2) *Required verification.*

a. One of the following shall satisfy the required verification when a vehicle owner junks or dismantles a vehicle to a licensed vehicle recycler under Iowa Code section 321.52(2)“*b*” or 321H.4A(2)“*b*”:

(1) The owner or authorized representative provides information to the licensed vehicle recycler who acquires the vehicle, including, at a minimum, government-issued photo identification and verification of prior reporting to the National Motor Vehicle Title Information System (NMVTIS). For a subsequent transaction with the licensed vehicle recycler, the vehicle owner or authorized representative is not required to provide government-issued photo identification if the licensed vehicle recycler has retained such information from a prior transaction. A licensed vehicle recycler is not required to report a vehicle verified under this subparagraph to the NMVTIS.

(2) The vehicle’s owner is a licensed vehicle recycler or is the authorized representative of an established commercial or industrial business, operating from a fixed location, that is known to the licensed vehicle recycler to be regularly engaged in the junking or dismantling of vehicles or may reasonably be expected to produce vehicles for junking or dismantling and has entered into a written agreement with the licensed vehicle recycler confirming it has reported the vehicles to the NMVTIS. The written agreement shall, at a minimum, contain the owner’s or authorized representative’s name and address. A licensed vehicle recycler is not required to report a vehicle covered under an agreement under this subparagraph to the NMVTIS.

(3) The licensed vehicle recycler obtains the vehicle owner’s or authorized representative’s name and the vehicle identification number for the vehicle being junked or dismantled, and the vehicle recycler reports the vehicle to the NMVTIS.

b. A licensed vehicle recycler acquiring a vehicle as described under this subrule shall cooperate with a law enforcement agency during normal business hours when the agency has reason to believe that fraud has occurred in connection with the junking or dismantling of the vehicle. A law enforcement agency shall maintain the information as confidential and shall not disclose the information to a third party, except as may be necessary for the prosecution of a criminal violation.

400.23(3) *Retitling a junked vehicle.* The department may authorize issuance of a new certificate of title to the vehicle owner named on the junking certificate only if the department determines that the junking certificate was issued in error.

a. The reasons a junking certificate was issued in error include but are not limited to the following:

(1) The owner inadvertently surrendered the wrong certificate of title. The owner shall submit to the department a photocopy of the ownership document for each vehicle and a signed statement explaining the circumstances that resulted in the error.

(2) A junking certificate was obtained in error and the vehicle continues to be registered. The owner shall submit to the department a photocopy of the current registration and a signed statement explaining the circumstances that resulted in the error.

(3) The owner intended to apply for a salvage title under Iowa Code subsection 321.52(4) but inadvertently submitted an application for a junking certificate. The owner shall submit to the department a bill of sale or other documentation from the previous owner stating that the vehicle was rebuildable when purchased and a signed statement explaining the owner’s original intention to obtain a salvage title. The department shall inspect the vehicle to verify the rebuildable condition.

b. If the department determines that the junking certificate was issued in error, the department shall authorize the proper county treasurer to issue a certificate of title for the vehicle after payment by the owner of appropriate fees and taxes, including the return of any credit or refund for registration fees paid to the owner because of the error.

c. If the department determines that the junking certificate was not issued in error and denies the application for reinstatement of the certificate of title for the vehicle, the owner may apply for a

certificate of title under the bonding procedure in rule 761—400.13(321) if the vehicle qualifies as an antique vehicle under Iowa Code subsection 321.115(1).

This rule is intended to implement Iowa Code sections 321.52 and 321H.4A.
[ARC 6489C, IAB 9/7/22, effective 10/12/22]

761—400.24(321) New vehicle registration fee. The registration fee shall be computed on the month of purchase of a new vehicle, except that the registration fee on a new vehicle acquired outside of this state shall be based on the month that the vehicle was brought into Iowa.

This rule is intended to implement Iowa Code sections 321.105 and 321.135.

761—400.25(321) Fees established by the department. If the department cannot obtain the retail list price and weight for a particular motor vehicle model registered under Iowa Code subsection 321.109(1), the department shall determine a list price and weight.

This rule is intended to implement Iowa Code sections 321.109, 321.157 and 321.159.

761—400.26(321) Anatomical gift. Voluntary contributions collected by the county treasurer or the department to the anatomical gift public awareness and transplantation fund shall be in whole dollar amounts. The county treasurer and the department shall remit contributions collected monthly to the funds specified in Iowa Code section 321.44A.

This rule is intended to implement Iowa Code section 321.44A.
[ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.27(321,322) Vehicles held for resale or trade by dealers. A motor vehicle dealer, as defined in Iowa Code section 321.1, is authorized to hold a motor vehicle for resale or trade under the following conditions.

400.27(1) Assignment to dealer. The certificate of title or manufacturer's certificate of origin for the vehicle shall be assigned to the dealer by the seller. The seller shall complete the assignment portion of the form, including the date of sale or trade and the name and address of the dealer, and shall sign the form. The date of the sale or trade shown in the assignment portion of the form shall be the date the dealer acquired the vehicle.

400.27(2) New certificate of title and registration not required.

a. A motor vehicle currently registered in Iowa may be held by a dealer without obtaining a new certificate of title or a new registration if the dealer holds for that vehicle a certificate of title or a manufacturer's certificate of origin properly assigned to the dealer.

b. A motor vehicle may also be held by a dealer without obtaining a new certificate of title or a new registration if the dealer has a title from a state that permits its titles to be reassigned by Iowa dealers and if a vacant reassignment space is available on the title.

400.27(3) New certificate of title required. A dealer shall obtain a new certificate of title, but is not required to pay registration fees for a vehicle if:

a. The vehicle has been registered in a foreign state or country that does not permit its titles to be reassigned by Iowa dealers.

b. The vehicle was assigned to the dealer using an affidavit of foreclosure form prescribed by the department or issued by a foreign jurisdiction.

c. The reassignment area of the certificate of title has been used.

d. Reserved.

e. The vehicle registration fee was delinquent in Iowa at the time the vehicle was acquired by the dealer. The delinquent fees and penalty shall be paid by the dealer from the first day the registration was due to the month the application for title is submitted.

f. In accordance with 761—Chapter 405, the dealer is required to obtain a salvage certificate of title.

400.27(4) New certificate of title and registration fee required. A dealer shall obtain both a new certificate of title and pay a registration fee for a vehicle if:

a. The vehicle has a foreign certificate of title but has never been registered and the dealer is not licensed under Iowa Code chapter 322 to sell that line-make of vehicle. The registration fee due shall be prorated for the remaining unexpired months of the dealer's registration year.

b. The vehicle was placed in storage by the previous owner. The registration fee due shall be a full registration year fee.

c. The vehicle has been registered in a foreign state or country that does not permit its titles to be reassigned by Iowa dealers or all reassignment spaces on the title are full and the application for a new certificate of title is submitted more than 30 days after the date the vehicle entered Iowa. The registration fee due shall be prorated for the remaining unexpired months of the dealer's registration year.

d. The vehicle was in the dealer's inventory and the dealer's license was revoked as provided in Iowa Code chapter 322 or 322C or surrendered in lieu of revocation. The dealer shall obtain title and registration within 30 days from the date of revocation or surrender of the license. The registration fee due shall be prorated for the remaining unexpired months of the registration year.

400.27(5) *Registration fee required.* A vehicle owned by a dealer and used as a work or service vehicle, or offered for lease, rent or hire, shall become subject to a registration fee in the month that the vehicle is first used for that purpose. The registration fee shall be due annually unless the vehicle is transferred to the dealer's inventory. To transfer the vehicle, the dealer shall surrender the registration plates that were issued for the vehicle.

400.27(6) *Violations.*

a. Failure to comply with this rule is a violation of Iowa Code subsection 321.104(2).

b. Failure to obtain a certificate of title when required shall result in a title penalty of \$10, as specified in Iowa Code subsection 321.49(1).

This rule is intended to implement Iowa Code sections 321.45, 321.46, 321.48, 321.49, 321.67, 321.70, 321.104 and chapter 322.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.28(321) *Special trucks.* The owner of a truck tractor registered as a special truck shall certify to the owner's county treasurer annually at the time of renewal that the truck tractor is not operated more than 15,000 miles annually.

This rule is intended to implement Iowa Code sections 321.1(75) and 321.121.

[ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.29(321) *Vehicles previously registered under Iowa Code chapter 326.* Rescinded IAB 11/23/05, effective 12/28/05.

761—400.30(321) *Registration of vehicles registered in another state or country.*

400.30(1) The registration fee for a vehicle from another state or country shall be due in the month that the vehicle becomes subject to registration in Iowa.

400.30(2) A vehicle registered in another state or country shall become subject to registration in Iowa and payment of the Iowa registration fee in:

a. The month of sale or transfer to an Iowa resident, or

b. The month that a nonresident owner establishes Iowa residency or accepts employment in Iowa of 90 days duration or longer. The county treasurer or the department may require from the applicant a written statement giving the date that the applicant established residency in Iowa.

400.30(3) Rescinded IAB 2/6/02, effective 3/13/02.

This rule is intended to implement Iowa Code sections 321.18, 321.20, 321.53 to 321.55, 321.101 and 321.135.

761—400.31 Rescinded, effective 12/1/83.

761—400.32(321) *Vehicles owned by nonresident members of the armed services.*

400.32(1) A vehicle owner who is a nonresident and a member of the armed services shall not be required to register the vehicle in Iowa if it is properly registered in the person's state of residence.

400.32(2) A vehicle owner who is a nonresident and a member of the armed services may register the vehicle in Iowa under the following conditions:

a. The vehicle is owned entirely by nonresidents.

b. The fee for a passenger-type vehicle registered under Iowa Code section 321.109 shall be based only on the weight of the vehicle; the part of the fee based on value shall be excluded. The fees for all other vehicles shall be determined as specified in Iowa Code chapter 321. The registration fee under Iowa Code sections 321.116 and 321.117 shall apply.

c. The application for vehicle registration shall include a certification by the person's commanding officer of the person's state of residence and assignment to Iowa.

400.32(3) If ownership of a passenger-type vehicle is transferred to another person, the vehicle shall be subject to registration in Iowa.

This rule is intended to implement Iowa Code sections 321.53 to 321.55, 321.109, 321.116 and 321.117.

[ARC 5178C, IAB 9/9/20, effective 10/14/20]

761—400.33(321) Disabled veterans exemption from payment of registration fees. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.34(321) Multipurpose vehicle registration fee. Rescinded IAB 11/7/07, effective 12/12/07.

761—400.35(321) Registration of vehicles equipped for persons with disabilities. The registration fee shall be reduced for an automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less with permanent equipment for assisting a person with a disability or for an automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less used by a person who uses a wheelchair as the person's only means of mobility. To qualify for the reduction, the owner of the vehicle must provide a written self-certification at the first registration and at each renewal:

400.35(1) That the automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less has permanently installed equipment manufactured for and necessary to assist a person with a disability, as defined in Iowa Code section 321L.1, to enter or exit the vehicle, or

400.35(2) That the owner or a member of the owner's household uses a wheelchair as the person's only means of mobility.

This rule is intended to implement Iowa Code sections 321.109, 321.124 and 321L.1.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.36(321) Land and water-type travel trailers registration fee. The registration fee for trailer-type vehicles designed to be used as a travel trailer and for use upon water shall be registered as a travel trailer. The exterior measurements used to determine the registration fee shall not include any pen deck area or area occupied by a trailer hitch.

This rule is intended to implement Iowa Code sections 321.1 and 321.123.

761—400.37(321) Motorcycle or autocyte primarily designed or converted to transport property. A motorcycle or autocyte primarily designed or converted to transport less than 1000 pounds of property shall be registered as a motorcycle or autocyte. A motorcycle or autocyte primarily designed or converted to transport 1000 pounds of property or more shall be registered as a motor truck.

This rule is intended to implement Iowa Code sections 321.1 and 321.117.

[ARC 2985C, IAB 3/15/17, effective 4/19/17]

761—400.38(321) Rescinded IAB 3/26/97, effective 4/30/97.

761—400.39(321) Conversion of motor vehicles.

400.39(1) An automobile converted to a truck with a carrying capacity of 1000 pounds or more shall be registered as a reconstructed motor vehicle.

400.39(2) A vehicle manufactured as a truck tractor or motor truck shall not be registered as a motor home unless the vehicle has been substantially altered to change its type and mode of operation so that it is a reconstructed vehicle as defined in Iowa Code section 321.1.

This rule is intended to implement Iowa Code sections 321.23, 321.111 and 321.124.
 [ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.40(321) Manufactured or mobile home converted to or from real property.

400.40(1) *Conversion to real property.* When a manufactured or mobile home is converted to real property under Iowa Code section 435.26, the process shall be as follows:

a. If a security interest is noted on the title and the secured party is given a mortgage for the land on which the home is located, the assessor shall collect the certificate of title as provided in rule 701—74.5(435).

b. If a security interest is noted on the title and the secured party is not given a mortgage for the land on which the home is located, the secured party shall retain the certificate of title as provided in Iowa Code section 435.26. At the time the security interest is released, the secured party may surrender the certificate of title to the county treasurer, who shall cancel the title as converted to real estate and destroy the title.

c. If there is no security interest noted on the title, the owner shall surrender the certificate of title to the assessor. The assessor shall note the conversion on the face of the certificate of title above the assessor's signature, date the notation and deliver the title to the county treasurer. The county treasurer shall note the conversion on the vehicle record and then cancel the title as converted to real estate and destroy the certificate of title.

d. If the assessor identifies in the county records a security interest no longer exists that would prevent the title to the home and the title to the land to merge under Iowa Code section 435.26 and the county treasurer verifies there is no lien on the certificate of title, the title to the home and the title to the land shall merge, and the county treasurer shall cancel the title as converted to real estate and destroy the certificate of title.

400.40(2) *Reconversion from real property.*

a. When a manufactured or mobile home is reconverted from real property by adding a vehicular frame, the owner may apply to the county treasurer for a certificate of title.

b. The owner shall submit a record of existing liens obtained from a local abstractor. The record shall identify the owner of the property, list all liens and encumbrances against the property, and shall be signed by the abstractor.

c. The owner shall also submit written consent to the reconversion from any person holding a mortgage on the real property (mortgagee). An existing mortgage shall be noted as a security interest on the certificate of title.

d. The county treasurer shall submit written notice of the reconversion to the county assessor's office.

400.40(3) *Affidavit for surrender of certificate of title.*

a. As provided in Iowa Code section 435.26B, an owner may effectuate a surrender of the certificate of title by recording with the county recorder Form 411186 if all of the following requirements are met:

(1) There is no record that a certificate of title has been issued or surrendered for a manufactured or mobile home that is located outside a manufactured home community or mobile home park.

(2) The manufactured home or mobile home has been converted to real estate by being placed on a permanent foundation.

(3) The manufactured or mobile home is entered on the tax rolls.

b. The fee for the duties performed by the department pursuant to Iowa Code section 435.26B(1) "i"(2) shall be \$5.

This rule is intended to implement Iowa Code sections 321.1, 435.1, 435.26, 435.26A, 435.26B and 435.27.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.41(321) Special registration plates. Rescinded IAB 3/1/95, effective 4/5/95.

761—400.42(321) Church bus registration fee. The church bus registration fee shall not apply if the bus is used in a manner other than provided by law or if ownership of the bus is transferred to a person who is not entitled to register the vehicle as a church bus.

400.42(1) When the church bus registration fee does not apply, the bus shall be registered under the provisions of Iowa Code section 321.122.

400.42(2) When Iowa Code section 321.122 applies and the bus is currently registered as a church bus, the registration fee shall be prorated for the remaining unexpired months of the registration year.

This rule is intended to implement Iowa Code sections 321.119 and 321.122.

761—400.43(321) Storage of vehicles.

400.43(1) The owner of a vehicle upon which the registration fee is not delinquent may surrender all registration plates for the vehicle to the county treasurer where the vehicle is registered and shall have the right to register the vehicle later upon payment of the annual registration fee due at the time of removal of the vehicle from storage. Payment of a registration fee shall not be required when the vehicle is removed from storage within the current registration year provided that registration fees have not been refunded. Plates that have been surrendered shall be destroyed. When a vehicle is removed from storage, the fee is \$5 for a set of replacement plates.

400.43(2) The owner of a motor vehicle which is placed in storage when the owner enters the military service of the United States shall comply with Iowa Code section 321.126, and subrule 400.43(1) does not apply.

This rule is intended to implement Iowa Code sections 321.126 and 321.134.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.44(321) Penalty on registration fees.

400.44(1) Monthly basis. The penalty on the delinquent payment of a registration fee shall be computed on a monthly basis, rounded to the nearest whole dollar. If multiple penalties are assessed, the penalties shall be first added together and then the sum shall be rounded to the nearest whole dollar.

400.44(2) Vehicle purchased. The penalty on the registration fee shall accrue from the first day of the month following the date of purchase, unless the application for a certificate of title is submitted within 30 days after the date of purchase.

400.44(3) Vehicle moved into Iowa. The penalty on the registration fee shall accrue on the first day of the month following 30 days from the date a vehicle is moved into Iowa.

400.44(4) When delinquency extends beyond the current year. When the penalty on a delinquent registration fee extends beyond the current year, the penalty shall continue to accrue until paid. Penalty shall only accrue on the fee applicable at the time the delinquency accrued and shall not be applicable to subsequent registration fees which have not been paid.

400.44(5) Statement of nonuse. If the owner of a vehicle, on which the registration fees have not been paid for more than three complete registration years, certifies to the county treasurer of the owner's residence, or to the department in a form and manner prescribed by the department if a vehicle is registered under Iowa Code chapter 326, that the vehicle has not been moved or operated upon the highway since the year it was last registered, the vehicle may be registered upon payment of the current year's registration fee.

400.44(6) Waiver of penalties for military members. Registration penalties shall be waived as provided in Iowa Code section 321.134, subsection 5, if the owner provides a copy of an official government document verifying that the applicant is in the military service of the United States and has been relocated as a result of being placed on active duty on or after September 11, 2001.

This rule is intended to implement Iowa Code sections 321.39, 321.46, 321.47, 321.49, 321.134 and 321.135.

[ARC 5178C, IAB 9/9/20, effective 10/14/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.45(321) Suspension, revocation or denial of registration.

400.45(1) The department shall suspend or revoke registration and plates under Iowa Code section 321.101 when a written request is received from a peace officer or the county treasurer's office that issued the registration or plates.

a. The notice of suspension or revocation shall contain the following:

(1) The basis of the request for suspension or revocation.

(2) Information regarding how the person may satisfy the violation and have the suspension or revocation removed, if applicable.

(3) Information notifying the person of the right to appeal the suspension or revocation in accordance with rule 761—400.56(321).

b. A request from a peace officer shall be submitted on a form prescribed by the department.

c. A request from a county treasurer's office shall be signed by the county treasurer or designee.

400.45(2) When the registration of a vehicle has been revoked as provided in Iowa Code sections 321.101 and 321.101A, the registration fee and penalty shall accrue as if the plates had never been issued, unless waiver of registration fees and penalties is specifically provided for in Iowa Code chapter 321.

400.45(3) In accordance with Iowa Code section 252J.8, the department shall suspend or deny the issuance or renewal of registration and plates upon receipt of a certificate of noncompliance from the child support recovery unit.

a. The suspension or denial shall become effective 30 days after notice to the vehicle owner and continue until the department receives a withdrawal of the certificate of noncompliance from the child support recovery unit.

b. If a person who is the named individual on a certificate of noncompliance subsequently purchases a vehicle, the vehicle shall be titled and registered, but the registration shall be immediately suspended.

This rule is intended to implement Iowa Code sections 252J.1, 252J.8, 252J.9, 321.101, 321.101A and 321.127.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4758C, IAB 11/6/19, effective 12/11/19; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.46(321) Termination of suspension of registration. Upon termination of the suspension of registration of a vehicle, the county treasurer shall issue new plates for the vehicle. If the new plates replace a current series of plates, there shall be a replacement fee as provided in Iowa Code section 321.42. If the vehicle is not currently registered at the time the suspension is lifted, the registration fee and penalties due shall be determined as follows:

400.46(1) If the registration fee was delinquent at the time that the suspension became effective, the penalty shall continue to accrue on the registration fee until the suspension became lifted and the registration fee is paid. In addition, if the suspension was for failure to pay an additional registration fee, the additional registration fee shall be paid before the suspension is lifted.

400.46(2) If the registration fee was not delinquent when the suspension became effective and the suspension is lifted after the beginning of another registration year, the annual registration fee for that year shall be due in the month the suspension is lifted. The penalty shall accrue on the registration fee the first day of the month following the month that the suspension was lifted. The annual registration fee on a recovered stolen vehicle for which the registration has been suspended shall be prorated for the remaining unexpired months of the registration year.

400.46(3) If the registration fee was not delinquent at the time that the suspension became effective and the suspension is lifted during the same registration period, no additional registration fees shall be due unless the suspension was for failure to pay an additional registration fee, in which event the additional registration fee shall be paid before the suspension is lifted.

This rule is intended to implement Iowa Code sections 321.42, 321.105 and 321.134.

761—400.47(321) Raw farm products. A vehicle may be operated with a gross weight of 25 percent in excess of the gross weight for which it is registered when transporting a load of raw farm products or soil fertilizers under Iowa Code section 321.466 except that nothing in this rule shall be construed to allow operation of a special truck on the public highways with a gross weight exceeding the maximum

gross weight allowed under Iowa Code section 321.463(6). In addition, the following products shall be considered raw farm products. This list shall not be deemed conclusive and shall not exclude other commodities which might be considered raw farm products:

Animals which are dead	Hides
Berries, fresh	Honey, comb or extracted
Blood	Melons
Corn, ear corn including hybrids	Milk, raw
Corn, shelled	Nursery stock
Corn, cobs	Potatoes
Cream, separated	Peat
Eggs, fresh or frozen in shell	Poultry, live
Flax	Saw logs
Flaxseed	Sod
Fodder	Soybeans
Fruit, fresh	Straw, baled or loose
Grain, threshed or unthreshed	Vegetables, fresh
Hair	Wood, cord or stove wood
Hay, baled or loose	Wool

This rule is intended to implement Iowa Code sections 321.466(4) and 321.466(5).
[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.48(321) Special mobile equipment. Rescinded IAB 3/7/90, effective 4/11/90.

761—400.49(321) Special mobile equipment transported on a registered vehicle. Rescinded IAB 3/7/90, effective 4/11/90.

761—400.50(321,326) Refund of registration fees.

400.50(1) Vehicles registered by county treasurer.

a. The department shall refund annual registration fees for vehicles registered by the county treasurer pursuant to Iowa Code section 321.126.

b. Except as provided in Iowa Code section 321.126, the owner may submit a claim for refund to the county treasurer's office in any county.

c. Registration plates shall be submitted with the claim if the vehicle is placed in storage or registered for apportioned registration, if the owner of the vehicle moves out of state, or if the plates have not been assigned to a replacement vehicle. If one or both plates have been lost or stolen, the claimant shall certify this fact in writing.

d. For a vehicle that was junked, the date on the junking certificate shall determine the date the vehicle was junked.

e. If the claim for refund is for excess credit or no replacement vehicle:

(1) The county treasurer shall enter into the state motor vehicle computer system the information required to process the refund. The information shall be entered within three days of receipt of the claim for refund.

(2) The claim for refund shall be approved or denied by the motor vehicle division.

f. The county treasurer shall forward all other claims for refund to the motor vehicle division for processing in the form and manner prescribed by the department.

400.50(2) Vehicles registered by the department. Forms and instructions for claiming a refund on apportioned registration fees under Iowa Code section 326.15 may be obtained from the motor vehicle division at the address in subrule 400.6(1). The claim for refund shall be filed at the same address.

This rule is intended to implement Iowa Code sections 25.1, 321.126 through 321.129 and 326.15. [ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.51(321) Assigned identification numbers. The department is authorized to issue to the owner an assigned vehicle identification number for a vehicle, an assigned component part number for a component part, and an assigned product identification number for a fence-line feeder, grain cart, or tank wagon. An identification number shall be assigned only if the department is satisfied as to the true identity and ownership of the vehicle, component part, fence-line feeder, grain cart or tank wagon. When an assigned vehicle identification number has been issued for a vehicle, the vehicle shall be registered and titled under that number. An assigned component part number or an assigned product identification number shall be used only for identification purposes.

400.51(1) Issuance of an identification number. The department shall issue an assigned vehicle identification number, assigned component part number or assigned product identification number, as applicable, only if:

- a. The original number has been destroyed, removed or obliterated.
- b. The vehicle has had a cab, body, or frame change and the replacement cab, body, or frame is within the manufacturer's interchangeability parts specifications catalog and is compatible with the make, model, and year of the vehicle. If the replacement cab, body, or frame change is not within the manufacturer's interchangeability parts specifications catalog or is not compatible with the make, year, and model of the vehicle, the vehicle shall be considered reconstructed and subject to rule 761—400.16(321).
- c. The vehicle is a specially constructed, reconstructed, street rod or replica motor vehicle. See rule 761—400.16(321) for the requirements and procedures applicable to specially constructed, reconstructed, street rod or replica motor vehicles.

400.51(2) Procedures.

a. *Request.* Whenever an assigned identification number is required under subrule 400.51(1) and the request does not apply to a specially constructed, reconstructed, street rod or replica motor vehicle, the owner of the vehicle, component part, fence-line feeder, grain cart or tank wagon, or the person holding lawful custody, shall contact the department's bureau of investigation and identity protection at the address in subrule 400.6(2) and request the assignment of a number.

b. *Examination.* A motor vehicle investigator shall contact the owner and schedule a time and place for examination of the vehicle, component part, fence-line feeder, grain cart or tank wagon and ownership documents. The owner of the vehicle may drive or tow the vehicle to and from the examination location by completing the affidavit to drive section on the certification of compliance form. The affidavit shall state that the vehicle is reasonably safe for operation and must be signed by the owner.

If the vehicle has had a cab, body, or frame change, the owner shall have, for evidence of ownership for the replacement cab, body, or frame, a bill of sale with a description of the part, complete with the manufacturer's identification number, if any, and the name, address, and telephone number of the seller. The bill of sale, the vehicle, and the cab, body, or frame that has been replaced shall be made available for examination at the time and place scheduled.

c. *Assigned vehicle identification number.*

(1) The investigator upon approval of the request shall affix to the vehicle an assigned vehicle identification number and authorize the county treasurer to issue a title and registration for the vehicle.

(2) The owner shall submit the certificate of title and the registration receipt issued for the vehicle to the county treasurer. If the certificate of title is in the possession of a secured party, the county treasurer shall notify the secured party to return the certificate of title to the county treasurer for the purpose of issuing a corrected title. Upon receipt of the notification, the secured party shall submit the certificate of title within ten days. The county treasurer, upon receipt of the certificate of title and the registration

receipt, shall issue a corrected title and registration receipt listing as the vehicle identification number the assigned vehicle identification number.

d. Assigned component part number. The investigator upon approval of the request shall affix to the component part an assigned component part number and give to the owner a component part form. The owner shall retain the form as a record of issuance and attachment. The form shall be made available on demand by any peace officer for examination.

e. Assigned product identification number. The investigator upon approval of the request shall affix an assigned product identification number to the fence-line feeder, grain cart or tank wagon and give to the owner an assigned product identification number form. The owner shall retain the form as a record of issuance and attachment. The form shall be made available on demand by any peace officer for examination.

400.51(3) Fees. A certificate of title fee and a fee for a notation of a security interest, if applicable, shall be collected by the county treasurer upon issuance of a corrected certificate of title. A corrected certificate of title shall not be required for a name change.

This rule is intended to implement Iowa Code sections 321.1, 321.43 and 321.92.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.52(321) Odometer statement.

400.52(1) Pursuant to Iowa Code section 321.71 and 49 U.S.C. Section 32705, an odometer disclosure statement shall be submitted with an application for certificate of title for a motor vehicle. The statement shall provide a current odometer reading and reflect whether the mileage is “actual,” “not actual” or “exceeds mechanical limits.”

400.52(2) If the transferor failed to provide an odometer disclosure statement or if the transferee lost the statement, and the transferee has attempted in good faith to contact the transferor to obtain a statement, the transferee may file a sworn statement of these facts on a form prescribed by the department. The sworn statement shall be accepted by the county treasurer or the department in lieu of the required odometer disclosure statement. The subsequent title issued from the sworn statement will record “not actual” mileage.

400.52(3) As required by 49 CFR Section 580.17, for vehicle transfers that occur through December 31, 2030, any vehicle that is model year 2011 or newer shall require an odometer disclosure statement. For vehicle transfers that occur on or after January 1, 2031, the model year formula for odometer disclosure statements shall be the current year minus 20. The resulting number represents the first model year for which a motor vehicle is exempt from the odometer statement requirements incident to a transfer.

This rule is intended to implement Iowa Code section 321.71.

[ARC 5829C, IAB 8/11/21, effective 9/15/21]

761—400.53(321) Stickers.

400.53(1) Placement of validation sticker. The validation sticker shall be affixed to the lower left corner of the rear registration plate. EXCEPTIONS: For motorcycle, autocycle and small trailer plates, the validation sticker shall be affixed to the upper left corner of the plate. For natural resources plates, the sticker may be affixed to the lower right corner of the rear plate.

400.53(2) Special fuel user identification sticker. If the vehicle uses a special fuel as defined in Iowa Code section 452A.2, a special fuel user identification sticker shall be issued. This sticker shall be displayed on the cover of the fuel inlet of the motor vehicle or on the outside panel of the motor vehicle within 3 inches of the fuel inlet so as to be in view when fuel is delivered into the motor vehicle.

400.53(3) Persons with disabilities parking sticker. A persons with disabilities special registration plate parking sticker shall be affixed to the lower right corner of the rear registration plate. A flying our colors plate sticker shall be affixed to the lower left corner of the rear registration plate and above the validation sticker to allow for full view of all numerals and letters printed on the plate pursuant to Iowa Code section 321.37.

400.53(4) *Special truck sticker.* An owner of a special truck, registered pursuant to Iowa Code section 321.121, who has been issued either regular registration plates or special registration plates other than special truck registration plates must obtain from the county treasurer a sticker which distinguishes the vehicle as a special truck. The sticker shall be affixed to the lower right corner of the rear registration plate. EXCEPTION: If the vehicle displays front and rear plates, two stickers shall be issued with one sticker affixed to the lower right corner of the front plate and rear plate. For natural resources plates and flying our colors plates, the stickers must be affixed to the lower left corner of the front and rear plates.

This rule is intended to implement Iowa Code sections 321.34, 321.37, 321.40, 321.41, 321.121 and 321.166.

[ARC 9833B, IAB 11/2/11, effective 12/7/11; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.54(321) Registration card issued for trailer-type vehicles. The registration card issued for trailer-type vehicles shall be carried in the vehicle which is described on the card or the registration card may be carried in the driver's compartment of the towing vehicle. If the registration card is carried in the vehicle which is described on such card, the registration card shall be enclosed in a registration card holder and the holder shall be attached to the vehicle so that the registration card may be viewed by any peace officer upon request.

This rule is intended to implement Iowa Code section 321.32.

761—400.55(321) Damage disclosure statement.

400.55(1) If the transferor failed to provide a damage disclosure statement or if the transferee lost the statement, and the transferee has attempted in good faith to contact the transferor to obtain a statement, the transferee may file a sworn statement of these facts. The transferee shall also complete section 2 of a separate damage disclosure statement and sign on the buyer's line. The sworn statement and damage disclosure statement completed by the transferee shall be accepted by the county treasurer or the department in lieu of the damage disclosure statement required from the transferor.

400.55(2) A model year formula for damage disclosure statements shall be the current year minus eight. The resulting number represents the first model year for which a motor vehicle is exempt from the damage disclosure statement requirements incident to a transfer.

400.55(3) If the transferor completes the damage disclosure on the assignment of title at the time of application for title, a transferor or transferee of a vehicle may submit a separate damage disclosure statement, Form 411108, indicating the damage level of the vehicle and whether the damage level exceeds 70 percent.

a. If the transferor signs both the damage disclosure on the assignment of title and the separate damage disclosure statement, Form 411108, the county treasurer shall accept the separate damage disclosure statement.

b. If the transferee signs the separate damage disclosure statement, Form 411108, the county treasurer shall accept the separate damage disclosure statement only if the separate damage disclosure statement indicates the damage level exceeds 70 percent. If the transferee's statement indicates the damage level is less than 70 percent, and there is no evidence that a prior Iowa title or foreign title was issued or designated as salvage, rebuilt or flood, the department shall review the transaction to confirm the damage level using data obtained from the insurance provider, motor vehicle repair facility, or other entity with direct knowledge of the damage.

This rule is intended to implement Iowa Code sections 321.52 and 321.69.

[ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—400.56(321) Hearings. The department shall send notice by certified mail to a person whose certificate of title, vehicle registration, license, or permit is to be revoked, suspended, canceled, or denied. The notice shall be mailed to the person's mailing address as shown on departmental records and shall become effective 20 days from the date mailed. A person who is aggrieved by a decision of the department and who is entitled to a hearing may contest the decision in accordance with 761—Chapter 13. The request shall be submitted in writing to the director of the motor vehicle division at the address in

subrule 400.6(1). The request for a contested case shall be deemed timely submitted if it is delivered or postmarked on or before the effective date specified in the notice of revocation, suspension, cancellation, or denial.

This rule is intended to implement Iowa Code sections 17A.10 through 17A.19, 321.101 and 321.102.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.57(321) Non-resident-owned vehicles. Rescinded IAB 2/6/02, effective 3/13/02.

761—400.58(321) Motorized bicycles. The following rules shall apply to motorized bicycles.

400.58(1) Maximum speed. If the department has reasonable cause to believe that a particular vehicle or model is capable of speeds exceeding 39 miles per hour, the department may conduct independent tests to determine the maximum speed of the vehicle or model. If the department determines that the maximum speed of the particular vehicle or model exceeds 39 miles per hour, the vehicle or model shall not be registered as a motorized bicycle.

400.58(2) Identification of a vehicle as a motorized bicycle. Registration plates issued for motorcycles shall also be issued for motorized bicycles.

This rule is intended to implement Iowa Code sections 321.1 and 321.166.

[ARC 2887C, IAB 1/4/17, effective 2/8/17]

761—400.59(321) Registration documents lost or damaged in transit through the United States postal service. To obtain without cost the reissuance of registration documents that were sent by the county treasurer to the owner through the United States postal service and which were lost or damaged in transit, the owner of the vehicle shall file application for reissuance within 60 days of the date the documents were issued by the county treasurer.

This rule is intended to implement Iowa Code section 321.42.

761—400.60(321) Credit of registration fees.

400.60(1) Credit for unexpired registration fee. The applicant may claim credit, as specified in Iowa Code section 321.46(3), toward the registration fee for one newly acquired replacement vehicle. No credit shall be given for an unexpired electric vehicle annual registration fee; however, an unexpired electric vehicle annual registration fee is eligible for a refund as provided in rule 761—400.50(321,326).

a. The credit may be claimed only when the owner of the newly acquired vehicle is applying for a certificate of title and registration (or just registration if the vehicle is not subject to titling provisions) for the newly acquired vehicle.

b. For a junked vehicle, the date on the junking certificate shall determine the date the vehicle was junked.

c. Excess credit shall not be applied toward the registration fee for a second vehicle.

d. Credit shall be allowed for one or two vehicles which have been sold, traded or junked toward one replacement vehicle. Credit shall be based on the remaining unexpired months of the registration year(s) of the vehicle(s) sold, traded or junked.

400.60(2) Credit for transfer to spouse, parent or child. Credit shall be allowed toward a new registration for a vehicle being transferred to the applicant from the applicant's spouse, parent or child, or from a former spouse pursuant to a dissolution of marriage decree, if application for the certificate of title and registration (or just registration if the vehicle is not subject to titling provisions) is made within 30 days after the date of transfer. If the owner is deceased, credit may be transferred under rule 761—400.14(321) of this chapter.

400.60(3) Credit from/to apportioned registration.

a. Pursuant to Iowa Code section 321.46A, an owner may claim credit toward the registration fees due when changing a vehicle's registration from apportioned registration under Iowa Code chapter 326 to registration under Iowa Code chapter 321. The owner shall surrender proof of apportioned registration

to the county treasurer. Credit shall be allowed for the unexpired complete calendar months remaining in the registration year from the date the application is filed with the county treasurer.

b. Pursuant to Iowa Code sections 321.126 and 321.127, the owner or lessee of a motor vehicle may claim credit for the apportioned registration fees due when changing the vehicle's registration from registration by the county treasurer to apportioned registration. Application for apportioned registration shall be submitted to the department's motor vehicle division; see 761—Chapter 500.

400.60(4) *Assignment of credit and registration plates from lessor to lessee.* When a lessee purchases the leased vehicle and within 30 days requests the assignment of the vehicle's fee credit and registration plates, the lessor shall assign the registration fee credit and registration plates for the purchased vehicle to the lessee.

400.60(5) *Rounding.* If credit from two registration years or two registration fees, or some combination of both, is available, the credits shall first be added together, then it shall be determined whether the sum meets the minimum required under Iowa Code section 321.46(3) "c," and then the sum shall be rounded to the nearest whole dollar.

This rule is intended to implement Iowa Code sections 321.46, 321.46A, 321.48, 321.116, 321.117, 321.126 and 321.127.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 5178C, IAB 9/9/20, effective 10/14/20; ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.61(321) Reassignment of registration plates.

400.61(1) Registration plates may be reassigned if one of the owners listed on the registration receipt before the transfer is also a listed owner following the transfer.

400.61(2) Registration plates may be reassigned when credit is allowed toward a new registration for a vehicle being transferred to the owner's spouse, parent, or child, or to a former spouse pursuant to a dissolution of marriage decree. If the owner is deceased, plates may be transferred under rule 761—400.14(321).

400.61(3) Registration plates shall not be reassigned between a natural person or persons and a corporation, association, copartnership, company, or firm.

400.61(4) Registration plates may be reassigned and credit allowed if two or more corporations, associations, partnerships, or firms merge into one corporation, association, partnership or firm.

400.61(5) Registration plates may be assigned and credit allowed if an owner listed on the certificate of title and registration transfers ownership of the vehicle to a trust created by that owner.

This rule is intended to implement Iowa Code sections 321.34 and 321.46.

761—400.62(321) Storage of registration plates, certificate of title forms and registration forms. Registration plates, certificate of title forms and registration forms which are consigned to county treasurers by the department shall be stored in a secure location. The location may be within the office of the county treasurer which is accessible only to authorized persons or in a storage area located outside the general office area assigned to the county treasurer. Any storage area located outside the general office area assigned to the county treasurer shall be of the construction that it is accessible only to authorized persons, as designated by the county treasurer or department.

This rule is intended to implement Iowa Code sections 321.5, 321.8, and 321.167.

761—400.63(321) Disposal of surrendered registration plates. The county treasurer shall return plates that have been surrendered to the county treasurer to Iowa state prison industries for recycling.

This rule is intended to implement Iowa Code sections 321.5 and 321.171.
[ARC 6287C, IAB 4/6/22, effective 5/11/22]

761—400.64(321) County treasurer's report of motor vehicle collections and funds. The county treasurer shall file the report provided for in Iowa Code section 321.153 in a manner prescribed by the department.

This rule is intended to implement Iowa Code section 321.153.

761—400.65 to 400.69 Reserved.

761—400.70(321) Removal of registration and plates by peace officer under financial liability coverage law. This rule applies to instances when a peace officer issues a citation and removes the registration receipt and registration plates of a motor vehicle registered in this state when the driver of the motor vehicle is unable to provide proof of financial liability coverage. This rule applies regardless of whether the vehicle was also impounded.

400.70(1) The peace officer shall forward the registration receipt and evidence of the violation to the county treasurer of the county in which the motor vehicle is registered. Evidence of the violation is one of the following:

a. A copy of the citation. The citation must either reference Iowa Code subparagraph 321.20B(4)“a”(3) or 321.20B(4)“a”(4), as applicable, or reference Iowa Code section 321.20B and indicate whether or not the vehicle was impounded.

b. A written statement from the peace officer listing the plate number of the registration plate removed from the vehicle and the vehicle owner’s name. The statement must either reference Iowa Code subparagraph 321.20B(4)“a”(3) or 321.20B(4)“a”(4), as applicable, or reference Iowa Code section 321.20B and indicate whether or not the vehicle was impounded. The statement must be signed by the peace officer or an employee of the law enforcement agency.

400.70(2) The peace officer may either destroy removed plates or deliver the removed plates to the county treasurer for destruction.

This rule is intended to implement Iowa Code section 321.20B.

761—400.71(321) Lemon law designation. Rescinded IAB 11/7/07, effective 12/12/07.

761—400.72(321) Electronic lien and title.

400.72(1) The department may authorize the use of an electronic lien and title (ELT) system to provide an electronic record of the certificate of title to a security interest holder, to subject a vehicle to an electronic lien, and to allow for the submission and receipt of forms related to security interests through electronic means.

a. The department shall authorize ELT providers for transmission of vehicle data, title data and forms necessary to process security interest transactions through electronic means. The department may establish application forms and approval processes as necessary for ELT providers.

b. The department may authorize an ELT lender to participate in the ELT system if the ELT lender has first established a service relationship with an authorized ELT provider. The department may establish application forms and approval processes as necessary for ELT lenders.

400.72(2) For each individual transaction, an authorized ELT lender may choose to use either the ELT process or the paper security interest process as provided in Iowa Code section 321.50 and rules 761—400.8(321) and 761—400.10(321).

400.72(3) If a security interest is released through ELT and there are no other secured parties, but the ELT lender does not request a paper title to be printed and provided to the owner, or the ELT lender does not otherwise provide a paper title to the owner, then the owner of the vehicle may apply to the county treasurer or the department for a certificate of title to be printed and provided to the owner by submitting an application form in the form and manner prescribed by the department.

a. If there is more than one owner of the vehicle, any owner may apply to the department or the county treasurer, as applicable, for the certificate of title to be printed and provided to whomever the owner specifies.

b. If an owner is deceased, the signatures and documents specified in subrules 400.14(4) and 400.14(5) shall be required. A person entitled to vehicle ownership under the laws of descent and distribution shall sign the required forms and shall insert the words “heir at law” following the signature on the application form.

This rule is intended to implement Iowa Code section 321.50.

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