

State of Iowa

Iowa
Administrative
Code
Supplement

Biweekly
March 9, 2011



STEPHANIE A. HOFF
ADMINISTRATIVE CODE EDITOR

Published by the
STATE OF IOWA
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement 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 imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

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.

Editor's telephone (515)281-3355 or (515)242-6873

Human Services Department[441]

Replace Analysis

Replace Chapter 75

Replace Chapters 78 to 81

Replace Reserved Chapters 165 and 166 with Reserved Chapter 165

Insert Chapter 166

Inspections and Appeals Department[481]

Replace Chapter 11

Professional Licensure Division[645]

Replace Analysis

Replace Chapters 121 and 122

Replace Reserved Chapter 123 with Chapter 123

Replace Chapter 124

Pharmacy Board[657]

Replace Analysis

Replace Chapters 2 and 3

Replace Chapters 7 and 8

Replace Chapter 10

Replace Chapter 13

Replace Chapters 35 and 36

Public Safety Department[661]

Replace Chapter 91

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.

TITLE I

GENERAL DEPARTMENTAL PROCEDURES

CHAPTER 1

DEPARTMENTAL ORGANIZATION AND PROCEDURES

- 1.1(17A) Director
- 1.2(17A) Council
- 1.3(17A) Organization at state level
- 1.4(17A) Field operations structure
- 1.5 Reserved
- 1.6(17A) Mental health and developmental disabilities commission
- 1.7(17A) Governor's developmental disabilities council (governor's DD council)
- 1.8(17A,217) Waivers of administrative rules (hereinafter referred to as exceptions to policy)
- 1.9 Reserved
- 1.10(17A,514I) HAWK-I board

CHAPTER 2

CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES
EMPLOYEES AND PROPERTY

- 2.1(23A,225C) Definitions
- 2.2(23A,225C) Contracts for use of the services of department employees
- 2.3(23A,225C) Contract provisions
- 2.4(23A,225C) Leasing of space at state institutions
- 2.5(23A,225C) Requirements prior to leasing

CHAPTER 3

DEPARTMENT PROCEDURE FOR RULE MAKING

- 3.1(17A) Applicability
- 3.2(17A) Advice on possible rules before notice of proposed rule adoption
- 3.3(17A) Public rule-making docket
- 3.4(17A) Notice of proposed rule making
- 3.5(17A) Public participation
- 3.6(17A) Regulatory analysis
- 3.7(17A,25B) Fiscal impact statement
- 3.8(17A) Time and manner of rule adoption
- 3.9(17A) Variance between adopted rule and published notice of proposed rule adoption
- 3.10(17A) Exemptions from public rule-making procedures
- 3.11(17A) Concise statement of reasons
- 3.12(17A) Contents, style, and form of rule
- 3.13(17A) Department rule-making record
- 3.14(17A) Filing of rules
- 3.15(17A) Effectiveness of rules prior to publication
- 3.16(17A) Review by department of rules

CHAPTER 4

PETITIONS FOR RULE MAKING

- 4.1(17A) Petition for rule making
- 4.2(17A) Briefs

- 4.3(17A) Inquiries
- 4.4(17A) Agency consideration

CHAPTER 5 DECLARATORY ORDERS

- 5.1(17A) Petition for declaratory order
- 5.2(17A) Notice of petition
- 5.3(17A) Intervention
- 5.4(17A) Briefs
- 5.5(17A) Inquiries
- 5.6(17A) Service and filing of petitions and other papers
- 5.7(17A) Consideration
- 5.8(17A) Action on petition
- 5.9(17A) Refusal to issue order
- 5.10(17A) Contents of declaratory order—effective date
- 5.11(17A) Copies of orders
- 5.12(17A) Effect of a declaratory order

CHAPTER 6 Reserved

CHAPTER 7 APPEALS AND HEARINGS

- 7.1(17A) Definitions
- 7.2 Reserved
- 7.3(17A) Presiding officer
- 7.4(17A) Notification of hearing procedures
- 7.5(17A) The right to appeal
- 7.6(17A) Informing persons of their rights
- 7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance
- 7.8(17A) Opportunity for hearing
- 7.9(17A) Continuation of assistance pending a final decision on appeal
- 7.10(17A) Procedural considerations
- 7.11(17A) Information and referral for legal services
- 7.12(17A) Subpoenas
- 7.13(17A) Rights of appellants during hearings
- 7.14(17A) Limitation of persons attending
- 7.15(17A) Medical examination
- 7.16(17A) The appeal decision
- 7.17(17A) Exhausting administrative remedies
- 7.18(17A) Ex parte communication
- 7.19(17A) Accessibility of hearing decisions
- 7.20(17A) Right of judicial review and stays of agency action
- 7.21(17A) Food assistance hearings and appeals
- 7.22 Reserved
- 7.23(17A) Contested cases with no factual dispute
- 7.24(17A) Emergency adjudicative proceedings

CHAPTER 8
PAYMENT OF SMALL CLAIMS

8.1(217) Authorization to reimburse

CHAPTER 9
PUBLIC RECORDS AND FAIR
INFORMATION PRACTICES

9.1(17A,22) Definitions
 9.2(17A,22) Statement of policy
 9.3(17A,22) Requests for access to records
 9.4(17A,22) Access to confidential records
 9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations
 9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
 9.7(17A,22,228) Consent to disclosure by the subject of a confidential record
 9.8(17A,22) Notice to suppliers of information
 9.9(17A,22) Release to subject
 9.10(17A,22) Use and disclosure without consent of the subject
 9.11(22) Availability of records
 9.12(22,252G) Personally identifiable information
 9.13(217) Distribution of informational materials
 9.14(17A,22) Special policies and procedures for protected health information
 9.15(17A,22) Person who may exercise rights of the subject

CHAPTER 10
Reserved

CHAPTER 11
COLLECTION OF PUBLIC ASSISTANCE DEBTS

11.1(217) Definitions
 11.2(217) Establishment of claim
 11.3(217) Application of payment
 11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages
 11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages

CHAPTER 12
VOLUNTEER SERVICES

12.1(234) Definition
 12.2(234) Allocation of block grant funds
 12.3(234) Requirements for volunteers
 12.4(234) Volunteer service programs
 12.5(234) Services and benefits available to volunteers

CHAPTER 13
PROGRAM EVALUATION

13.1(234,239B,249A) Definitions
 13.2(234,239B,249A) Review of public assistance records by the department
 13.3(234,239B,249A) Who shall be reviewed
 13.4(234,239B,249A) Notification of review
 13.5(234,239B,249A) Review procedure

- 13.6(234,239B,249A) Failure to cooperate
- 13.7(234,239B,249A) Report of findings
- 13.8(234,239B,249A) Federal rereview

CHAPTER 14

OFFSET OF COUNTY DEBTS OWED DEPARTMENT

- 14.1(217,234) Definitions
- 14.2(217,234) Identifying counties with liabilities
- 14.3(217,234) List of counties with amounts owed
- 14.4(217,234) Notification to county regarding offset
- 14.5(217,234) Implementing the final decision
- 14.6(217,234) Offset completed

CHAPTER 15

RESOLUTION OF LEGAL SETTLEMENT DISPUTES

- 15.1(225C) Definitions
- 15.2(225C) Assertion of legal settlement dispute
- 15.3(225C) Response to dispute notification
- 15.4(225C) Contested case hearing
- 15.5(225C) Change in determination

TITLE II
Reserved

CHAPTERS 16 to 21

Reserved

TITLE III
MENTAL HEALTH

CHAPTER 22

STANDARDS FOR SERVICES TO PERSONS WITH MENTAL ILLNESS,
CHRONIC MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL
DISABILITIES, OR BRAIN INJURY

- 22.1(225C) Definitions
- 22.2(225C) Principles
- 22.3(225C) General guidelines for service delivery
- 22.4(225C) Services
- 22.5(225C) Compliance hearing

CHAPTER 23

Reserved

CHAPTER 24

ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS,
MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES

- 24.1(225C) Definitions
- 24.2(225C) Standards for policy and procedures
- 24.3(225C) Standards for organizational activities
- 24.4(225C) Standards for services
- 24.5(225C) Accreditation
- 24.6(225C) Deemed status
- 24.7(225C) Complaint process
- 24.8(225C) Appeal procedure
- 24.9(225C) Exceptions to policy

CHAPTER 25
DISABILITY SERVICES MANAGEMENT

DIVISION I
DETERMINATION OF STATE PAYMENT AMOUNT

25.1 to 25.10 Reserved

DIVISION II
COUNTY MANAGEMENT PLAN

25.11(331) Definitions
25.12(331) County management plan—general criteria
25.13(331) Policies and procedures manual
25.14(331) Policies and procedures manual review
25.15(331) Amendments
25.16(331) Reconsideration
25.17(331) Management plan annual review
25.18(331) Strategic plan
25.19(331) Technical assistance
25.20(331) Consumer financial eligibility and payment responsibility
25.21 to 25.40 Reserved

DIVISION III
MINIMUM DATA SET

25.41(331) Minimum data set
25.42 to 25.50 Reserved

DIVISION IV
INCENTIVE AND EFFICIENCY POOL FUNDING

25.51(77GA,HF2545) Desired results areas
25.52(77GA,HF2545) Methodology for applying for incentive funding
25.53(77GA,HF2545) Methodology for awarding incentive funding
25.54(77GA,HF2545) Subsequent year performance factors
25.55(77GA,HF2545) Phase-in provisions
25.56 to 25.60 Reserved

DIVISION V
RISK POOL FUNDING

25.61(426B) Definitions
25.62(426B) Risk pool board
25.63(426B) Application process
25.64(426B) Methodology for awarding risk pool funding
25.65(426B) Repayment provisions
25.66(426B) Appeals
25.67 to 25.70 Reserved

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

25.71(78GA,ch1221) Definitions
25.72(78GA,ch1221) Risk pool board
25.73(78GA,ch1221) Rate-setting process
25.74(78GA,ch1221) Application process
25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding
25.76(78GA,ch1221) Repayment provisions
25.77(78GA,ch1221) Appeals
25.78 to 25.80 Reserved

DIVISION VII
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

25.81(225C) Waiver request

CHAPTERS 26 and 27
Reserved

CHAPTER 28
POLICIES FOR ALL INSTITUTIONS

- 28.1(218) Definitions
- 28.2(218,222) Selection of facility
- 28.3(222,230) Evidence of legal settlement
- 28.4(225C,229) Grievances
- 28.5(217,218) Photographing and recording of individuals and use of cameras
- 28.6(217,218) Interviews and statements
- 28.7(218) Use of grounds, facilities, or equipment
- 28.8(218) Tours of institution
- 28.9(218) Donations
- 28.10 and 28.11 Reserved
- 28.12(217) Release of confidential information
- 28.13(218) Applying county institutional credit balances

CHAPTER 29
MENTAL HEALTH INSTITUTES

- 29.1(218) Catchment areas
- 29.2(218,229) Voluntary admissions
- 29.3(229,230) Certification of settlement
- 29.4(218,230) Charges for care
- 29.5(229) Authorization for treatment
- 29.6(217,228,229) Rights of individuals
- 29.7(218) Visiting

CHAPTER 30
STATE RESOURCE CENTERS

- 30.1(218,222) Catchment areas
- 30.2(218,222) Admission
- 30.3(222) Certification of settlement
- 30.4(222) Liability for support
- 30.5(217,218,225C) Rights of individuals
- 30.6(218) Visiting

CHAPTERS 31 to 33
Reserved

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES

- 34.1(225C) Definitions
- 34.2(225C) Function
- 34.3(225C) Standards

CHAPTER 35
Reserved

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I

ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

- 36.1(249A) Assessment of fee
- 36.2(249A) Determination and payment of fee for facilities certified to participate in the
 Medicaid program
- 36.3(249A) Determination and payment of fee for facilities not certified to participate in the
 Medicaid program
- 36.4(249A) Termination of fee assessment
- 36.5 Reserved

DIVISION II

QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

- 36.6(249L) Assessment
- 36.7(249L) Determination and payment of assessment
- 36.8 and 36.9 Reserved

DIVISION III

HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

- 36.10(83GA,SF2388) Application of assessment
- 36.11(83GA,SF2388) Determination and payment of assessment
- 36.12(83GA,SF2388) Termination of health care access assessment

CHAPTER 37

Reserved

CHAPTER 38

DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

- 38.1(225C,217) Definitions
- 38.2(225C,217) Program eligibility
- 38.3(225C,217) Application under competitive process
- 38.4(225C,217) Competitive project awards
- 38.5(225C,217) Sole source or emergency selection project awards
- 38.6(225C,217) Field-initiated proposals
- 38.7(225C,217) Notification
- 38.8(225C,217) Request for reconsideration
- 38.9(225C,217) Contracts
- 38.10 Reserved
- 38.11(225C,217) Reallocation of funds
- 38.12(225C,217) Conflict of interest policy

CHAPTER 39

Reserved

TITLE IV

FAMILY INVESTMENT PROGRAM

CHAPTER 40

APPLICATION FOR AID

DIVISION I

FAMILY INVESTMENT PROGRAM—CONTROL GROUP

- 40.1 to 40.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

- 40.21(239B) Definitions
- 40.22(239B) Application
- 40.23(239B) Date of application
- 40.24(239B) Procedure with application
- 40.25(239B) Time limit for decision
- 40.26(239B) Effective date of grant
- 40.27(239B) Continuing eligibility
- 40.28(239B) Referral for investigation

CHAPTER 41
GRANTING ASSISTANCE

DIVISION I
FAMILY INVESTMENT PROGRAM—
CONTROL GROUP

- 41.1 to 41.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

- 41.21(239B) Eligibility factors specific to child
- 41.22(239B) Eligibility factors specific to payee
- 41.23(239B) Home, residence, citizenship, and alienage
- 41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program
- 41.25(239B) Uncategorized factors of eligibility
- 41.26(239B) Resources
- 41.27(239B) Income
- 41.28(239B) Need standards
- 41.29(239B) Composite FIP/SSI cases
- 41.30(239B) Time limits

CHAPTER 42
Reserved

CHAPTER 43
ALTERNATE PAYEES

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

- 43.1 to 43.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

- 43.21(239B) Conservatorship or guardianship
- 43.22 and 43.23 Reserved
- 43.24(239B) Emergency payee

CHAPTER 44
Reserved

CHAPTER 45
PAYMENT

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

- 45.1 to 45.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

45.21(239B)	Issuing payment
45.22(239B)	Return
45.23(239B)	Held warrants
45.24(239B)	Underpayment
45.25(239B)	Deceased payees
45.26(239B)	Limitation on payment
45.27(239B)	Rounding of need standard and payment amount

CHAPTER 46
OVERPAYMENT RECOVERY

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

46.1 to 46.20	Reserved
---------------	----------

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

46.21(239B)	Definitions
46.22(239B)	Monetary standards
46.23(239B)	Notification and appeals
46.24(239B)	Determination of overpayments
46.25(239B)	Source of recoupment
46.26	Reserved
46.27(239B)	Procedures for recoupment
46.28	Reserved
46.29(239B)	Fraudulent misrepresentation of residence

CHAPTER 47
DIVERSION INITIATIVES

DIVISION I
PROMOTING AWARENESS OF THE BENEFITS OF A HEALTHY MARRIAGE

47.1(234)	Eligibility criteria
47.2(234)	Notice and eligibility period
47.3 to 47.20	Reserved

DIVISION II
FAMILY SELF-SUFFICIENCY GRANTS PROGRAM

47.21(239B)	Definitions
47.22(239B)	Availability of the family self-sufficiency grants program
47.23(239B)	General criteria
47.24(239B)	Assistance available in family self-sufficiency grants
47.25(239B)	Application, notification, and appeals
47.26(239B)	Approved local plans for family self-sufficiency grants

CHAPTERS 48 and 49
Reserved

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

50.1(249)	Definitions
50.2(249)	Application procedures
50.3(249)	Approval of application and effective date of eligibility

- 50.4(249) Reviews
- 50.5(249) Application under conditional benefits

CHAPTER 51
ELIGIBILITY

- 51.1(249) Application for other benefits
- 51.2(249) Supplementation
- 51.3(249) Eligibility for residential care
- 51.4(249) Dependent relatives
- 51.5(249) Residence
- 51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles
- 51.7(249) Income from providing room and board
- 51.8(249) Furnishing of social security number
- 51.9(249) Recovery

CHAPTER 52
PAYMENT

- 52.1(249) Assistance standards

CHAPTER 53
Reserved

CHAPTER 54
FACILITY PARTICIPATION

- 54.1(249) Application and contract agreement
- 54.2(249) Maintenance of case records
- 54.3(249) Financial and statistical report
- 54.4(249) Goods and services provided
- 54.5(249) Personal needs account
- 54.6(249) Case activity report
- 54.7(249) Billing procedures
- 54.8(249) Audits

TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTERS 55 and 56
Reserved

CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT

- 57.1(249) Definitions
- 57.2(249) Requirements for reimbursement
- 57.3(249) Certificate of authority

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

- 58.1(29C) Definitions
- 58.2(29C) Program implementation
- 58.3(29C) Application for assistance
- 58.4(29C) Eligibility criteria
- 58.5(29C) Eligible categories of assistance
- 58.6(29C) Eligibility determination and payment

58.7(29C) Contested cases
 58.8(29C) Discontinuance of program
 58.9 to 58.20 Reserved

DIVISION II
 FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE

58.21 to 58.40 Reserved

DIVISION III
 TEMPORARY MEASURES RELATED TO DISASTERS

58.41(217) Purpose
 58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements
 58.43(237A) Need for child care services
 58.44(249A,249J,514I) Premium payments
 58.45(249A) Citizenship and identity
 58.46 to 58.50 Reserved

DIVISION IV
 IOWANS HELPING IOWANS UNMET NEEDS DISASTER ASSISTANCE PROGRAM

58.51(234) Definitions
 58.52(234) Program implementation
 58.53(234) Application for assistance
 58.54(234) Eligibility criteria
 58.55(234) Eligible categories of assistance
 58.56(234) Eligibility determination and payment
 58.57(234) Contested cases
 58.58(234) Discontinuance of program
 58.59 and 58.60 Reserved

DIVISION V
 TICKET TO HOPE PROGRAM

58.61(234) Definitions
 58.62(234) Application process
 58.63(234) Eligibility criteria
 58.64(234) Provider participation
 58.65(234) Provider reimbursement
 58.66(234) Reconsideration
 58.67(234) Appeal
 58.68(234) Discontinuance of program

CHAPTER 59
 Reserved

CHAPTER 60
 REFUGEE CASH ASSISTANCE

60.1(217) Alienage requirements
 60.2(217) Application procedures
 60.3(217) Effective date of grant
 60.4(217) Accepting other assistance
 60.5(217) Eligibility factors
 60.6(217) Students in institutions of higher education
 60.7(217) Time limit for eligibility
 60.8(217) Criteria for exemption from registration for employment services, registration,
 and refusal to register
 60.9(217) Work and training requirements
 60.10(217) Uncategorized factors of eligibility

60.11(217)	Temporary absence from home
60.12(217)	Application
60.13(217)	Continuing eligibility
60.14(217)	Alternate payees
60.15(217)	Payment
60.16(217)	Overpayment recovery

CHAPTER 61
REFUGEE SERVICES PROGRAM

61.1(217)	Definitions
61.2(217)	Authority
61.3(217)	Eligibility for refugee services
61.4(217)	Planning and coordinating the placement of refugees in advance of their arrival
61.5(217)	Services of the department available for refugees
61.6(217)	Provision of services
61.7(217)	Application for services
61.8(217)	Adverse service actions
61.9(217)	Client appeals
61.10(217)	Refugee sponsors
61.11(217)	Adverse actions regarding sponsor applications
61.12(217)	Administrative review of denial of sponsorship application
61.13(217)	Refugee resettlement moneys
61.14(217)	Unaccompanied refugee minors program
61.15(217,622A)	Interpreters and translators for legal proceedings
61.16(217)	Pilot recredentialing services
61.17(217)	Targeted assistance grants
61.18(217)	Iowa refugee services foundation

CHAPTERS 62 to 64
Reserved

TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

DIVISION I

65.1(234)	Definitions
65.2(234)	Application
65.3(234)	Administration of program
65.4(234)	Issuance
65.5(234)	Simplified reporting
65.6(234)	Delays in certification
65.7	Reserved
65.8(234)	Deductions
65.9(234)	Treatment centers and group living arrangements
65.10	Reserved
65.11(234)	Discrimination complaint
65.12(234)	Appeals
65.13(234)	Joint processing
65.14	Reserved
65.15(234)	Proration of benefits
65.16(234)	Complaint system

65.17(234)	Involvement in a strike
65.18 and 65.19	Reserved
65.20(234)	Notice of expiration issuance
65.21(234)	Claims
65.22(234)	Verification
65.23(234)	Prospective budgeting
65.24(234)	Inclusion of foster children in household
65.25(234)	Effective date of change
65.26(234)	Eligible students
65.27(234)	Voluntary quit or reduction in hours of work
65.28(234)	Work requirements
65.29(234)	Income
65.30(234)	Resources
65.31(234)	Homeless meal providers
65.32(234)	Basis for allotment
65.33(234)	Dependent care deduction
65.34 to 65.36	Reserved
65.37(234)	Eligibility of noncitizens
65.38(234)	Income deductions
65.39(234)	Categorical eligibility
65.40	Reserved
65.41(234)	Actions on changes increasing benefits
65.42 and 65.43	Reserved
65.44(234)	Reinstatement
65.45	Reserved
65.46(234)	Disqualifications
65.47 to 65.49	Reserved
65.50(234)	No increase in benefits
65.51(234)	State income and eligibility verification system
65.52(234)	Systematic alien verification for entitlements (SAVE) program

CHAPTER 66

EMERGENCY FOOD ASSISTANCE PROGRAM

66.1(234)	Definitions
66.2(234)	Application to be a TEFAP contractor
66.3(234)	Contracts
66.4(234)	Distribution
66.5(234)	Household eligibility
66.6(234)	Reimbursement for allowable costs
66.7(234)	Commodity losses and claims
66.8(234)	State monitoring
66.9(234)	Limits on unrelated activities
66.10(234)	Complaints

CHAPTERS 67 to 74

Reserved

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 75
CONDITIONS OF ELIGIBILITY

DIVISION I

GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

- 75.1(249A) Persons covered
- 75.2(249A) Medical resources
- 75.3(249A) Acceptance of other financial benefits
- 75.4(249A) Medical assistance lien
- 75.5(249A) Determination of countable income and resources for persons in a medical institution
- 75.6(249A) Entrance fee for continuing care retirement community or life care community
- 75.7(249A) Furnishing of social security number
- 75.8(249A) Medical assistance corrective payments
- 75.9(249A) Treatment of Medicaid qualifying trusts
- 75.10(249A) Residency requirements
- 75.11(249A) Citizenship or alienage requirements
- 75.12(249A) Inmates of public institutions
- 75.13(249A) Categorical relatedness
- 75.14(249A) Establishing paternity and obtaining support
- 75.15(249A) Disqualification for long-term care assistance due to substantial home equity
- 75.16(249A) Client participation in payment for medical institution care
- 75.17(249A) Verification of pregnancy
- 75.18(249A) Continuous eligibility for pregnant women
- 75.19(249A) Continuous eligibility for children
- 75.20(249A) Disability requirements for SSI-related Medicaid
- 75.21(249A) Health insurance premium payment (HIPP) program
- 75.22(249A) AIDS/HIV health insurance premium payment program
- 75.23(249A) Disposal of assets for less than fair market value after August 10, 1993
- 75.24(249A) Treatment of trusts established after August 10, 1993
- 75.25(249A) Definitions
- 75.26 Reserved
- 75.27(249A) AIDS/HIV settlement payments
- 75.28 to 75.49 Reserved

DIVISION II

ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

- 75.50(249A) Definitions
- 75.51 Reserved
- 75.52(249A) Continuing eligibility
- 75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups
- 75.54(249A) Eligibility factors specific to child
- 75.55(249A) Eligibility factors specific to specified relatives
- 75.56(249A) Resources
- 75.57(249A) Income
- 75.58(249A) Need standards
- 75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups
- 75.60(249A) Pending SSI approval

CHAPTER 76
APPLICATION AND INVESTIGATION

76.1(249A)	Application
76.2(249A)	Information and verification procedure
76.3(249A)	Time limit for decision
76.4(249A)	Notification of decision
76.5(249A)	Effective date
76.6(249A)	Certification for services
76.7(249A)	Reinvestigation
76.8(249A)	Investigation by quality control or the department of inspections and appeals
76.9(249A)	Member lock-in
76.10(249A)	Client responsibilities
76.11(249A)	Automatic redetermination
76.12(249A)	Recovery
76.13(249A)	Health care data match program

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

77.1(249A)	Physicians
77.2(249A)	Retail pharmacies
77.3(249A)	Hospitals
77.4(249A)	Dentists
77.5(249A)	Podiatrists
77.6(249A)	Optometrists
77.7(249A)	Opticians
77.8(249A)	Chiropractors
77.9(249A)	Home health agencies
77.10(249A)	Medical equipment and appliances, prosthetic devices and medical supplies
77.11(249A)	Ambulance service
77.12(249A)	Remedial services providers
77.13(249A)	Hearing aid dispensers
77.14(249A)	Audiologists
77.15(249A)	Community mental health centers
77.16(249A)	Screening centers
77.17(249A)	Physical therapists
77.18(249A)	Orthopedic shoe dealers and repair shops
77.19(249A)	Rehabilitation agencies
77.20(249A)	Independent laboratories
77.21(249A)	Rural health clinics
77.22(249A)	Psychologists
77.23(249A)	Maternal health centers
77.24(249A)	Ambulatory surgical centers
77.25(249A)	Home- and community-based habilitation services
77.26(249A)	Behavioral health services
77.27(249A)	Birth centers
77.28(249A)	Area education agencies
77.29(249A)	Case management provider organizations
77.30(249A)	HCBS ill and handicapped waiver service providers
77.31(249A)	Occupational therapists
77.32(249A)	Hospice providers
77.33(249A)	HCBS elderly waiver service providers

77.34(249A)	HCBS AIDS/HIV waiver service providers
77.35(249A)	Federally qualified health centers
77.36(249A)	Advanced registered nurse practitioners
77.37(249A)	Home- and community-based services intellectual disability waiver service providers
77.38	Reserved
77.39(249A)	HCBS brain injury waiver service providers
77.40(249A)	Lead inspection agencies
77.41(249A)	HCBS physical disability waiver service providers
77.42	Reserved
77.43(249A)	Infant and toddler program providers
77.44(249A)	Local education agency services providers
77.45(249A)	Indian health service 638 facilities
77.46(249A)	HCBS children's mental health waiver service providers

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

78.1(249A)	Physicians' services
78.2(249A)	Prescribed outpatient drugs
78.3(249A)	Inpatient hospital services
78.4(249A)	Dentists
78.5(249A)	Podiatrists
78.6(249A)	Optometrists
78.7(249A)	Opticians
78.8(249A)	Chiropractors
78.9(249A)	Home health agencies
78.10(249A)	Durable medical equipment (DME), prosthetic devices and medical supplies
78.11(249A)	Ambulance service
78.12(249A)	Remedial services
78.13(249A)	Nonemergency medical transportation
78.14(249A)	Hearing aids
78.15(249A)	Orthopedic shoes
78.16(249A)	Community mental health centers
78.17(249A)	Physical therapists
78.18(249A)	Screening centers
78.19(249A)	Rehabilitation agencies
78.20(249A)	Independent laboratories
78.21(249A)	Rural health clinics
78.22(249A)	Family planning clinics
78.23(249A)	Other clinic services
78.24(249A)	Psychologists
78.25(249A)	Maternal health centers
78.26(249A)	Ambulatory surgical center services
78.27(249A)	Home- and community-based habilitation services
78.28(249A)	List of medical services and equipment requiring prior approval, preprocedure review or preadmission review
78.29(249A)	Behavioral health services
78.30(249A)	Birth centers
78.31(249A)	Hospital outpatient services
78.32(249A)	Area education agencies
78.33(249A)	Case management services

78.34(249A)	HCBS ill and handicapped waiver services
78.35(249A)	Occupational therapist services
78.36(249A)	Hospice services
78.37(249A)	HCBS elderly waiver services
78.38(249A)	HCBS AIDS/HIV waiver services
78.39(249A)	Federally qualified health centers
78.40(249A)	Advanced registered nurse practitioners
78.41(249A)	HCBS intellectual disability waiver services
78.42(249A)	Pharmacies administering influenza vaccine to children
78.43(249A)	HCBS brain injury waiver services
78.44(249A)	Lead inspection services
78.45	Reserved
78.46(249A)	Physical disability waiver service
78.47(249A)	Pharmaceutical case management services
78.48	Reserved
78.49(249A)	Infant and toddler program services
78.50(249A)	Local education agency services
78.51(249A)	Indian health service 638 facility services
78.52(249A)	HCBS children's mental health waiver services

CHAPTER 79

OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

79.1(249A)	Principles governing reimbursement of providers of medical and health services
79.2(249A)	Sanctions against provider of care
79.3(249A)	Maintenance of records by providers of service
79.4(249A)	Reviews and audits
79.5(249A)	Nondiscrimination on the basis of handicap
79.6(249A)	Provider participation agreement
79.7(249A)	Medical assistance advisory council
79.8(249A)	Requests for prior authorization
79.9(249A)	General provisions for Medicaid coverage applicable to all Medicaid providers and services
79.10(249A)	Requests for preadmission review
79.11(249A)	Requests for preprocedure surgical review
79.12(249A)	Advance directives
79.13(249A)	Requirements for enrolled Medicaid providers supplying laboratory services
79.14(249A)	Provider enrollment
79.15(249A)	Education about false claims recovery
79.16(249A)	Electronic health record incentive program

CHAPTER 80

PROCEDURE AND METHOD OF PAYMENT

80.1	Reserved
80.2(249A)	Submission of claims
80.3(249A)	Payment from other sources
80.4(249A)	Time limit for submission of claims and claim adjustments
80.5(249A)	Authorization process
80.6(249A)	Payment to provider—exception

CHAPTER 81
NURSING FACILITIES

DIVISION I
GENERAL POLICIES

81.1(249A)	Definitions
81.2	Reserved
81.3(249A)	Initial approval for nursing facility care
81.4(249A)	Arrangements with residents
81.5(249A)	Discharge and transfer
81.6(249A)	Financial and statistical report and determination of payment rate
81.7(249A)	Continued review
81.8	Reserved
81.9(249A)	Records
81.10(249A)	Payment procedures
81.11(249A)	Billing procedures
81.12(249A)	Closing of facility
81.13(249A)	Conditions of participation for nursing facilities
81.14(249A)	Audits
81.15	Reserved
81.16(249A)	Nurse aide requirements and training and testing programs
81.17	Reserved
81.18(249A)	Sanctions
81.19	Reserved
81.20(249A)	Out-of-state facilities
81.21(249A)	Outpatient services
81.22(249A)	Rates for Medicaid eligibles
81.23(249A)	State-funded personal needs supplement
81.24 to 81.30	Reserved

DIVISION II
ENFORCEMENT OF COMPLIANCE

81.31(249A)	Definitions
81.32(249A)	General provisions
81.33(249A)	Factors to be considered in selecting remedies
81.34(249A)	Available remedies
81.35(249A)	Selection of remedies
81.36(249A)	Action when there is immediate jeopardy
81.37(249A)	Action when there is no immediate jeopardy
81.38(249A)	Action when there is repeated substandard quality of care
81.39(249A)	Temporary management
81.40(249A)	Denial of payment for all new admissions
81.41(249A)	Secretarial authority to deny all payments
81.42(249A)	State monitoring
81.43(249A)	Directed plan of correction
81.44(249A)	Directed in-service training
81.45(249A)	Closure of a facility or transfer of residents, or both
81.46(249A)	Civil money penalties—basis for imposing penalty
81.47(249A)	Civil money penalties—when penalty is collected
81.48(249A)	Civil money penalties—notice of penalty
81.49(249A)	Civil money penalties—waiver of hearing, reduction of penalty amount
81.50(249A)	Civil money penalties—amount of penalty
81.51(249A)	Civil money penalties—effective date and duration of penalty
81.52(249A)	Civil money penalties—due date for payment of penalty

- 81.53(249A) Use of penalties collected by the department
- 81.54(249A) Continuation of payments to a facility with deficiencies
- 81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy
- 81.56(249A) Duration of remedies
- 81.57(249A) Termination of provider agreement

CHAPTER 82

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

- 82.1(249A) Definition
- 82.2(249A) Licensing and certification
- 82.3(249A) Conditions of participation for intermediate care facilities for the mentally retarded
- 82.4 Reserved
- 82.5(249A) Financial and statistical report
- 82.6(249A) Eligibility for services
- 82.7(249A) Initial approval for ICF/MR care
- 82.8(249A) Determination of need for continued stay
- 82.9(249A) Arrangements with residents
- 82.10(249A) Discharge and transfer
- 82.11(249A) Continued stay review
- 82.12(249A) Quality of care review
- 82.13(249A) Records
- 82.14(249A) Payment procedures
- 82.15(249A) Billing procedures
- 82.16(249A) Closing of facility
- 82.17(249A) Audits
- 82.18(249A) Out-of-state facilities
- 82.19(249A) State-funded personal needs supplement

CHAPTER 83

MEDICAID WAIVER SERVICES

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

- 83.1(249A) Definitions
- 83.2(249A) Eligibility
- 83.3(249A) Application
- 83.4(249A) Financial participation
- 83.5(249A) Redetermination
- 83.6(249A) Allowable services
- 83.7(249A) Service plan
- 83.8(249A) Adverse service actions
- 83.9(249A) Appeal rights
- 83.10 to 83.20 Reserved

DIVISION II—HCBS ELDERLY WAIVER SERVICES

- 83.21(249A) Definitions
- 83.22(249A) Eligibility
- 83.23(249A) Application
- 83.24(249A) Client participation
- 83.25(249A) Redetermination
- 83.26(249A) Allowable services
- 83.27(249A) Service plan
- 83.28(249A) Adverse service actions
- 83.29(249A) Appeal rights

83.30(249A) Enhanced services
83.31 to 83.40 Reserved

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

83.41(249A) Definitions
83.42(249A) Eligibility
83.43(249A) Application
83.44(249A) Financial participation
83.45(249A) Redetermination
83.46(249A) Allowable services
83.47(249A) Service plan
83.48(249A) Adverse service actions
83.49(249A) Appeal rights
83.50 to 83.59 Reserved

DIVISION IV—HCBS MR WAIVER SERVICES

83.60(249A) Definitions
83.61(249A) Eligibility
83.62(249A) Application
83.63(249A) Client participation
83.64(249A) Redetermination
83.65 Reserved
83.66(249A) Allowable services
83.67(249A) Service plan
83.68(249A) Adverse service actions
83.69(249A) Appeal rights
83.70(249A) County reimbursement
83.71 Reserved
83.72(249A) Rent subsidy program
83.73 to 83.80 Reserved

DIVISION V—BRAIN INJURY WAIVER SERVICES

83.81(249A) Definitions
83.82(249A) Eligibility
83.83(249A) Application
83.84(249A) Client participation
83.85(249A) Redetermination
83.86(249A) Allowable services
83.87(249A) Service plan
83.88(249A) Adverse service actions
83.89(249A) Appeal rights
83.90(249A) County reimbursement
83.91 to 83.100 Reserved

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

83.101(249A) Definitions
83.102(249A) Eligibility
83.103(249A) Application
83.104(249A) Client participation
83.105(249A) Redetermination
83.106(249A) Allowable services
83.107(249A) Individual service plan
83.108(249A) Adverse service actions
83.109(249A) Appeal rights

83.110 to 83.120 Reserved

DIVISION VII—HCBS CHILDREN’S MENTAL HEALTH WAIVER SERVICES

83.121(249A) Definitions
 83.122(249A) Eligibility
 83.123(249A) Application
 83.124(249A) Financial participation
 83.125(249A) Redetermination
 83.126(249A) Allowable services
 83.127(249A) Service plan
 83.128(249A) Adverse service actions
 83.129(249A) Appeal rights

CHAPTER 84

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

84.1(249A) Definitions
 84.2(249A) Eligibility
 84.3(249A) Screening services
 84.4(249A) Referral
 84.5(249A) Follow up

CHAPTER 85

SERVICES IN PSYCHIATRIC INSTITUTIONS

DIVISION I
 PSYCHIATRIC HOSPITALS

85.1(249A) Acute care in psychiatric hospitals
 85.2(249A) Out-of-state placement
 85.3(249A) Eligibility of persons under the age of 21
 85.4(249A) Eligibility of persons aged 65 and over
 85.5(249A) Client participation
 85.6(249A) Responsibilities of hospitals
 85.7(249A) Psychiatric hospital reimbursement
 85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64
 85.9 to 85.20 Reserved

DIVISION II
 PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

85.21(249A) Conditions for participation
 85.22(249A) Eligibility of persons under the age of 21
 85.23(249A) Client participation
 85.24(249A) Responsibilities of facilities
 85.25(249A) Reimbursement to psychiatric medical institutions for children
 85.26(249A) Outpatient day treatment for persons aged 20 or under
 85.27 to 85.40 Reserved

DIVISION III
 NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

85.41(249A) Conditions of participation
 85.42(249A) Out-of-state placement
 85.43(249A) Eligibility of persons aged 65 and over
 85.44(249A) Client participation
 85.45(249A) Responsibilities of nursing facility
 85.46(249A) Policies governing reimbursement
 85.47(249A) State-funded personal needs supplement

CHAPTER 86

HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

86.1(514I)	Definitions
86.2(514I)	Eligibility factors
86.3(514I)	Application process
86.4(514I)	Coordination with Medicaid
86.5(514I)	Effective date of coverage
86.6(514I)	Selection of a plan
86.7(514I)	Cancellation
86.8(514I)	Premiums and copayments
86.9(514I)	Annual reviews of eligibility
86.10(514I)	Reporting changes
86.11(514I)	Notice requirements
86.12(514I)	Appeals and fair hearings
86.13(514I)	Third-party administrator
86.14(514I)	Covered services
86.15(514I)	Participating health and dental plans
86.16(514I)	Clinical advisory committee
86.17(514I)	Use of donations to the HAWK-I program
86.18(505)	Health insurance data match program
86.19(514I)	Recovery
86.20(514I)	Supplemental dental-only coverage

CHAPTER 87

STATE-FUNDED FAMILY PLANNING PROGRAM

87.1(82GA,ch1187)	Definitions
87.2(82GA,ch1187)	Eligibility
87.3(82GA,ch1187)	Application
87.4(82GA,ch1187)	Effective date
87.5(82GA,ch1187)	Period of eligibility and reapplication
87.6(82GA,ch1187)	Reporting changes
87.7(82GA,ch1187)	Allocation of funds
87.8(82GA,ch1187)	Availability of services
87.9(82GA,ch1187)	Payment of covered services
87.10(82GA,ch1187)	Submission of claims

CHAPTER 88

MANAGED HEALTH CARE PROVIDERS

DIVISION I

HEALTH MAINTENANCE ORGANIZATION

88.1(249A)	Definitions
88.2(249A)	Participation
88.3(249A)	Enrollment
88.4(249A)	Disenrollment
88.5(249A)	Covered services
88.6(249A)	Emergency and urgent care services
88.7(249A)	Access to service
88.8(249A)	Grievance procedures
88.9(249A)	Records and reports
88.10(249A)	Marketing
88.11(249A)	Patient education
88.12(249A)	Reimbursement

88.13(249A)	Quality assurance
88.14(249A)	Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs)
88.15 to 88.20	Reserved

DIVISION II
PREPAID HEALTH PLANS

88.21(249A)	Definitions
88.22(249A)	Participation
88.23(249A)	Enrollment
88.24(249A)	Disenrollment
88.25(249A)	Covered services
88.26(249A)	Emergency services
88.27(249A)	Access to service
88.28(249A)	Grievance procedures
88.29(249A)	Records and reports
88.30(249A)	Marketing
88.31(249A)	Patient education
88.32(249A)	Payment to the PHP
88.33(249A)	Quality assurance
88.34 to 88.40	Reserved

DIVISION III
MEDICAID PATIENT MANAGEMENT

88.41(249A)	Definitions
88.42(249A)	Eligible recipients
88.43(249A)	Project area
88.44(249A)	Eligible providers
88.45(249A)	Contracting for the provision of patient management
88.46(249A)	Enrollment and changes in enrollment
88.47(249A)	Disenrollment
88.48(249A)	Services
88.49(249A)	Grievance procedure
88.50(249A)	Payment
88.51(249A)	Utilization review and quality assessment
88.52(249A)	Marketing
88.53 to 88.60	Reserved

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

88.61(249A)	Definitions
88.62(249A)	Participation
88.63(249A)	Enrollment
88.64(249A)	Disenrollment
88.65(249A)	Covered services
88.66(249A)	Emergency services
88.67(249A)	Access to service
88.68(249A)	Review of contractor decisions and actions
88.69(249A)	Records and reports
88.70(249A)	Marketing
88.71(249A)	Enrollee education
88.72(249A)	Payment to the contractor
88.73(249A)	Claims payment
88.74(249A)	Quality assurance

88.75(249A) Iowa Plan advisory committee
 88.76 to 88.80 Reserved

DIVISION V
 PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

88.81(249A) Scope and definitions
 88.82(249A) PACE organization application and waiver process
 88.83(249A) PACE program agreement
 88.84(249A) Enrollment and disenrollment
 88.85(249A) Program services
 88.86(249A) Access to PACE services
 88.87(249A) Program administrative requirements
 88.88(249A) Payment

CHAPTER 89
 DEBTS DUE FROM TRANSFERS OF ASSETS

89.1(249F) Definitions
 89.2(249F) Creation of debt
 89.3(249F) Exceptions
 89.4(249F) Presumption of intent
 89.5(249F) Notice of debt
 89.6(249F) No timely request of a hearing
 89.7(249F) Timely request for a hearing
 89.8(249F) Department-requested hearing
 89.9(249F) Filing and docketing of the order
 89.10(249F) Exemption from Iowa Code chapter 17A

CHAPTER 90
 TARGETED CASE MANAGEMENT

90.1(249A) Definitions
 90.2(249A) Eligibility
 90.3(249A) Determination of need for service
 90.4(249A) Application
 90.5(249A) Service provision
 90.6(249A) Terminating services
 90.7(249A) Appeal rights
 90.8(249A) Provider requirements

CHAPTER 91
 MEDICARE DRUG SUBSIDY

91.1(249A) Definitions
 91.2(249A) Application
 91.3(249A) Eligibility determination
 91.4(249A) Notice of decision
 91.5(249A) Effective date
 91.6(249A) Changes in circumstances
 91.7(249A) Reinvestigation
 91.8(249A) Appeals

CHAPTER 92
 IOWACARE

92.1(249A,249J) Definitions
 92.2(249A,249J) Eligibility
 92.3(249A,249J) Application

92.4(249A,249J)	Application processing
92.5(249A,249J)	Determining income eligibility
92.6(249A,249J)	Effective date
92.7(249A,249J)	Financial participation
92.8(249A,249J)	Benefits
92.9(249A,249J)	Claims and reimbursement methodologies
92.10(249A,249J)	Reporting changes
92.11(249A,249J)	Reapplication
92.12(249A,249J)	Terminating eligibility
92.13(249A,249J)	Recovery
92.14(249A,249J)	Discontinuance of the program
92.15(249A,249J)	Right to appeal

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM

93.1(239B)	Definitions
93.2(239B)	Program administration
93.3(239B)	Registration and referral
93.4(239B)	The family investment agreement (FIA)
93.5(239B)	Assessment
93.6(239B)	Job readiness and job search activities
93.7(239B)	Work activities
93.8(239B)	Education and training activities
93.9(239B)	Other FIA activities
93.10(239B)	Required documentation and verification
93.11(239B)	Supportive payments
93.12(239B)	Recovery of PROMISE JOBS expense payments
93.13(239B)	Resolution of participation issues
93.14(239B)	Problems that may provide good cause for participation issues
93.15(239B)	Right of appeal
93.16(239B)	Resolution of a limited benefit plan
93.17(239B)	Worker displacement grievance procedure

CHAPTER 94
Reserved

TITLE X
SUPPORT RECOVERY

CHAPTER 95
COLLECTIONS

95.1(252B)	Definitions
95.2(252B)	Child support recovery eligibility and services
95.3(252B)	Crediting of current and delinquent support
95.4(252B)	Prepayment of support
95.5(252B)	Lump sum settlement
95.6(252B)	Offset against state income tax refund or rebate
95.7(252B)	Offset against federal income tax refund and federal nontax payment
95.8(96)	Child support offset of unemployment insurance benefits
95.9 to 95.11	Reserved
95.12(252B)	Procedures for providing information to consumer reporting agencies
95.13(17A)	Appeals

95.14(252B)	Termination of services
95.15(252B)	Child support recovery unit attorney
95.16(252B)	Handling and use of federal 1099 information
95.17(252B)	Effective date of support
95.18(252B)	Continued services available to canceled family investment program (FIP) or Medicaid recipients
95.19(252B)	Cooperation of public assistance recipients in establishing and obtaining support
95.20(252B)	Cooperation of public assistance applicants in establishing and obtaining support
95.21(252B)	Cooperation in establishing and obtaining support in nonpublic assistance cases
95.22(252B)	Charging pass-through fees
95.23(252B)	Reimbursing assistance with collections of assigned support
95.24(252B)	Child support account
95.25(252B)	Emancipation verification

CHAPTER 96

INFORMATION AND RECORDS

96.1(252B)	Access to information and records from other sources
96.2(252B)	Refusal to comply with written request or subpoena
96.3(252B)	Procedure for refusal
96.4(252B)	Conference conducted
96.5(252B)	Fine assessed
96.6(252B)	Objection to fine or failure to pay

CHAPTER 97

COLLECTION SERVICES CENTER

97.1(252B)	Definitions
97.2(252B)	Transfer of records and payments
97.3(252B)	Support payment records
97.4(252B)	Method of payment
97.5(252D)	Electronic transmission of payments
97.6(252B)	Authorization of payment
97.7(252B)	Processing misdirected payments

CHAPTER 98

SUPPORT ENFORCEMENT SERVICES

DIVISION I

MEDICAL SUPPORT ENFORCEMENT

98.1(252E)	Definitions
98.2(252E)	Provision of services
98.3(252E)	Establishing medical support
98.4(252E)	Accessibility of the health benefit plan
98.5(252E)	Health benefit plan information
98.6(252E)	Insurer authorization
98.7(252E)	Enforcement
98.8(252E)	Contesting the order
98.9 to 98.20	Reserved

DIVISION II

INCOME WITHHOLDING

PART A

DELINQUENT SUPPORT PAYMENTS

98.21(252D)	When applicable
98.22 and 98.23	Reserved
98.24(252D)	Amount of withholding

98.25 to 98.30 Reserved

PART B
IMMEDIATE INCOME WITHHOLDING

98.31(252D) Effective date
 98.32(252D) Withholding automatic
 98.33 Reserved
 98.34(252D) Approval of request for immediate income withholding
 98.35(252D) Modification or termination of withholding
 98.36(252D) Immediate income withholding amounts
 98.37(252D) Immediate income withholding amounts when current support has ended
 98.38 Reserved

PART C
INCOME WITHHOLDING—GENERAL PROVISIONS

98.39(252D,252E) Provisions for medical support
 98.40(252D,252E) Maximum amounts to be withheld
 98.41(252D) Multiple obligations
 98.42(252D) Notice to employer and obligor
 98.43(252D) Contesting the withholding
 98.44(252D) Termination of order
 98.45(252D) Modification of income withholding
 98.46(252D) Refunds of amounts improperly withheld
 98.47(252D) Additional information about hardship
 98.48 to 98.50 Reserved

DIVISION III
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

98.51 to 98.60 Reserved

DIVISION IV
PUBLICATION OF NAMES

98.61(252B) List for publication
 98.62(252B) Releasing the list
 98.63 to 98.70 Reserved

DIVISION V
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

98.71(252B) Seek employment order
 98.72(252B) Effective date of order
 98.73(252B) Method and requirements of reporting
 98.74(252B) Reasons for noncompliance
 98.75(252B) Method of service
 98.76(252B) Duration of order
 98.77 to 98.80 Reserved

DIVISION VI
DEBTOR OFFSET

98.81(252B) Offset against payment owed to a person by a state agency
 98.82 to 98.90 Reserved

DIVISION VII
ADMINISTRATIVE LEVY

98.91(252I) Administrative levy
 98.92 Reserved
 98.93(252I) Verification of accounts
 98.94(252I) Notice to financial institution
 98.95(252I) Notice to support obligor

- 98.96(252I) Responsibilities of financial institution
- 98.97(252I) Challenging the administrative levy
- 98.98 to 98.100 Reserved

DIVISION VIII
LICENSE SANCTION

- 98.101(252J) Referral for license sanction
- 98.102(252J) Reasons for exemption
- 98.103(252J) Notice of potential sanction of license
- 98.104(252J) Conference
- 98.105(252J) Payment agreement
- 98.106(252J) Staying the process due to full payment of support
- 98.107(252J) Duration of license sanction
- 98.108 to 98.120 Reserved

DIVISION IX
EXTERNAL ENFORCEMENT

- 98.121(252B) Difficult-to-collect arrearages
- 98.122(252B) Enforcement services by private attorney entitled to state compensation

CHAPTER 99
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

DIVISION I
CHILD SUPPORT GUIDELINES

- 99.1(234,252B,252H) Income considered
- 99.2(234,252B) Allowable deductions
- 99.3(234,252B) Determining net income
- 99.4(234,252B) Applying the guidelines
- 99.5(234,252B) Deviation from guidelines
- 99.6 to 99.9 Reserved

DIVISION II
PATERNITY ESTABLISHMENT
PART A
JUDICIAL PATERNITY ESTABLISHMENT

- 99.10(252A) Temporary support
- 99.11 to 99.20 Reserved

PART B
ADMINISTRATIVE PATERNITY ESTABLISHMENT

- 99.21(252F) When paternity may be established administratively
- 99.22(252F) Mother's certified statement
- 99.23(252F) Notice of alleged paternity and support debt
- 99.24(252F) Conference to discuss paternity and support issues
- 99.25(252F) Amount of support obligation
- 99.26(252F) Court hearing
- 99.27(252F) Paternity contested
- 99.28(252F) Paternity test results challenge
- 99.29(252F) Agreement to entry of paternity and support order
- 99.30(252F) Entry of order establishing paternity only
- 99.31(252F) Exception to time limit
- 99.32(252F) Genetic test costs assessed
- 99.33 to 99.35 Reserved

PART C
PATERNITY DISESTABLISHMENT

- 99.36(598,600B) Definitions
- 99.37(598,600B) Communication between parents
- 99.38(598,600B) Continuation of enforcement
- 99.39(598,600B) Satisfaction of accrued support
- 99.40 Reserved

DIVISION III
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT

- 99.41(252C) Establishment of an administrative order
- 99.42 to 99.60 Reserved

DIVISION IV
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

- 99.61(252B,252H) Definitions
- 99.62(252B,252H) Review of permanent child support obligations
- 99.63(252B,252H) Notice requirements
- 99.64(252B,252H) Financial information
- 99.65(252B,252H) Review and adjustment of a child support obligation
- 99.66(252B,252H) Medical support
- 99.67(252B,252H) Confidentiality of financial information
- 99.68(252B,252H) Payment of service fees and other court costs
- 99.69(252B,252H) Denying requests
- 99.70(252B,252H) Withdrawing requests
- 99.71(252H) Effective date of adjustment
- 99.72 to 99.80 Reserved

DIVISION V
ADMINISTRATIVE MODIFICATION

- 99.81(252H) Definitions
- 99.82(252H) Availability of service
- 99.83(252H) Modification of child support obligations
- 99.84(252H) Notice requirements
- 99.85(252H) Financial information
- 99.86(252H) Challenges to the proposed modification action
- 99.87(252H) Voluntary reduction of income
- 99.88(252H) Effective date of modification
- 99.89(252H) Confidentiality of financial information
- 99.90(252H) Payment of fees
- 99.91(252H) Denying requests
- 99.92(252H) Withdrawing requests
- 99.93 to 99.100 Reserved

DIVISION VI
SUSPENSION AND REINSTATEMENT OF SUPPORT

- 99.101(252B) Definitions
- 99.102(252B) Availability of service
- 99.103(252B) Basis for suspension of support
- 99.104(252B) Request for assistance to suspend
- 99.105(252B) Order suspending support
- 99.106(252B) Suspension of enforcement of current support
- 99.107(252B) Request for reinstatement
- 99.108(252B) Reinstatement
- 99.109(252B) Reinstatement of enforcement of support
- 99.110(252B) Temporary suspension becomes final

CHAPTER 100
CHILD SUPPORT PARENTAL OBLIGATION PILOT PROJECTS

- 100.1(17A,80GA,HF667) Definitions
- 100.2(17A,80GA,HF667) Incentives
- 100.3(17A,80GA,HF667) Application to be a funded pilot project
- 100.4(17A,80GA,HF667) Selection of projects
- 100.5(17A,80GA,HF667) Termination of pilot projects
- 100.6(17A,80GA,HF667) Reports and records
- 100.7(17A,80GA,HF667) Appeals
- 100.8(17A,80GA,HF667) Continued application of rules and sunset provisions

TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA JUVENILE HOME

- 101.1(218) Definitions
- 101.2(218) Standards
- 101.3(218) Admission
- 101.4(218) Plan of care
- 101.5(218) Communication with individuals
- 101.6(218) Photographing and recording of individuals
- 101.7(218) Employment of individual
- 101.8(218) Temporary home visits
- 101.9(218) Grievances
- 101.10(218) Alleged child abuse
- 101.11(233B) Cost of care
- 101.12(218) Buildings and grounds
- 101.13(8,218) Gifts and bequests

CHAPTER 102
Reserved

CHAPTER 103
STATE TRAINING SCHOOL

- 103.1(218) Definitions
- 103.2(218) Admission
- 103.3(218) Plan of care
- 103.4(218) Communication with individuals
- 103.5(218) Photographing and recording of individuals
- 103.6(218) Employment of individual
- 103.7(218) Temporary home visits
- 103.8(218) Grievances
- 103.9(692A) Sex offender registration
- 103.10(218) Alleged child abuse
- 103.11(233A) Cost of care
- 103.12(218) Buildings and grounds
- 103.13(8,218) Gifts and bequests

CHAPTER 104
Reserved

TITLE XII
LICENSING AND APPROVED STANDARDS

CHAPTER 105

COUNTY AND MULTICOUNTY JUVENILE DETENTION HOMES AND COUNTY
AND MULTICOUNTY JUVENILE SHELTER CARE HOMES

105.1(232)	Definitions
105.2(232)	Buildings and grounds
105.3(232)	Personnel policies
105.4(232)	Procedures manual
105.5(232)	Staff
105.6(232)	Intake procedures
105.7(232)	Assessments
105.8(232)	Program services
105.9(232)	Medication management and administration
105.10(232)	Control room—juvenile detention home only
105.11(232)	Clothing
105.12(232)	Staffings
105.13(232)	Child abuse
105.14(232)	Daily log
105.15(232)	Children's rights
105.16(232)	Discipline
105.17(232)	Case files
105.18(232)	Discharge
105.19(232)	Approval
105.20(232)	Provisional approval
105.21(232)	Mechanical restraint—juvenile detention only
105.22(232)	Chemical restraint

CHAPTER 106

SAFETY STANDARDS FOR CHILDREN'S CENTERS

106.1(237B)	Definitions
106.2(237B)	Application of the standards
106.3(237B)	Providing for basic needs
106.4(237B)	Protection from mistreatment, physical abuse, sexual abuse, and neglect
106.5(237B)	Record checks
106.6(237B)	Seclusion and restraints
106.7(237B)	Health
106.8(237B)	Safety
106.9(237B)	Emergencies
106.10(237B)	Buildings

CHAPTER 107

CERTIFICATION OF ADOPTION INVESTIGATORS

107.1(600)	Introduction
107.2(600)	Definitions
107.3(600)	Application
107.4(600)	Requirements for certification
107.5(600)	Granting, denial, or revocation of certification
107.6(600)	Certificate
107.7(600)	Renewal of certification
107.8(600)	Investigative services
107.9(600)	Retention of adoption records

- 107.10(600) Reporting of violations
- 107.11(600) Appeals

CHAPTER 108

LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

- 108.1(238) Definitions
- 108.2(238) Licensing procedure
- 108.3(238) Administration and organization
- 108.4(238) Staff qualifications
- 108.5(238) Staffing requirements
- 108.6(238) Personnel administration
- 108.7(238) Foster care services
- 108.8(238) Foster home studies
- 108.9(238) Adoption services
- 108.10(238) Supervised apartment living placement services

CHAPTER 109

CHILD CARE CENTERS

- 109.1(237A) Definitions
- 109.2(237A) Licensure procedures
- 109.3(237A) Inspection and evaluation
- 109.4(237A) Administration
- 109.5(237A) Parental participation
- 109.6(237A) Personnel
- 109.7(237A) Professional growth and development
- 109.8(237A) Staff ratio requirements
- 109.9(237A) Records
- 109.10(237A) Health and safety policies
- 109.11(237A) Physical facilities
- 109.12(237A) Activity program requirements
- 109.13(237A) Extended evening care
- 109.14(237A) Get-well center
- 109.15(237A) Food services

CHAPTER 110

CHILD DEVELOPMENT HOMES

- 110.1(237A) Definitions
- 110.2(237A) Application for registration
- 110.3(237A) Renewal
- 110.4(237A) Number of children
- 110.5(237A) Standards
- 110.6(237A) Compliance checks
- 110.7(234) Registration decision
- 110.8(237A) Additional requirements for child development home category A
- 110.9(237A) Additional requirements for child development home category B
- 110.10(237A) Additional requirements for child development home category C
- 110.11(237A) Complaints
- 110.12(237A) Registration actions for nonpayment of child support
- 110.13(237A) Transition exception
- 110.14(237A) Prohibition from involvement with child care

CHAPTER 111
FAMILY-LIFE HOMES

- 111.1(249) Definitions
- 111.2(249) Application for certification
- 111.3(249) Provisions pertaining to the certificate
- 111.4(249) Physical standards
- 111.5(249) Personal characteristics of family-life home family
- 111.6(249) Health of family
- 111.7(249) Planned activities and personal effects
- 111.8(249) Client eligibility
- 111.9(249) Medical examinations, records, and care of a client
- 111.10(249) Placement agreement
- 111.11(249) Legal liabilities
- 111.12(249) Emergency care and release of client
- 111.13(249) Information about client to be confidential

CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

- 112.1(237) Applicability
- 112.2(237) Definitions
- 112.3(237) Application for license
- 112.4(237) License
- 112.5(237) Denial
- 112.6(237) Revocation
- 112.7(237) Provisional license
- 112.8(237) Adverse actions
- 112.9(237) Suspension
- 112.10(232) Mandatory reporting of child abuse

CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

- 113.1(237) Applicability
- 113.2(237) Definitions
- 113.3(237) Licensing procedure
- 113.4(237) Provisions pertaining to the license
- 113.5(237) Physical standards
- 113.6(237) Sanitation, water, and waste disposal
- 113.7(237) Safety
- 113.8(237) Foster parent training
- 113.9(237) Involvement of kin
- 113.10(237) Information on the foster child
- 113.11(237) Health of foster family
- 113.12(237) Characteristics of foster parents
- 113.13(237) Record checks
- 113.14(237) Reference checks
- 113.15(237) Unannounced visits
- 113.16(237) Planned activities and personal effects
- 113.17(237) Medical examinations and health care of the child
- 113.18(237) Training and discipline of foster children
- 113.19(237) Emergency care and release of children
- 113.20(237) Changes in foster family home

CHAPTER 114
LICENSING AND REGULATION OF ALL
GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

- 114.1(237) Applicability
- 114.2(237) Definitions
- 114.3(237) Physical standards
- 114.4(237) Sanitation, water, and waste disposal
- 114.5(237) Safety
- 114.6(237) Organization and administration
- 114.7(237) Policies and record-keeping requirements
- 114.8(237) Staff
- 114.9(237) Intake procedures
- 114.10(237) Program services
- 114.11(237) Case files
- 114.12(237) Drug utilization and control
- 114.13(237) Children's rights
- 114.14(237) Personal possessions
- 114.15(237) Religion—culture
- 114.16(237) Work or vocational experiences
- 114.17(237) Family involvement
- 114.18(237) Children's money
- 114.19(237) Child abuse
- 114.20(237) Discipline
- 114.21(237) Illness, accident, death, or absence from the facility
- 114.22(237) Records
- 114.23(237) Unannounced visits
- 114.24(237) Standards for private juvenile shelter care and detention homes

CHAPTER 115
LICENSING AND REGULATION OF
COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

- 115.1(237) Applicability
- 115.2(237) Definitions
- 115.3(237) Information upon admission
- 115.4(237) Staff
- 115.5(237) Program services
- 115.6(237) Restraints
- 115.7(237) Control room
- 115.8(237) Locked cottages
- 115.9(237) Mechanical restraint
- 115.10(237) Chemical restraint

CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES
FOR MENTALLY RETARDED CHILDREN

- 116.1(237) Applicability
- 116.2(237) Definitions
- 116.3(237) Qualifications of staff
- 116.4(237) Staff to client ratio
- 116.5(237) Program components
- 116.6(237) Restraint

CHAPTER 117
FOSTER PARENT TRAINING

- 117.1(237) Required preservice training
- 117.2(237) Required orientation
- 117.3(237) Application materials for in-service training
- 117.4(237) Application process for in-service training
- 117.5(237) Application decisions
- 117.6(237) Application conference available
- 117.7(237) Required in-service training
- 117.8(237) Specific in-service training required
- 117.9(237) Foster parent training expenses

CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

- 118.1(237A) Definitions
- 118.2(237A) Application for quality rating
- 118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011)
- 118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011)
- 118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school
- 118.6(237A) Rating criteria for child development homes
- 118.7(237A) Award of quality rating
- 118.8(237A) Adverse actions

CHAPTER 119
RECORD CHECK EVALUATIONS FOR HEALTH CARE PROGRAMS

- 119.1(135C) Definitions
- 119.2(135C) When record check evaluations are requested
- 119.3(135C) Request for evaluation
- 119.4(135C) Completion of evaluation
- 119.5(135C) Appeal rights

CHAPTERS 120 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

- 130.1(234) Definitions
- 130.2(234) Application
- 130.3(234) Eligibility
- 130.4(234) Fees
- 130.5(234) Adverse service actions
- 130.6(234) Social casework
- 130.7(234) Case plan
- 130.8 Reserved
- 130.9(234) Entitlement

CHAPTER 131
SOCIAL CASEWORK

- 131.1(234) Definitions
- 131.2(234) Eligibility

- 131.3(234) Service provision
- 131.4 Reserved
- 131.5(234) Adverse actions

CHAPTER 132

Reserved

CHAPTER 133

IV-A EMERGENCY ASSISTANCE PROGRAM

- 133.1(235) Definitions
- 133.2(235) Application
- 133.3(235) Eligibility
- 133.4(235) Method of service provision
- 133.5(235) Duration of services
- 133.6(235) Discontinuance of the program

CHAPTERS 134 to 141

Reserved

CHAPTER 142

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

- 142.1(238) Compact agreement
- 142.2(238) Compact administrator
- 142.3(238) Article II(d)
- 142.4(238) Article III(a)
- 142.5(238) Article III(a) procedures
- 142.6(238) Article III(c)
- 142.7(238) Article VIII(a)
- 142.8(238) Applicability

CHAPTER 143

INTERSTATE COMPACT ON JUVENILES

- 143.1(232) Compact agreement
- 143.2(232) Compact administrator
- 143.3(232) Sending a juvenile out of Iowa under the compact
- 143.4(232) Receiving cases in Iowa under the interstate compact
- 143.5(232) Runaways

CHAPTERS 144 to 149

Reserved

TITLE XIV

GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150

PURCHASE OF SERVICE

DIVISION I

TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND
INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND
IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

- 150.1(234) Definitions
- 150.2(234) Categories of contracts
- 150.3(234) Iowa purchase of social services agency contract
- 150.4(234) Iowa purchase of social services contract—individual providers
- 150.5(234) Iowa purchase of administrative support

150.6 to 150.8 Reserved
 150.9(234) Public access to contracts

CHAPTER 151
 JUVENILE COURT SERVICES DIRECTED PROGRAMS

DIVISION I
 GENERAL PROVISIONS

151.1(232) Definitions
 151.2(232) Administration of funds for court-ordered services and graduated sanction services
 151.3(232) Administration of juvenile court services programs within each judicial district
 151.4(232) Billing and payment
 151.5(232) Appeals
 151.6(232) District program reviews and audits
 151.7 to 151.19 Reserved

DIVISION II
 COURT-ORDERED SERVICES

151.20(232) Juvenile court services responsibilities
 151.21(232) Certification process
 151.22(232) Expenses
 151.23 to 151.29 Reserved

DIVISION III
 GRADUATED SANCTION SERVICES

151.30(232) Life skills
 151.31(232) School-based supervision
 151.32(232) Supervised community treatment
 151.33(232) Tracking, monitoring, and outreach
 151.34(232) Administration of graduated sanction services
 151.35(232) Contract development for graduated sanction services

CHAPTER 152
 FOSTER GROUP CARE CONTRACTING

152.1(234) Definitions
 152.2(234) Conditions of participation
 152.3(234) Determination of rates
 152.4(234) Initiation of contract proposal
 152.5(234) Contract
 152.6(234) Client eligibility and referral
 152.7(234) Billing procedures
 152.8(234) Contract management
 152.9(234) Provider reviews
 152.10(234) Sanctions against providers
 152.11(234) Appeals of departmental actions

CHAPTER 153
 FUNDING FOR LOCAL SERVICES

DIVISION I
 SOCIAL SERVICES BLOCK GRANT

153.1(234) Definitions
 153.2(234) Development of preexpenditure report
 153.3(234) Amendment to preexpenditure report
 153.4(234) Service availability
 153.5(234) Allocation of block grant funds

- 153.6 and 153.7 Reserved
- 153.8(234) Expenditure of supplemental funds
- 153.9 and 153.10 Reserved

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

- 153.11(232) Definitions
- 153.12(232) Implementation requirements
- 153.13(232) Role and responsibilities of decategorization project governance boards
- 153.14(232) Realignment of decategorization project boundaries
- 153.15(232) Decategorization services funding pool
- 153.16(232) Relationship of decategorization funding pool to other department child welfare funding
- 153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams
- 153.18(232) Requirements for annual services plan
- 153.19(232) Requirements for annual progress report
- 153.20 to 153.30 Reserved

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES

- 153.31 to 153.50 Reserved

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

- 153.51(331) Definitions
- 153.52(331) Eligibility requirements
- 153.53(331) Application procedure
- 153.54(331) Eligibility determination
- 153.55(331) Eligible services
- 153.56(331) Program administration
- 153.57(331) Reduction, denial, or termination of benefits
- 153.58(331) Appeals

CHAPTER 154

Reserved

CHAPTER 155

CHILD ABUSE PREVENTION PROGRAM

- 155.1(235A) Definitions
- 155.2(235A) Child abuse prevention program administration
- 155.3(235A) Project eligibility
- 155.4(235A) Proposals
- 155.5(235A) Selection of project proposals
- 155.6(235A) Project contracts
- 155.7(235A) Project records
- 155.8(235A) Quarterly project progress reports
- 155.9(235A) Evaluation
- 155.10(235A) Termination
- 155.11(235A) Advisory council

CHAPTER 156
PAYMENTS FOR FOSTER CARE

156.1(234)	Definitions
156.2(234)	Foster care recovery
156.3 to 156.5	Reserved
156.6(234)	Rate of maintenance payment for foster family care
156.7	Reserved
156.8(234)	Additional payments
156.9(234)	Rate of payment for foster group care
156.10(234)	Payment for reserve bed days
156.11(234)	Emergency care
156.12(234)	Supervised apartment living
156.13	Reserved
156.14(234,252C)	Voluntary placements
156.15(234)	Child's earnings
156.16(234)	Trust funds and investments
156.17(234)	Preadoptive homes
156.18	Reserved
156.19(237)	Rate of payment for care in a residential care facility
156.20(234)	Eligibility for foster care payment

CHAPTER 157
Reserved

CHAPTER 158
FOSTER HOME INSURANCE FUND

158.1(237)	Payments from the foster home insurance fund
158.2(237)	Payment limits
158.3(237)	Claim procedures
158.4(237)	Time frames for filing claims
158.5(237)	Appeals

CHAPTER 159
CHILD CARE RESOURCE AND REFERRAL SERVICES

159.1(237A)	Definitions
159.2(237A)	Availability of funds
159.3(237A)	Participation requirements
159.4(237A)	Request for proposals for project grants
159.5(237A)	Selection of proposals

CHAPTER 160
ADOPTION OPPORTUNITY GRANT PROGRAM

160.1(234)	Definitions
160.2(234)	Availability of grant funds
160.3(234)	Project eligibility
160.4(234)	Request for proposals for project grants
160.5(234)	Selection of proposals
160.6(234)	Project contracts
160.7(234)	Records
160.8(234)	Evaluation of projects
160.9(234)	Termination
160.10(234)	Appeals

CHAPTER 161
IOWA SENIOR LIVING TRUST FUND

- 161.1(249H) Definitions
- 161.2(249H) Funding and operation of trust fund
- 161.3(249H) Allocations from the senior living trust fund
- 161.4(249H) Participation by government-owned nursing facilities

CHAPTER 162
NURSING FACILITY CONVERSION
AND LONG-TERM CARE SERVICES
DEVELOPMENT GRANTS

- 162.1(249H) Definitions
- 162.2(249H) Availability of grants
- 162.3(249H) Grant eligibility
- 162.4(249H) Grant application process
- 162.5(249H) Grant dispersal stages
- 162.6(249H) Project contracts
- 162.7(249H) Grantee responsibilities
- 162.8(249H) Offset
- 162.9(249H) Appeals

CHAPTER 163
ADOLESCENT PREGNANCY PREVENTION AND SERVICES
TO PREGNANT AND PARENTING ADOLESCENTS
PROGRAMS

- 163.1(234) Definitions
- 163.2(234) Availability of grants for projects
- 163.3(234) Project eligibility
- 163.4(234) Request for proposals for pilot project grants
- 163.5(234) Selection of proposals
- 163.6(234) Project contracts
- 163.7(234) Records
- 163.8(234) Evaluation
- 163.9(234) Termination of contract
- 163.10(234) Appeals

CHAPTER 164
IOWA HOSPITAL TRUST FUND

- 164.1(249I) Definitions
- 164.2(249I) Funding and operation of trust fund
- 164.3(249I) Allocations from the hospital trust fund
- 164.4(249I) Participation by public hospitals

CHAPTER 165
Reserved

CHAPTER 166
QUALITY IMPROVEMENT INITIATIVE GRANTS

- 166.1(249A) Definitions
- 166.2(249A) Availability of grants
- 166.3(249A) Requirements for applicants
- 166.4(249A) Requirements for initiatives
- 166.5(249A) Applications

- 166.6(249A) Awarding of grants
- 166.7(249A) Grant requirements

CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT

DIVISION I
ANNUAL REIMBURSEMENT PROGRAM

- 167.1(232) Definitions
- 167.2(232) Availability of funds
- 167.3(232) Eligible facilities
- 167.4(232) Available reimbursement
- 167.5(232) Submission of voucher
- 167.6(232) Reimbursement by the department

CHAPTER 168
CHILD CARE EXPANSION PROGRAMS

- 168.1(234) Definitions
- 168.2(234) Availability of funds
- 168.3(234) Eligibility requirements
- 168.4(234) Request for proposals
- 168.5(234) Selection of proposals
- 168.6(234) Appeals
- 168.7(234) Contracts
- 168.8(234) Reporting requirements
- 168.9(234) Termination of contract

CHAPTER 169
FUNDING FOR EMPOWERMENT AREAS

- 169.1(7I) Definitions
- 169.2(7I) Use of funds
- 169.3(7I) Eligibility for funding
- 169.4(7I) Funding availability
- 169.5(7I) Community empowerment areas' responsibilities
- 169.6(7I) Iowa empowerment board's responsibilities
- 169.7(7I) Department of human services' responsibilities
- 169.8(7I) Revocation of funding
- 169.9(7I) Appeals

TITLE XV
*INDIVIDUAL AND FAMILY SUPPORT
AND PROTECTIVE SERVICES*

CHAPTER 170
CHILD CARE SERVICES

- 170.1(237A) Definitions
- 170.2(237A,239B) Eligibility requirements
- 170.3(237A,239B) Application and determination of eligibility
- 170.4(237A) Elements of service provision
- 170.5(237A) Adverse actions
- 170.6(237A) Appeals
- 170.7(237A) Provider fraud
- 170.8 Reserved
- 170.9(237A) Child care assistance overpayments

CHAPTER 171

Reserved

CHAPTER 172

FAMILY-CENTERED CHILD WELFARE SERVICES

DIVISION I
GENERAL PROVISIONS

- 172.1(234) Definitions
- 172.2(234) Purpose and scope
- 172.3(234) Authorization
- 172.4(234) Reimbursement
- 172.5(234) Client appeals
- 172.6(234) Reviews and audits
- 172.7 to 172.9 Reserved

DIVISION II
SAFETY PLAN SERVICES

- 172.10(234) Service requirements
- 172.11(234) Provider selection
- 172.12(234) Service eligibility
- 172.13(234) Service components
- 172.14(234) Monitoring of service delivery
- 172.15(234) Billing and payment
- 172.16 to 172.19 Reserved

DIVISION III
FAMILY SAFETY, RISK, AND PERMANENCY SERVICES

- 172.20(234) Service requirements
- 172.21(234) Provider selection
- 172.22(234) Service eligibility
- 172.23(234) Service components
- 172.24(234) Monitoring of service delivery
- 172.25(234) Billing and payment
- 172.26 to 172.29 Reserved

DIVISION IV
FAMILY-CENTERED SUPPORTIVE SERVICES

- 172.30(234) Service components
- 172.31(234) Provider selection
- 172.32(234) Service eligibility
- 172.33(234) Monitoring of service delivery
- 172.34(234) Billing and payment

CHAPTERS 173 and 174

Reserved

CHAPTER 175

ABUSE OF CHILDREN

DIVISION I
CHILD ABUSE

- 175.1 to 175.20 Reserved

DIVISION II
CHILD ABUSE ASSESSMENT

- 175.21(232,235A) Definitions
- 175.22(232) Receipt of a report of child abuse

175.23(232)	Sources of report of child abuse
175.24(232)	Child abuse assessment intake process
175.25(232)	Child abuse assessment process
175.26(232)	Completion of a child protective assessment summary
175.27(232)	Contact with juvenile court or the county attorney
175.28(232)	Consultation with health practitioners or mental health professionals
175.29(232)	Consultation with law enforcement
175.30(232)	Information shared with law enforcement
175.31(232)	Completion of required correspondence
175.32(232,235A)	Case records
175.33(232,235A)	Child protection centers
175.34(232)	Department-operated facilities
175.35(232,235A)	Jurisdiction of assessments
175.36(235A)	Multidisciplinary teams
175.37(232)	Community education
175.38(235)	Written authorizations
175.39(232)	Founded child abuse
175.40(235A)	Retroactive reviews
175.41(235A)	Access to child abuse information
175.42(235A)	Person conducting research
175.43(235A)	Child protection services citizen review panels

CHAPTER 176

DEPENDENT ADULT ABUSE

176.1(235B)	Definitions
176.2(235B)	Denial of critical care
176.3(235B)	Appropriate evaluation
176.4(235B)	Reporters
176.5(235B)	Reporting procedure
176.6(235B)	Duties of the department upon receipt of report
176.7(235B)	Appropriate evaluation or assessment
176.8(235B)	Immunity from liability for reporters
176.9(235B)	Registry records
176.10(235B)	Adult abuse information disseminated
176.11(235B)	Person conducting research
176.12(235B)	Examination of information
176.13(235B)	Dependent adult abuse information registry
176.14	Reserved
176.15(235B)	Multidisciplinary teams
176.16(235B)	Medical and mental health examinations
176.17(235B)	Request for correction or expungement

CHAPTER 177

IN-HOME HEALTH RELATED CARE

177.1(249)	In-home health related care
177.2(249)	Own home
177.3(249)	Service criteria
177.4(249)	Eligibility
177.5(249)	Providers of health care services
177.6(249)	Health care plan
177.7(249)	Client participation
177.8(249)	Determination of reasonable charges

- 177.9(249) Written agreements
- 177.10(249) Emergency services
- 177.11(249) Termination

CHAPTERS 178 to 183
Reserved

CHAPTER 184
INDIVIDUAL AND FAMILY DIRECT SUPPORT

DIVISION I
FAMILY SUPPORT SUBSIDY PROGRAM

- 184.1(225C) Definitions
- 184.2(225C) Eligibility requirements
- 184.3(225C) Application process
- 184.4(225C) Family support services plan
- 184.5 Reserved
- 184.6(225C) Amount of subsidy payment
- 184.7(225C) Redetermination of eligibility
- 184.8(225C) Termination of subsidy payments
- 184.9(225C) Appeals
- 184.10 to 184.20 Reserved

DIVISION II
COMPREHENSIVE FAMILY SUPPORT PROGRAM

- 184.21(225C) Definitions
- 184.22(225C) Eligibility
- 184.23(225C) Application
- 184.24(225C) Contractor selection and duties
- 184.25(225C) Direct assistance
- 184.26(225C) Appeals
- 184.27(225C) Parent advisory council

CHAPTER 185
Reserved

CHAPTER 186
COMMUNITY CARE

- 186.1(234) Definitions
- 186.2(234) Eligibility
- 186.3(234) Services provided
- 186.4(234) Appeals

CHAPTER 187
AFTERCARE SERVICES AND SUPPORTS

DIVISION I
AFTERCARE SERVICES

- 187.1(234) Purpose
- 187.2(234) Eligibility
- 187.3(234) Services and supports provided
- 187.4(234) Termination
- 187.5(234) Waiting list
- 187.6(234) Administration
- 187.7 to 187.9 Reserved

DIVISION II
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

187.10(234)	Purpose
187.11(234)	Eligibility
187.12(234)	Payment
187.13(234)	Termination of stipend
187.14(234)	Waiting list
187.15(234)	Administration

CHAPTERS 188 to 199
Reserved

TITLE XVI
ALTERNATIVE LIVING

CHAPTER 200
ADOPTION SERVICES

200.1(600)	Definitions
200.2(600)	Release of custody services
200.3(600)	Application
200.4(600)	Adoption services
200.5(600)	Termination of parental rights
200.6 and 200.7	Reserved
200.8(600)	Interstate placements
200.9	Reserved
200.10(600)	Requests for home studies
200.11(600)	Reasons for denial
200.12(600)	Removal of child from preadoptive family
200.13(600)	Consents
200.14(600)	Requests for access to information for research or treatment
200.15(600)	Requests for information for purposes other than research or treatment
200.16(600)	Appeals

CHAPTER 201
SUBSIDIZED ADOPTIONS

201.1(600)	Administration
201.2(600)	Definitions
201.3(600)	Conditions of eligibility or ineligibility
201.4(600)	Application
201.5(600)	Negotiation of amount of presubsidy or subsidy
201.6(600)	Types of subsidy
201.7(600)	Termination of subsidy
201.8(600)	Reinstatement of subsidy
201.9(600)	New application
201.10(600)	Medical assistance based on residency
201.11(600)	Presubsidy recovery

CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

202.1(234)	Definitions
202.2(234)	Eligibility
202.3(234)	Voluntary placements
202.4(234)	Selection of facility
202.5(234)	Preplacement

202.6(234)	Placement
202.7(234)	Out-of-area placements
202.8(234)	Out-of-state placements
202.9(234)	Supervised apartment living
202.10(234)	Services to foster parents
202.11(234)	Services to the child
202.12(234)	Services to parents
202.13(234)	Removal of the child
202.14(234)	Termination
202.15(234)	Case permanency plan
202.16(135H)	Department approval of need for a psychiatric medical institution for children
202.17(232)	Area group care targets
202.18(235)	Local transition committees

CHAPTER 203
IOWA ADOPTION EXCHANGE

203.1(232)	Definitions
203.2(232)	Children to be registered on the exchange system
203.3(232)	Families to be registered on the exchange system
203.4(232)	Matching process

CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

204.1(234)	Definitions
204.2(234)	Eligibility
204.3(234)	Application
204.4(234)	Negotiation of amount of subsidy
204.5(234)	Parental liability
204.6(234)	Termination of subsidy
204.7(234)	Reinstatement of subsidy
204.8(234)	Appeals
204.9(234)	Medical assistance

TITLE VIII
MEDICAL ASSISTANCE
CHAPTER 75
CONDITIONS OF ELIGIBILITY
[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.

75.1(1) *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

- a. Persons denied RCA because the amount of payment would be less than \$10.
- b. Rescinded IAB 7/30/08, effective 10/1/08.
- c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) *Persons receiving care in a medical facility who would be eligible under a special income standard.*

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
 - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
 - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.
 - (3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.
 - (4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.
- b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized 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. A “period of 30 days” is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain “under the jurisdiction of the institution” a person must first have been physically admitted to the institution.

75.1(8) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of “essential person” in effect in the public assistance program on December 31, 1973.

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249. Medical assistance shall also be available to the individual’s dependent relative as defined in 441—subrule 51.4(4).

75.1(10) *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

75.1(12) *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and

b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and

c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

75.1(14) *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed \$2,000 for applicant households or \$5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.

b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).

c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2) "a," "b," "c," and "d" shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1) "a" but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8) "c" and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the \$30 or the \$30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC))*. Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) "b" and "c," shall be treated in accordance with paragraphs 75.57(9) "b" and "c."

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed \$10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.

2. Rural health clinic services (if contained in the state plan).

3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, “family” shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. “Family” also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

- (1) Beginning employment.
- (2) Increased rate of pay.
- (3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months’ Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph “f” below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs “g” and “i” of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) “f” and 75.57(2) “l.”

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional six-month period as required in paragraph 75.1(31) “h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The family offers a good cause beyond the family's control.
4. There was a failure to receive the department's notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client's achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family's average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1) "a," including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph "g" or "i" above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person's monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person's resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person's income and resources shall be determined as under the SSI program.

75.1(34) *Specified low-income Medicare beneficiaries.* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) Medically needy persons.

a. *Coverage groups.* Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. *Resources and income of all persons considered.*

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)“b”(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)“b”(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. *Resources.*

(1) The resource limit for adults in SSI-related households shall be \$10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. *Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) “b,” “c,” “g,” “h,” and “i” regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	\$483	\$483	\$566	\$666	\$733	\$816	\$891	\$975	\$1058	\$1158

Each additional person \$116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the provider of the applicant’s or member’s spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that

period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3" above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

- (1) Care in a nursing facility or an intermediate care facility for the mentally retarded.
- (2) Care in an institution for mental disease.
- (3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) Expanded specified low-income Medicare beneficiaries. As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

- a. The person is not otherwise eligible for Medicaid.
- b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.
- d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.
- e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) Home health specified low-income Medicare beneficiaries. Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) Continued Medicaid for disabled children from August 22, 1996. Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) Working persons with disabilities.

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
 - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
 - (2) They are less than 65 years of age.
 - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards.
 - (4) They receive earned income from employment or self-employment or are eligible under paragraph "c."
 - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph (1) above.
 - (6) They have paid any premium assessed under paragraph "b" below.

- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

- (1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$33
180% of Federal Poverty Level	\$53
220% of Federal Poverty Level	\$73
250% of Federal Poverty Level	\$94
280% of Federal Poverty Level	\$109
310% of Federal Poverty Level	\$129
340% of Federal Poverty Level	\$154
370% of Federal Poverty Level	\$188
400% of Federal Poverty Level	\$221
430% of Federal Poverty Level	\$255
460% of Federal Poverty Level	\$295
510% of Federal Poverty Level	\$342
590% of Federal Poverty Level	\$396
680% of Federal Poverty Level	\$457
775% of Federal Poverty Level	\$524
900% of Federal Poverty Level	\$608

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

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

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the premium must be paid in full within the calendar month following the month the payment was due for reopening.

(8) Premiums may be submitted in the form of cash, money orders, or personal checks to the department at the following address: Department of Human Services, Supply Unit A-Level, Room 77, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3694, Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPS Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

"Family," if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual's family. An individual living alone or with others not listed above shall be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

“*Retirement account*” means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) “*f*” as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph “*a*” continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph “*a*” shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider’s application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Women eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available to women as provided in this subrule.

a. Eligibility. The following are eligible for assistance under this coverage group:

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who are of childbearing age, are capable of bearing children but are not pregnant, and have income that does not exceed 200 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

b. Application.

(1) Women eligible under subparagraph 75.1(41)“a”(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) Women requesting assistance based on subparagraph 75.1(41)“a”(2) shall file an application as required in rule 441—76.1(249A).

c. Determining income eligibility. The department shall determine the countable income of a woman applying under subparagraph 75.1(41)“a”(2) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in 441—subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in 441—subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in 441—paragraph 75.54(1)“b.”

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.
2. Child support.
3. Alimony.
4. Social security and railroad retirement benefits.
5. Worker’s compensation and disability payments.
6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in 441—subrule 75.57(2).

(5) Disregard of changes. A woman found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

d. Effective date. Assistance for family planning services under this coverage group 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. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

75.1(42) Medicaid for independent young adults. Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

- a.* The person is at least 18 years of age and under 21 years of age.
- b.* On the person’s eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.
- c.* The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person’s household size.

(1) “Household” shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person’s own children;
2. The person’s spouse; and
3. Any children of the person’s spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person’s household. A person who lives alone or with others not listed above, including the person’s parents, shall be considered a household of one.

(2) The department shall determine the household’s countable income pursuant to rule 75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) *Medicaid for children with disabilities.* Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

- a. The child is under 19 years of age.
- b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.
- c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.
- d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) *Presumptive eligibility for children.* Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. *Qualified entity.* A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

- (1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and
- (2) Has signed an agreement with the department as a qualified entity.

b. *Application process.* Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) "f." The qualified entity shall use the department's Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child's presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. Eligibility requirements. To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

- (1) Age. The child must be under the age of 19.
- (2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household's gross income, with no deductions, diversions, or disregards.
- (3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).
- (4) Iowa residency. The child must be a resident of Iowa.
- (5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. Period of presumptive eligibility. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

- (1) The last day of the next calendar month;
- (2) The day the child is determined eligible for Medicaid;
- (3) The last day of the month that the child is determined eligible for HAWK-I; or
- (4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child's eligibility during the presumptive period.

e. Services covered. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7833B, IAB 6/3/09, effective 8/1/09; ARC 7929B, IAB 7/1/09, effective 7/1/09; ARC 7931B, IAB 7/1/09, effective 7/1/09; ARC 8095B, IAB 9/9/09, effective 10/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8261B, IAB 11/4/09, effective 10/15/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8713B, IAB 5/5/10, effective 8/1/10; ARC 8897B, IAB 6/30/10, effective 9/1/10]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

- (1) File a claim or submit an application for any reasonably available medical resource, and
- (2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

- a. Physical or emotional harm to the member for whom medical resources are being sought.
- b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a member, the department shall have a lien, to the extent of those payments, to all monetary claims which the member may have against third parties.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the

lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be 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 for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately

for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)“a” live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is \$1500 or less per spouse.

(10) An amount, not in excess of \$1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of \$1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

- (1) That the attribution is incorrect, or
- (2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) "d" shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the

following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) "f"(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

b. Definition. “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term “well-established religious objections” means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

75.7(3) Social security account numbers may be requested for people in the eligible group for whom Medicaid is not being requested or received, but provision of the number shall not be a condition of eligibility for the people in the eligible group for whom Medicaid is being requested or received.

This rule is intended to implement Iowa Code section 249A.3.

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) Definitions.

“*Incapable of expressing intent*” shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

“*Institution*” shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) Determining residency. Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person’s state of residence is:

1. That of the parent applying for Medicaid on the person’s behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.
2. The parent’s or legal guardian’s state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.

4. The state of residence of the person who has been abandoned by the person’s parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person’s parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent’s or legal guardian’s state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.

2. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized or in foster care in that state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

- (1) The other state does not issue medical cards.
- (2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.
- (3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

This rule is intended to implement Iowa Code section 249A.3.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) Definitions.

"Care and services necessary for the treatment of an emergency medical condition" shall mean services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" shall mean a medical condition (including labor and delivery) 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 one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to

have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor. "Qualified alien" means an alien who is:

1. Lawfully admitted for permanent residence under the Immigration and Nationality Act;
2. Granted asylum under Section 208 of the Immigration and Nationality Act;
3. A refugee and who is admitted to the United States under Section 207 of the Immigration and Nationality Act;

4. Paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year;

5. An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or

6. Granted conditional entry pursuant to Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to April 1, 1980.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) Citizenship and alienage.

a. To be eligible for Medicaid a person must be one of the following:

- (1) A citizen or national of the United States.
- (2) A qualified alien residing in the United States before August 22, 1996.
- (3) An alien child under the age of 19 who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

(4) A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act.

(5) An alien who has been granted asylum under Section 208 of the Immigration and Nationality Act.

(6) An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act.

(7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0466 (Spanish);
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS);

c. Except as provided in paragraph "*f*," applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph "*b*" shall present satisfactory documentation of citizenship or nationality as defined in paragraph "*d*," "*e*," or "*i*." A reference to a form in paragraph "*d*" or "*e*" includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2) "*i*"(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. Medicaid shall not be approved for an applicant or continued for a member who has already received benefits during any portion of a reasonable period until satisfactory documentation is provided.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph "*d*," "*e*," or "*i*." The retroactive months are outside the "reasonable period" during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

- (1) A United States passport.
- (2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.
- (3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or
2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph “*b*” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is eligible for child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is eligible for adoption or foster care assistance funded under Part E of Title IV of the federal Social Security Act; or

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

g. If no other identity documentation allowed by subparagraph 75.11(2)“*e*”(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child’s parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)“*e*”(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph “*d*” or “*e*,” satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual’s name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual’s citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual’s citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration’s records, or to provide other documentation of citizenship or nationality pursuant to paragraph “*d*” or “*e*.”

75.11(3) Deeming of sponsor’s income and resources.

a. In determining the eligibility and amount of benefits of an alien, the income and resources of the alien shall be deemed to include the following:

(1) The income and resources of any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act (as implemented by the Personal Responsibility and Work Reconciliation Act of 1996) on behalf of the alien.

(2) The income and resources of the spouse of the person who executed the affidavit of support.

b. When an alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act or has worked 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with qualifying quarters as defined at subrule 75.11(1) and, in the case of any qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any federal means-tested public benefits, as defined in subrule 75.11(1), during any period, deeming of the sponsor’s income and resources no longer applies.

75.11(4) Eligibility for payment of emergency medical services. Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider’s designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, the phrase “inmate of a public institution” is defined by 42 CFR Section 435.1009, as amended on November 10, 1994.

This rule is intended to implement Iowa Code section 249A.3.

441—75.13(249A) Categorical relatedness.

75.13(1) FMAP-related Medicaid eligibility. Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) SSI-related Medicaid. Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for

the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3) “b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) Resource eligibility for SSI-related Medicaid for children. Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.
- (4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

- (1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.
- (2) Appearing as a witness at judicial or other hearings or proceedings.
- (3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that

because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

- (1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.
- (2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.
- (3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.
- (4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

- (1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.
- (2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.
- (3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.
- (4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or member that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

(1) Advise the applicant or member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative

father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. SSI-related clients returning home within three months. If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. Clients receiving a VA pension. The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) Allowable deductions from income. In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is

made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) *Income considered.* The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) *Needs of spouse.* The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) *Needs of other dependents.* The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) Exceptions to coverage. This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children who are eligible only in a retroactive month.

e. Children whose citizenship is not verified within the “reasonable period” described at paragraph 75.11(2) “c.”

75.19(2) Duration of coverage. Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household’s annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) Assignment of review date. Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) Applicants receiving federal benefits. An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) Applicants not receiving federal benefits. When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant’s condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant’s condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

- (1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
- (2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

- a.* Using the standards applicable to persons who are 18 years of age or older, and
- b.* Regardless of whether a review of the member's disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined

cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

- (1) There was a serious illness or death of the parent or a member of the parent's family.
- (2) There was a family emergency or household disaster, such as a fire, flood, or tornado.
- (3) The parent offers a good cause beyond the parent's control.
- (4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) Individual health plans. Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

- a.* A household member is currently enrolled in the plan; and
- b.* The health plan is cost-effective as defined in subrule 75.21(3).

75.21(3) Cost-effectiveness. Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of \$50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members.

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) Exceptions to payment. Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.
b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.
d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the health plan are currently in foster care.

o. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) Duplicate policies. When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) Discontinuation of premium payments.

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) Effective date of premium payment. The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) Method of premium payment. Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

e. Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

d. Redeterminations shall be completed whenever:

- (1) A premium rate, deductible, or coinsurance changes,
- (2) A person covered under the policy loses full Medicaid eligibility,
- (3) Changes in employment or hours of employment affect the availability of health insurance,
- (4) The insurance carrier changes,
- (5) The policyholder leaves the Medicaid home, or
- (6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16) “a,” shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(8)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

- (1) The department has determined the health plan is no longer cost-effective, or
- (2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) Rate refund. The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) Reinstatement of eligibility.

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) Amount of premium paid.

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) Reporting changes. Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

- (1) Unobligated cash.
- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. 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 day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets

occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2010, through June 30, 2011, this average statewide cost shall be \$4,842.72 per month or \$159.30 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.
3. A vehicle required by the client for transportation.
4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
 2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) "b"(2));
 3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
 4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) "c");
 5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) "d");
- or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value

unless the annuity meets one of the conditions described in paragraph 75.23(9) "b" and also meets the condition described in paragraph 75.23(9) "c."

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) Purchase of promissory notes, loans, or mortgages.

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9) "a" were met.

75.23(11) Purchase of life estates.

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

- (1) The life estate was purchased before February 8, 2006; or
- (2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 3/9/11, effective 5/1/11]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) Establishment of trust.

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

- (1) The purposes for which a trust is established.
- (2) Whether the trustees have or exercise any discretion under the trust.
- (3) Any restrictions on when or whether distribution may be made for the trust.
- (4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) Treatment of revocable and irrevocable trusts.

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be

considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) Exceptions. This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2010, to June 30, 2011, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$4,422 per month.
- (2) and (3) Rescinded IAB 7/7/04, effective 7/1/04.
- (4) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is \$23,845 per month.
- (5) The average statewide charge to a resident of a mental health institute is \$16,720 per month.
- (6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$5,010 per month.
- (7) The average statewide charge to a home- and community-based waiver applicant or recipient shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

- (1) The trust is established and managed by a nonprofit association.
- (2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.
- (4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8898B, IAB 6/30/10, effective 7/1/10]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“Aged” shall mean a person 65 years of age or older.

“Applicant” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Blind*” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“*Break in assistance*” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“*Central office*” shall mean the state administrative office of the department of human services.

“*Certification period*” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“*Client*” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*CMAP-related medically needy*” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“*Community spouse*” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Conditionally eligible*” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“*Coverage group*” shall mean a group of persons who meet certain common eligibility requirements.

“*Department*” shall mean the Iowa department of human services.

“*Disabled*” shall mean a person 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 from the date of application.

“*FMAP-related medically needy*” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“*Health insurance*” shall mean protection which provides payment of benefits for covered sickness or injury.

“*Incurred medical expenses*” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“*Institutionalized person*” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“*Institutionalized spouse*” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Local office*” shall mean the county office of the department of human services or the mental health institute or hospital school.

“*Medically needy income level (MNIL)*” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“*Member*” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“Necessary medical and remedial services” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

“Noncovered Medicaid services” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“Nursing facility services” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“Obligated medical expense” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“Ongoing eligibility” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“Pay and chase” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“Payee” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“Recertification” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“Recipient” shall mean a person who is receiving assistance including receiving assistance for another person.

“Responsible relative” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“Retroactive certification period” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“Retroactive period” shall mean the three calendar months immediately preceding the month in which an application is filed.

“Spenddown” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“SSI-related” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“SSI-related medically needy” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“Supply” shall mean the requested information is received by the department by the specified due date.

“Transfer of assets” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“Unborn child” shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 7935B, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28 to 75.49 Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“Applicant” shall mean a person who is requesting assistance on the person’s own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Application period” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“Assistance unit” includes any person whose income is considered when determining eligibility.

“Bona fide offer” means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

“Central office” shall mean the state administrative office of the department of human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Change in work expenses” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or *“dependent children”* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

“Income in-kind” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“Initial two months” means the first two consecutive months for which eligibility is granted.

“Medical institution,” when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

“Needy specified relative” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“*Nonrecurring lump sum unearned income*” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

“*Parent*” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“*Prospective budgeting*” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

“*Recipient*” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“*Schedule of needs*” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

“*Stepparent*” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

“*Unborn child*” shall include an unborn child during the entire term of the pregnancy.

“*Uniformed service*” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) Additional reviews. A redetermination of specific eligibility factors shall be made when:

- a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or
- b. A change in the member’s circumstances comes to the attention of a staff member.

75.52(3) Forms.

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) Client responsibilities. For the purposes of this subrule, “clients” shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) “f” and 75.57(2) “l.”

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

- (1) Income from all sources, including any change in care expenses.
- (2) Resources.
- (3) Members of the household.
- (4) School attendance.
- (5) A stepparent recovering from an incapacity.
- (6) Change of mailing or living address.
- (7) Payment of child support.
- (8) Receipt of a social security number.
- (9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8) “b.”
- (10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

- (1) Members of the household.
- (2) Change of mailing or living address.
- (3) Sources of income.
- (4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

- (1) A person enters or leaves the household.
- (2) The mailing or living address changes.
- (3) A source of income changes.
- (4) A health insurance premium or coverage change is effective.
- (5) Of any change in income.
- (6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4) “c” through “e,” any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4) “c” through “e.”

75.52(5) Effective date. After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) Definition of resident. A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) Absence from the home.

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph "b."

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

(2) An individual is out of the home to secure education or training as defined for children in paragraph 75.54(1) "b" as long as the child remains a dependent and as defined for adults in 441—subrule 93.114(1), first sentence.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) Age. Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of

vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible

group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) Limitation. Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) “*n*” or “*o*,” the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one’s home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1) “*e*.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9) “*c*” reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph "e."

o. Nonhomestead property that produces income consistent with the property's fair market value.

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1) "e" and 75.24(2) "b."

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) *Income.* When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule

of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1) “e,” 75.57(6) “u,” and 75.57(7) “o.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this

information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“*b*” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“*c*” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual’s employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)“*a*” and “*b*” and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)“*a*”(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) Shared living arrangements. When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) Income of unmarried specified relatives under the age of 19.

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative

had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) Exempt as income and resources. The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) Exempt as income. The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective family investment program (FIP) payment.

- j.* The training allowance issued by the division of vocational rehabilitation, department of education.
- k.* Payments from the PROMISE JOBS program.
- l.* The training allowance issued by the department for the blind.
- m.* Payments from passengers in a car pool.
- n.* Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o.* Rescinded IAB 10/4/00, effective 10/1/00.
- p.* Rescinded IAB 10/4/00, effective 10/1/00.
- q.* Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r.* Rescinded IAB 10/4/00, effective 10/1/00.
- s.* Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- t.* Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
- u.* Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)“b”(1) and (2). The exemption applies through the entire month of the person’s twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

- v.* Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)“c” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.
- w.* Incentive payments received from participation in the adolescent pregnancy prevention programs.
- x.* Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.
- y.* Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.
- z.* Interest and dividend income.
- aa.* Rescinded IAB 10/4/00, effective 10/1/00.
- ab.* Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.
- ac.* Income that an individual contributes to a trust as specified at paragraph 75.24(3)“b” shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.
- ad.* Benefits paid to the eligible household under the family investment program (FIP).
- ae.* Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in

accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4) "b" and 75.57(1) "d."

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) "a," "b," and "c," and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) "b"(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) "b"(1) through

(4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) "b" (1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) "a" (2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1) "f."

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8) "b" (1) through (7). Child care expenses at subparagraph 75.57(8) "b" (2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8) "b" (8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8) "b" (1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8) "b" (2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8) "b" (8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) Budgeting process.

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)“d” and “e” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)“c” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)“i.”

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)“b” and “c,” shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers’ compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or
2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)“b,” shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined

to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) Restriction on diversion of income. Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) Divesting of income. Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 8556B, IAB 3/10/10, effective 2/10/10; ARC 9043B, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) Definition of eligible group. The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required

CHART OF BASIC NEEDS COMPONENTS
(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
- (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
- (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

- (4) Food: Including school lunches.
- (5) Clothing: Including layette, laundry, dry cleaning.
- (6) Personal care and supplies: Including regular school supplies.
- (7) Medicine chest items.
- (8) Communications: Telephone, newspapers, magazines.
- (9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

- (1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

- (2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) Exclusions from the eligible group. In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

- a. Siblings (of whole or half blood, or adoptive) of eligible children.
- b. Self-supporting parents of minor unmarried parents.
- c. Stepparents of eligible children.
- d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) Situations where parent's needs are excluded. In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

75.59(5) Situations where child's needs, income, and resources are excluded. In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

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

[Filed 3/11/70; amended 12/17/73, 5/16/74, 7/1/74]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

- [Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
- [Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
- [Filed 1/31/77, Notice 12/1/76—published 2/23/77, effective 3/30/77]
- [Filed 4/13/77, Notice 11/3/76—published 5/4/77, effective 6/8/77]
- [Filed emergency 6/22/77—published 7/13/77, effective 7/1/77]
- [Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
- [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed emergency 7/28/78 after Notice 4/19/78—published 8/23/78, effective 7/28/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
- [Filed 6/5/79, Notice 4/4/79—published 6/27/79, effective 8/1/79]
- [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
- [Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]
- [Filed emergency 5/5/80—published 5/28/80, effective 5/5/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed without Notice 9/25/80—published 10/15/80, effective 12/1/80]
- [Filed 12/19/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]
- [Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
- [Filed 9/25/81, Notice 7/22/81—published 10/14/81, effective 11/18/81]
- [Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
- [Filed 1/28/82, Notice 12/9/81—published 2/17/82, effective 4/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 6/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
- [Filed emergency 7/30/82—published 8/18/82, effective 8/1/82]
- [Filed 9/23/82, Notices 6/9/82, 8/4/82—published 10/13/82, effective 12/1/82]
- [Filed emergency 3/18/83—published 4/13/83, effective 4/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
- [Filed 10/28/83, Notice 9/14/83—published 11/23/83, effective 1/1/84]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
- [Filed emergency 1/13/84—published 2/1/84, effective 2/8/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
- [Filed emergency 1/17/85—published 2/13/85, effective 1/17/85]
- [Filed without Notice 1/22/85—published 2/13/85, effective 4/1/85]
- [Filed emergency 3/22/85—published 4/10/85, effective 4/1/85]
- [Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
- [Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
- [Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
- [Filed 2/21/86, Notice 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 3/21/86 after Notice 2/12/86—published 4/9/86, effective 4/1/86]
- [Filed emergency 4/28/86—published 5/21/86, effective 5/1/86]
- [Filed emergency 8/28/86—published 9/24/86, effective 9/1/86]
- [Filed 9/5/86, Notice 6/18/86—published 9/24/86, effective 11/1/86]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed without Notice 1/15/87—published 2/11/87, effective 4/1/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 3/26/87, Notice 2/11/87—published 4/22/87, effective 6/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed emergency 5/29/87 after Notice 4/22/87—published 6/17/87, effective 7/1/87]

- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed emergency after Notice 9/24/87, Notice 8/12/87—published 10/21/87, effective 10/1/87]
 - [Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
- [Filed emergency after Notice 10/23/87, Notice 9/9/87—published 11/18/87, effective 11/1/87]
 - [Filed 10/23/87, Notice 9/9/87—published 11/18/87, effective 1/1/88]
 - [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
 - [Filed emergency 3/16/88—published 4/6/88, effective 3/16/88]
 - [Filed 3/17/88, Notice 1/13/88—published 4/6/88, effective 6/1/88]
 - [Filed emergency 4/22/88—published 5/18/88, effective 5/1/88]
 - [Filed 4/22/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
 - [Filed 6/9/88, Notice 4/20/88—published 6/29/88, effective 9/1/88]
 - [Filed 8/4/88, Notices 6/29/88^o—published 8/24/88, effective 10/1/88]
 - [Filed without Notice 9/21/88—published 10/19/88, effective 12/1/88]
 - [Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
 - [Filed emergency 11/14/88—published 11/30/88, effective 11/14/88]
- [Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]
 - [Filed emergency 4/13/89 after Notice 3/8/89—published 5/3/89, effective 5/1/89]
 - [Filed 4/13/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]
 - [Filed 5/10/89, Notice 4/5/89—published 5/31/89, effective 8/1/89]
 - [Filed emergency 6/9/89 after Notice 5/3/89—published 6/28/89, effective 7/1/89]
 - [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
 - [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
 - [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
 - [Filed emergency 10/10/89—published 11/1/89, effective 12/1/89]
 - [Filed 10/10/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
 - [Filed 12/19/89, Notice 11/1/89—published 1/10/90, effective 3/1/90]
 - [Filed emergency 1/10/90—published 2/7/90, effective 1/10/90]
 - [Filed 1/16/90, Notice 11/15/89—published 2/7/90, effective 4/1/90]
 - [Filed emergency 2/16/90—published 3/7/90, effective 4/1/90]
 - [Filed without Notice 2/16/90—published 3/7/90, effective 5/1/90]
 - [Filed emergency 3/14/90—published 4/4/90, effective 3/14/90]
 - [Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 6/1/90]
 - [Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
 - [Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]
 - [Filed emergency 6/20/90 after Notice 4/18/90—published 7/11/90, effective 7/1/90]
 - [Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
 - [Filed emergency 8/16/90 after Notice of 6/27/90—published 9/5/90, effective 10/1/90]
 - [Filed 8/16/90, Notices 6/13/90, 7/11/90—published 9/5/90, effective 11/1/90]
 - [Filed emergency 12/13/90—published 1/9/91, effective 1/1/91]
 - [Filed 2/14/91, Notice 1/9/91—published 3/6/91, effective 5/1/91]
 - [Filed emergency 3/14/91—published 4/3/91, effective 3/14/91]
 - [Filed 3/14/91, Notice 1/23/91—published 4/3/91, effective 6/1/91]
 - [Filed emergency 4/11/91—published 5/1/91, effective 4/11/91]
 - [Filed 4/11/91, Notice 2/20/91—published 5/1/91, effective 7/1/91]
 - [Filed emergency 5/17/91 after Notice 4/3/91—published 6/12/91, effective 7/1/91]
 - [Filed 5/17/91, Notices 4/3/90^o—published 6/12/91, effective 8/1/91]
 - [Filed emergency 6/14/91 after Notice 5/1/91—published 7/10/91, effective 7/1/91]
 - [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
 - [Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
 - [Filed emergency 9/18/91 after Notice 4/17/91—published 10/16/91, effective 10/1/91]
 - [Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
 - [Filed emergency 12/11/91—published 1/8/92, effective 1/1/92]

- [Filed emergency 12/11/91 after Notice 10/30/91—published 1/8/92, effective 1/1/92]
 - [Filed 12/11/92, Notice 10/16/91—published 1/8/92, effective 3/1/92]¹
 - [Filed 1/15/92, Notice 11/13/91—published 2/5/92, effective 4/1/92]
 - [Filed 2/13/92, Notices 1/8/92^o—published 3/4/92, effective 5/1/92]
 - [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 4/16/92 after Notice 2/19/92—published 5/13/92, effective 5/1/92]
- [Filed emergency 5/14/92 after Notice 3/18/92—published 6/10/92, effective 7/1/92]
 - [Filed 5/14/92, Notices 3/18/92^o—published 6/10/92, effective 8/1/92]
 - [Filed 6/11/92, Notice 4/29/92—published 7/8/92, effective 9/1/92]
 - [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
 - [Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
 - [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
 - [Filed emergency 12/1/92—published 12/23/92, effective 1/1/93]
- [Filed emergency 1/14/93 after Notice 10/28/92—published 2/3/93, effective 2/1/93]
- [Filed 1/14/93, Notices 10/28/92, 11/25/92, 12/9/92—published 2/3/93, effective 4/1/93]
 - [Filed 2/10/93, Notice 12/23/92—published 3/3/93, effective 5/1/93]
 - [Filed 4/15/93, Notice 2/17/93—published 5/12/93, effective 7/1/93]
 - [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed emergency 6/11/93 after Notice 4/28/93—published 7/7/93, effective 7/1/93]
 - [Filed 7/14/93, Notice 5/12/93—published 8/4/93, effective 10/1/93]
 - [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
 - [Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
 - [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
 - [Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
 - [Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
 - [Filed without Notice 12/16/93—published 1/5/94, effective 2/9/94]
- [Filed 12/16/93, Notices 10/13/93, 10/27/93—published 1/5/94, effective 3/1/94]
 - [Filed 2/10/94, Notices 12/8/93, 1/5/94^o—published 3/2/94, effective 5/1/94]
 - [Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
 - [Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
 - [Filed 5/11/94, Notice 3/16/94—published 6/8/94, effective 8/1/94]
 - [Filed 6/16/94, Notice 4/27/94—published 7/6/94, effective 9/1/94]
 - [Filed 9/15/94, Notice 8/3/94—published 10/12/94, effective 11/16/94]
 - [Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
 - [Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
- [Filed 12/15/94, Notices 10/26/94, 11/9/94—published 1/4/95, effective 3/1/95]
- [Filed 2/16/95, Notices 11/23/94, 12/21/94, 1/4/95—published 3/15/95, effective 5/1/95]
 - [Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
 - [Filed emergency 9/25/95—published 10/11/95, effective 10/1/95]
- [Filed 11/16/95, Notices 9/27/95, 10/11/95—published 12/6/95, effective 2/1/96]
 - [Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
 - [Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
 - [Filed 2/14/96, Notice 1/3/96—published 3/13/96, effective 5/1/96]
 - [Filed 4/10/96, Notice 2/14/96—published 5/8/96, effective 7/1/96]
 - [Filed emergency 9/19/96—published 10/9/96, effective 9/19/96]
 - [Filed 10/9/96, Notice 8/28/96—published 11/6/96, effective 1/1/97]
 - [Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]^o
- [Filed 12/12/96, Notices 9/11/96, 10/9/96—published 1/1/97, effective 3/1/97]
 - [Filed 2/12/97, Notice 1/1/97—published 3/12/97, effective 5/1/97]
 - [Filed 3/12/97, Notice 1/1/97—published 4/9/97, effective 6/1/97]
 - [Filed 4/11/97, Notice 2/26/97—published 5/7/97, effective 7/1/97]
 - [Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]

- [Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
- [Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]
- [Filed emergency 12/10/97 after Notices 10/22/97, 11/5/97—published 12/31/97, effective 1/1/98]
- [Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
- [Filed 2/11/98, Notice 12/31/97—published 3/11/98, effective 5/1/98][◊]
- [Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
- [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
- [Filed emergency 6/25/98—published 7/15/98, effective 7/1/98]
- [Filed 7/15/98, Notices 6/3/98—published 8/12/98, effective 10/1/98]
- [Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
- [Filed emergency 12/9/98—published 12/30/98, effective 1/1/99]
- [Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/15/99]
- [Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 6/1/99]
- [Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 7/1/99]
- [Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
- [Filed 5/14/99, Notice 4/7/99—published 6/2/99, effective 8/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 6/10/99, Notice 4/21/99—published 6/30/99, effective 9/1/99]
- [Filed emergency 8/12/99 after Notice 6/16/99—published 9/8/99, effective 9/1/99]
- [Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed emergency 11/10/99 after Notice 10/6/99—published 12/1/99, effective 12/1/99]
- [Filed emergency 12/8/99—published 12/29/99, effective 1/1/00]
- [Filed 12/8/99, Notice 11/3/99—published 12/29/99, effective 2/2/00]
- [Filed 12/8/99, Notice 10/6/99—published 12/29/99, effective 3/1/00]
- [Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00][◊]
- [Filed emergency 3/8/00—published 4/5/00, effective 4/1/00]
- [Filed 5/10/00, Notice 3/22/00—published 5/31/00, effective 8/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed emergency 6/8/00 after Notice 4/19/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/5/00—published 6/28/00, effective 9/1/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/12/00—published 10/4/00, effective 10/1/00]
- [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
- [Filed 11/8/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]
- [Filed emergency 12/14/00—published 1/10/01, effective 1/1/01]
- [Filed 2/14/01, Notice 1/10/01—published 3/7/01, effective 5/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01][◊]
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01][◊]
- [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]
- [Filed emergency 12/12/01—published 1/9/02, effective 1/1/02]
- [Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
- [Filed 2/14/02, Notice 12/26/01—published 3/6/02, effective 5/1/02]
- [Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
- [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02][◊]
- [Filed emergency 6/13/02—published 7/10/02, effective 7/1/02]
- [Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
- [Filed emergency 12/12/02—published 1/8/03, effective 1/1/03][◊]
- [Filed emergency 1/9/03 after Notice 11/27/02—published 2/5/03, effective 2/1/03]

- [Filed 1/9/03, Notice 11/27/02—published 2/5/03, effective 4/1/03]
- [Filed emergency 3/14/03—published 4/2/03, effective 4/1/03]
- [Filed without Notice 5/16/03—published 6/11/03, effective 7/16/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
- [Filed emergency 10/10/03—published 10/29/03, effective 10/10/03]
- [Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
- [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
- [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed emergency 3/11/04—published 3/31/04, effective 4/1/04]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
- [Filed emergency 9/23/04 after Notice 7/7/04—published 10/13/04, effective 10/1/04]
- [Filed 10/8/04, Notice 7/7/04—published 10/27/04, effective 12/1/04]
- [Filed 10/14/04, Notice 8/4/04—published 11/10/04, effective 1/1/05]
- [Filed emergency 12/14/04—published 1/5/05, effective 1/1/05]
- [Filed emergency 1/13/05 after Notice 12/8/04—published 2/2/05, effective 2/1/05]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed emergency 6/17/05 after Notice 8/4/04—published 7/6/05, effective 7/1/05]
- [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
- [Filed emergency 7/15/05 after Notice 5/11/05—published 8/3/05, effective 8/1/05]
- [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
- [Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
- [Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
- [Filed emergency 1/12/06 after Notice 11/23/05—published 2/1/06, effective 2/1/06]
- [Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
- [Filed without Notice 4/17/06—published 5/10/06, effective 7/1/06]
- [Filed emergency 5/12/06—published 6/7/06, effective 6/1/06]
- [Filed emergency 6/16/06 after Notice 4/12/06—published 7/5/06, effective 7/1/06]
- [Filed emergency 6/16/06 after Notice 5/10/06—published 7/5/06, effective 7/1/06]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]◊
- [Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]
- [Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
- [Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
- [Filed 12/13/06, Notice 7/5/06—published 1/3/07, effective 2/7/07]
- [Filed 4/11/07, Notice 2/28/07—published 5/9/07, effective 7/1/07]
- [Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
- [Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]◊
- [Filed emergency 6/15/07—published 7/4/07, effective 7/1/07]◊
- [Filed emergency 6/13/07—published 7/4/07, effective 8/1/07]
- [Filed emergency 7/12/07 after Notice 5/9/07—published 8/1/07, effective 8/1/07]
- [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]◊
- [Filed emergency 10/10/07 after Notice 8/29/07—published 11/7/07, effective 11/1/07]
- [Filed 12/12/07, Notice 7/4/07—published 1/2/08, effective 2/6/08]◊
- [Filed emergency 1/9/08 after Notice 12/5/07—published 1/30/08, effective 2/1/08]
- [Filed emergency 2/13/08 after Notice 12/19/07—published 3/12/08, effective 2/15/08]
- [Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
- [Filed 4/10/08, Notice 1/30/08—published 5/7/08, effective 7/1/08]
- [Filed 4/10/08, Notice 2/27/08—published 5/7/08, effective 7/1/08]
- [Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]◊
- [Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]
- [Filed 7/9/08, Notice 5/7/08—published 7/30/08, effective 10/1/08]
- [Filed emergency 10/14/08 after Notice 7/2/08—published 11/5/08, effective 11/1/08]
- [Filed emergency 10/14/08 after Notice 8/27/08—published 11/5/08, effective 11/1/08]

- [Filed emergency 11/12/08 after Notice 9/24/08—published 12/3/08, effective 1/1/09]
 [Filed 11/12/08, Notice 8/13/08—published 12/3/08, effective 2/1/09]
 [Filed ARC 7546B (Notice ARC 7356B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
 [Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]
 [Filed ARC 7834B (Notice ARC 7630B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
 [Filed ARC 7833B (Notice ARC 7629B, IAB 3/11/09), IAB 6/3/09, effective 8/1/09]
 [Filed Emergency ARC 7929B, IAB 7/1/09, effective 7/1/09]
 [Filed Emergency ARC 7931B, IAB 7/1/09, effective 7/1/09]
 [Filed Emergency ARC 7932B, IAB 7/1/09, effective 7/1/09]
 [Filed ARC 7935B (Notice ARC 7718B, IAB 4/22/09), IAB 7/1/09, effective 9/1/09]
 [Filed ARC 8095B (Notice ARC 7930B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
 [Filed ARC 8096B (Notice ARC 7934B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
 [Filed ARC 8260B (Notice ARC 8056B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]
 [Filed Emergency After Notice ARC 8261B, IAB 11/4/09, effective 10/15/09]
 [Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]
 [Filed ARC 8443B (Notice ARC 8220B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]
 [Filed ARC 8444B (Notice ARC 8221B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]
 [Filed Emergency After Notice ARC 8503B (Notice ARC 8311B, IAB 11/18/09), IAB 2/10/10,
 effective 1/13/10]
 [Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10,
 effective 3/1/10]
 [Filed Emergency After Notice ARC 8556B (Notice ARC 8407B, IAB 12/16/09), IAB 3/10/10,
 effective 2/10/10]
 [Filed ARC 8642B (Notice ARC 8461B, IAB 1/13/10), IAB 4/7/10, effective 6/1/10]
 [Filed Without Notice ARC 8713B, IAB 5/5/10, effective 8/1/10]
 [Filed Emergency After Notice ARC 8786B (Notice ARC 8552B, IAB 2/24/10), IAB 6/2/10, effective
 6/1/10]
 [Filed ARC 8785B (Notice ARC 8619B, IAB 3/24/10), IAB 6/2/10, effective 8/1/10]
 [Filed Emergency ARC 8898B, IAB 6/30/10, effective 7/1/10]
 [Filed ARC 8897B (Notice ARC 8705B, IAB 4/21/10), IAB 6/30/10, effective 9/1/10]
 [Filed ARC 9043B (Notice ARC 8853B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]
 [Filed ARC 9044B (Notice ARC 8864B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]
 [Filed ARC 9404B (Notice ARC 9277B, IAB 12/15/10), IAB 3/9/11, effective 5/1/11]

◊ Two or more ARCs

¹ 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.

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, therapeutically certified 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. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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 Iowa Foundation for Medical Care 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 Iowa Foundation for Medical Care, 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 Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

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. Rescinded IAB 1/30/08, effective 4/1/08.

e. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

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 will not be approved for vaccines which are available through the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health.

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 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 physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in subrule 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) Rescinded, effective 8/1/87.

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, physician's assistants, 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 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—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone.

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, or otherwise handicapped 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(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) 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 IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, 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 IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1) "e.")

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 bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lymphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin's lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

(4) Liver transplants for persons with extrahepatic biliary arsesia 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 Iowa Foundation for Medical Care. (Cross-reference 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. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, 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 and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 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 Iowa Foundation for Medical Care. (Cross-reference 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 Iowa Foundation for Medical Care. (Cross-reference 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) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians 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.

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

[ARC 8714B, IAB 5/5/10, effective 5/1/10]

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 by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

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, a prescription shall

be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions 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 as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(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.

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 to cause anorexia, weight gain, or weight loss, except for lipase inhibitor drugs prescribed for weight loss with prior authorization as provided in paragraph “a.”

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

(4) Drugs used to promote smoking cessation, except for varenicline with prior authorization as provided in paragraph “a” above and generic, sustained-release bupropion products that are indicated for smoking cessation by the U.S. Food and Drug Administration.

(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, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(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)).

78.2(5) *Nonprescription drugs.* 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 325 mg, 650 mg, 81 mg (chewable)
- 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
- Calcium carbonate chewable tablets 1250 mg (500 mg elemental calcium)
- Calcium carbonate suspension 1250 mg/5 ml
- Calcium carbonate tablets 600 mg
- Calcium carbonate-vitamin D tablets 500 mg-200 units
- Calcium carbonate-vitamin D tablets 600 mg-200 units
- Calcium citrate tablets 950 mg (200 mg elemental calcium)
- Calcium gluconate tablets 650 mg
- Calcium lactate tablets 650 mg
- 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 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
- Guaifenesin 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%
- Loperamide hydrochloride liquid 1 mg/5 ml
- Loperamide hydrochloride tablets 2 mg
- Loratadine syrup 5 mg/5 ml
- Loratadine tablets 10 mg
- Magnesium hydroxide suspension 400 mg/5 ml
- Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
- Magnesium oxide tablets 400 mg
- Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
- Miconazole nitrate cream 2% topical and vaginal
- Miconazole nitrate vaginal suppositories, 100 mg
- Multiple vitamin and mineral products with prior authorization

Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin liquid 1%
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
 Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
 Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
 Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
 Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
 Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
 Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution
 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
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) Quantity prescribed and dispensed.

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

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]

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 Foundation for Medical Care (IFMC). 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. Readmissions to the same facility due to premature discharge shall

not be paid a new DRG. 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(5)) The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, 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. Hospitals that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members.

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) Rescinded IAB 2/6/91, effective 4/1/91.

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 IFMC 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 IFMC that the lower level of care is required or (b) for the days IFMC 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 IFMC 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 IFMC that the lower level of care is required or (b) for the days IFMC 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 on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted 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 Iowa Foundation for Medical Care, 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 Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

78.3(16) 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.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

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. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

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 physical or mental disability, 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 in a six-month period except for people who need more frequent applications because of physical or mental disability. (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 disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

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

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

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

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panoramic-type radiography with bitewings is considered the same as a complete 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 when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

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. Rescinded IAB 5/1/02, effective 7/1/02.

d. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2) "e")

e. Cast post and core, steel post and composite or amalgam in addition to a crown is 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 restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(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) Rescinded IAB 5/1/02, effective 7/1/02.

(5) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled 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 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 when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.28(2) "a"(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). 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 patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2) "a"(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2) "a"(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2) "a"(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

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 extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

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 is payable when prior approval has been received. Payment for 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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(2) "d")

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, and failure has been demonstrated with a radiograph and narrative history.

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. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

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

k. 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 and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2) "c"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2) "c"(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2) "c"(3))

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

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

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

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

k. 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.

l. 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.

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

a. When prior approval has been given for orthodontic services to treat the most handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of

the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)“d”)

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) Treatment in a hospital. Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) 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.

78.4(11) 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 exams are not billed for that visit.

78.4(12) 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.

78.4(13) 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 writing prescriptions.

78.4(14) Services to members 21 years of age or older. Orthodontic procedures are not covered for members 21 years of age or older.

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

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 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.

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

(1) When 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 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) Protective lenses 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. Rescinded IAB 4/3/02, effective 6/1/02.

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 six years of age.

3. When there is a prescribed 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.

g. Rescinded IAB 4/3/02, effective 6/1/02.

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 once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

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, manufactured by reputable American manufacturers.
- b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.
- 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.

a. Materials payable by fee schedule are:

- (1) 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) Protective lenses and safety frames.
- (5) Subnormal visual aids.

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 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.

(Cross-reference 78.28(3))

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 protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3) "b"(4).
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1) "i."

78.6(6) Therapeutically certified optometrists. Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09]

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(3))

78.7(1) to 78.7(3) Rescinded IAB 4/3/02, effective 6/1/02.

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

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-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		

ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	723.5 Torticollis, unspecified	
	724.01 Spinal stenosis, thoracic region	
	724.02 Spinal stenosis, lumbar region	
	724.4 Thoracic or lumbosacral neuritis or radiculitis	
	724.6 Disorders of sacrum, ankylosis	
	724.79 Disorders of coccyx, coccygodynia	
	724.8 Other symptoms referable to back, facet syndrome	
	729.1 Myalgia and myositis, unspecified	
	729.4 Fascitis, unspecified	
	738.40 Acquired spondylolisthesis	
	756.12 Spondylolisthesis	
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

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.

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician 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, evidenced by the physician'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 62 days thereafter. 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.
 - (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 62 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's signature and date. The plan of care must be signed and dated by the physician

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 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 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 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, 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, 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. 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 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.

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

- (1) Are reasonable and necessary to the treatment of a member's illness or injury.
- (2) Contribute meaningfully to the treatment of the member's condition.
- (3) Are under the direction of a physician.
- (4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.
- (5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

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, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.
- (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 mental retardation.
- (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) Mental retardation 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(9))

78.9(11) Vaccines. Home health agencies which wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

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]

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 diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, 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 approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval 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 patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

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 will be maintained on a rental basis for the duration of use.

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.

78.10(2) Durable medical equipment. DME is equipment which 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 will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.
Automated medication dispenser. See 78.10(2) "d" for prior authorization requirements.
Bedpan.
Blood glucose monitors, subject to the limitation in 78.10(2) "e."
Blood pressure cuffs.
Cane.
Cardiorespiratory monitor (rental and supplies).
Commode.
Commode pail.
Crutches.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2) "d" for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2) "d" for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2) "a" and 78.10(2) "c."
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2) "d" for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription 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 at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician's Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;

2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient'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 (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

(5) All accessories, disposable supplies, servicing, and repairing of concentrators are included in the monthly Medicaid payment for concentrators.

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

2. The patient's mobility puts the patient at risk for injury.

3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient 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 of lung function.

2. The patient 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.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

2. The member is on two or more medications prescribed to be administered more than one time a day.

3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

4. Less costly alternatives, such as medisets or telephone reminders, have failed.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

- (1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

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 patient's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a patient prior to the time the patient undergoes a procedure which will make necessary the use of the device.

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3) "c" for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3) "c" for prior approval requirements.

(5) Hearing aids. See rule 441—78.14(249A).

(6) Oral nutritional products. See 78.10(3) "c" for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3) "d" for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) 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.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) 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(4))

c. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1) "c")

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.
2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.
3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only 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 the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.
2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.
3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. 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 photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

- (1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is between 6 and 18 months 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. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

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 blood glucose test strips, subject to the limitation in 78.10(4)“c.”

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

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 the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

Diabetic supplies (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).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

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]

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 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) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) Covered services. Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

- (5) Community psychiatric supportive treatment is not intended to be provided in a group.
- b.* Crisis intervention 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.
- c.* Health or behavior intervention, used 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: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.
- (2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.
- (3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.
- d.* Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.
- (1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.
- (2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.
- e.* Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.
- (1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.
- (2) Skills training and development services are covered only for Medicaid members aged 18 or over.
- 78.12(2) Excluded services.** Services that are habilitative in nature are not covered as remedial services. 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.
- 78.12(3) Coverage requirements.** Medicaid covers remedial services 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. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:
- (1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and
- (2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).
- b.* The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

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 using the same instrument every six months thereafter if continued services are ordered.

d. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) Approval of plan. The remedial services provider shall submit the treatment plan, the results of the formal assessment, and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. *Initial plan.* The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(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 can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

(5) The plan does not exceed six months' duration; and

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. *Subsequent plans.* The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph "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;

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(3) "c"(3); and

(4) Submitted the results of the formal assessment with the recommendation for continued services.

c. *Quality review.* The IME medical services unit will establish a quality review process. Reviews will evaluate:

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

(2) The continuity of treatment;

(3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;

(4) Gaps in service;

(5) The results achieved; and

(6) Member satisfaction.

78.12(5) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of remedial 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.

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

[ARC 8504B, IAB 2/10/10, effective 3/22/10]

441—78.13(249A) Nonemergency medical transportation. Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

78.13(1) Member request. When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

78.13(2) Necessary services. Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

78.13(3) Access to free transportation. Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

78.13(4) Closest medical provider. Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

a. The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

b. The additional cost of transportation to the provider requested by the member is medically justified based on:

- (1) A previous relationship between the member and the requested provider,
- (2) Prior experience of the member with closer providers, or
- (3) Special expertise or experience of the requested provider.

78.13(5) Coverage. Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

a. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

b. The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

c. When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

d. The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

78.13(6) Exceptions for nursing facility residents.

a. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

b. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

78.13(7) Grievances. Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.” For transportation providers, 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]

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(4)“*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(4)“*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]

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.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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) Rescinded IAB 12/3/08, effective 2/1/09.

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.

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 recipient'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. Services provided a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(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 (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.

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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) Rescinded IAB 10/12/94, effective 12/1/94.

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).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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. Rescinded IAB 12/3/08, effective 2/1/09.

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. Rescinded IAB 12/3/08, effective 2/1/09.

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

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 Web site.

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 Iowa Foundation for Medical Care (IFMC) 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 IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8205B, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services.

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.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, 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.

“*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.

“*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.

“*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.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member’s case manager has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department 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). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) 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 case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service 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 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 shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager 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 service plan and annual updates to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written case plan must be completed, signed and dated by the case manager or service worker within 30 calendar days after plan approval.

(10) Any changes to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system 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 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 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 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 service 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) "e."

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—90.5(249A) and 441—90.8(249A).

b. Exclusion. 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 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 of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. 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 assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member’s maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member’s:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;
- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;

- (10) Self-advocacy skills; or
- (11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or 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).

d. Exclusions. Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

- (1) Services that are available 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 for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member

may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available 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 under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments 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 or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) Rescinded IAB 12/29/10, effective 1/1/11.

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) 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 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 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 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.

78.27(12) County reimbursement. The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement 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. Automated medication dispenser. (Cross-reference 78.10(2) "b") Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition. (Cross-reference 78.10(3) "c"(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical

necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3) "c"(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) 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 IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, 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 IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2) "c") The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

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. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)“c”) The department shall approve payment for oral nutritional products 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.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member’s total medical condition that includes a description of the member’s metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member’s nutritional status and indicate that the member’s nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)“c”) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient 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.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)“b”)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)“c”)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)“d”)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy

may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4) "e")

b. Surgical endodontic treatment which includes 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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 78.4(5) "c")

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7) "c")

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7) "d")

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7) "e")

(4) Dental implants and related services will be authorized 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.

d. Orthodontic services will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;

5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8) "a")

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3) "d")

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.28(3) 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.

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(4) 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(5) 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 preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC 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 IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) 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 by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) Rescinded IAB 6/4/08, effective 5/15/08.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) 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(10) 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")

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]

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, or master social worker 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.

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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 Iowa Foundation for Medical Care. 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. Hospital outpatient programs that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

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, bulimia, or bulimarexia. Compulsive overeaters are not acceptable 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 as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

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, dysrhythmia 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. A complete diabetic education program is payable once in the lifetime of a recipient.

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.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

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 on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS intellectual disability waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

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 client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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 one hour.

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 rule 441—83.1(249A).

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.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

- (1) Dressing.
- (2) Bath, shampoo, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- (4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
- (5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping services which are essential to the member's health care at home.
- (7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
- (8) Wound care.
- (9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Cognitive assistance with tasks such as handling money and scheduling.
- (11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
- (12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private

insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
 - (8) Colostomy care.
 - (9) Care of medical conditions out of control which includes 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.
- c.* A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.
- d.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.
- e.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.
- f.* The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.
- g.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.
- h.* If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.
- i.* If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.
- j.* The frequency or intensity of services shall be indicated in the service plan.
- k.* Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.
- l.* Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 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 one-hour units 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 only in the member's home; in a registered child development home; in 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 one hour.

78.34(9) *Home and vehicle modification.* Covered home and 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.
- (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 department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

(1) Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

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 maximum of two meals is allowed per day. A unit of service is a meal.

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 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. 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 ill and handicapped 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) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)“b”(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) 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.

(4) 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. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)“b”(2) or the utilization adjustment factor in subparagraph 78.34(13)“b”(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member’s service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) 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 or goods 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 service worker.

(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 service worker.

(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." 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.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(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 by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (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.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. 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 accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. 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 service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(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 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 shall be consistent with rates 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.

(4) Authorize payment for optional service components identified in the individual budget.

(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. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(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 what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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 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.

l. 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) Enter the individual budget into the Web-based tracking system chosen by the department and enter 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.

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]

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, 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.

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The

consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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 client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

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, and washing and mending clothes.

- c. Accompaniment to medical or psychiatric services.
- d. Meal preparation: planning and preparing balanced meals.
- e. Bathing and dressing for self-directing recipients.

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 one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 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.

78.37(7) Chore services. Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

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 maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) Home and vehicle modification. Covered home and 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.
- (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 department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and 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 recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

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.

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 one hour.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

- (1) Dressing.
- (2) Bath, shampoo, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- (4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
- (5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping services which are essential to the member's health care at home.
- (7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
- (8) Wound care.
- (9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Cognitive assistance with tasks such as handling money and scheduling.
- (11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
- (12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider

present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- (8) Colostomy care.
- (9) Care of medical conditions out of control which includes 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.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.37(16) Consumer choices option. The consumer choices option 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. 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 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 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.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) 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.

(4) 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. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16) "b"(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16) "b"(2) or the utilization adjustment factor in subparagraph 78.37(16) "b"(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) 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 or goods 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 service worker.

(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 service worker.

(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 78.37(16) "d." 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.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(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 78.37(16)“d.” The savings plan shall meet the requirements in paragraph 78.37(16)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (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.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. 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 accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. 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 service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(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 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 shall be consistent with rates 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.

(4) Authorize payment for optional service components identified in the individual budget.

(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. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(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 what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

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 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.

l. 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) Enter the individual budget into the Web-based tracking system chosen by the department and enter 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.

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—90.5(249A) and 441—90.8(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.

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]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

- 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 client, and dishes.
- c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.
- d. 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 one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 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.

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 maximum of two meals is allowed per day. A unit of service is a meal.

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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) Consumer choices option. The consumer choices option 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. 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 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 AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) 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.

(4) 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. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)“b”(3).

(6) 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 or goods 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 service worker.

(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 service worker.

(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 78.38(9)“d.” 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.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(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 78.38(9) "d." The savings plan shall meet the requirements in paragraph 78.38(9) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (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.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. 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 accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. 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 service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(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 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 shall be consistent with rates 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.
- (4) Authorize payment for optional service components identified in the individual budget.
- (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. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (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 what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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 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) Enter the individual budget into the Web-based tracking system chosen by the department and enter 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.

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]

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

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) Vaccine administration. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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. All services include the applicable and necessary instruction, supervision, assistance and support as required by the member in achieving the member's life goals. The services, amount and supports provided under the HCBS intellectual disability waiver shall be delivered in the least restrictive environment and in conformity with the member's service

plan. Reimbursement shall not be available under the waiver for any services that the member can obtain through the Medicaid state plan. All services shall be billed in whole units.

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 service excludes transportation to and from work.

(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 an hourly 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. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. 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) One hour 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) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly 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 one hour.

d. Payment for respite services shall not exceed \$7,050 per the member's waiver year.

e. The service shall be identified in the member's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

g. 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.

h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. 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.

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 and 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.

(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 department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and 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 individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a

work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “a” and “b” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person’s employment needs. Second, the consumer’s interdisciplinary team must determine that the identified services are necessary. Third, the consumer’s case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member’s service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer’s customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer’s employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
 2. Job coaching.
 3. On-the-job or work-related crisis intervention.
 4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
 5. Consumer-directed attendant care services as defined in subrule 78.41(8).
 6. Assistance with time management.
 7. Assistance with appropriate grooming.
 8. Employment-related supportive contacts.
 9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
 10. On-site vocational assessment after employment.
 11. Employer consultation.
- (2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.
- (3) A unit of service is one hour.
- (4) A maximum of 40 units may be received per week.
- c. The following requirements apply to all supported employment services:
- (1) Employment-related adaptations required to assist the consumer within the performance of the consumer’s job functions shall be provided by the provider as part of the services.
 - (2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.
 - (3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.
 - (4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.
 - (5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.
 - (6) All services shall be identified in the consumer’s service plan maintained pursuant to rule 441—83.67(249A).
 - (7) The following services are not covered:
 1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
 2. Supports for volunteer work or unpaid internships;
 3. Tuition for education or vocational training; or
 4. Individual advocacy that is not consumer specific.
 - (8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

- (1) Dressing.
- (2) Bath, shampoo, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- (4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
- (5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping services which are essential to the member's health care at home.
- (7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
- (8) Wound care.
- (9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Cognitive assistance with tasks such as handling money and scheduling.
- (11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
- (12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- (8) Colostomy care.
- (9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 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 one-hour units 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 only in the member's home; in a registered child development home; in 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 one hour.
- 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 receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service.

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. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized rehabilitative goals, and are reflected in a rehabilitative plan that focuses on general rehabilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.41(14) *Day habilitation services.*

a. *Scope.* Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

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 consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. *Unit of service.* Except as provided in paragraph “b,” the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) Consumer choices option. The consumer choices option 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. 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 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 intellectual disabilities 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.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)"b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) 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.

(4) 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. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)"b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)"b"(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)"b"(2) or the utilization adjustment factor in subparagraph 78.41(15)"b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual

budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) 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 or goods 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 service worker.

(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 service worker.

(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 78.41(15) "d." 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.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(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 78.41(15)“d.” The savings plan shall meet the requirements in paragraph 78.41(15)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (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.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. 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 accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. 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 service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(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 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 shall be consistent with rates 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.
- (4) Authorize payment for optional service components identified in the individual budget.
- (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. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (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 what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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 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.

l. 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) Enter the individual budget into the Web-based tracking system chosen by the department and enter 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.

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]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the vaccines for children

program administered by the department of public health if the pharmacy is enrolled in the vaccines for children program. No payment will be made for the vaccine.

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

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—90.5(249A) and 441—90.8(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 at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, 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 service excludes transportation to and from work or day programs.

(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 an hourly 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) One hour 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) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly 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 one hour.

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. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. 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.

78.43(4) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “a” and “b” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or rehabilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A

consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
 2. Assistance with applying for a job, including completion of applications or interviews.
 3. Work site assessment and job accommodation evaluation.
 - b. Supports to maintain employment.
- (1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:
1. Individual work-related behavioral management.
 2. Job coaching.
 3. On-the-job or work-related crisis intervention.
 4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
 5. Consumer-directed attendant care services as defined in subrule 78.43(13).
 6. Assistance with time management.
 7. Assistance with appropriate grooming.
 8. Employment-related supportive contacts.
 9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
 10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) Home and vehicle modification. Covered home and 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.
 - (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 department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.
- f. 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.
- 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 consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

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 \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

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.

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 a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). 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 services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized rehabilitative goals and are reflected in a rehabilitative plan which focuses on general rehabilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with

understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 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 one-hour units 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 only in the member's home; in a registered child development home; in 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 one hour.

78.43(15) Consumer choices option. The consumer choices option 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. 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 brain injury 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. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) 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.

(4) 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. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15) "b"(2) or the utilization adjustment factor in subparagraph 78.43(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) 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 or goods 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 service worker.

(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 service worker.

(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 78.43(15) "d." 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.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(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 78.43(15)"d." The savings plan shall meet the requirements in paragraph 78.43(15)"f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (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.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. 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 accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. 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 service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(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 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 shall be consistent with rates 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.

- (4) Authorize payment for optional service components identified in the individual budget.

- (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. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (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 what responsibilities the representative shall have.

- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.

- (2) Select employees from a worker registry.

- (3) Verify employee qualifications.

- (4) Specify additional employee qualifications.

- (5) Determine employee duties.

- (6) Determine employee wages and benefits.

- (7) Schedule employees.

- (8) Train and supervise employees.

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 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.

l. 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) Enter the individual budget into the Web-based tracking system chosen by the department and enter 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.

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]

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) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

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. The services must be cost-effective and necessary to prevent institutionalization.

a. Providers must demonstrate proficiency in delivery of the services in the member's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training.

(1) All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan.

(2) The member shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the member.

b. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

c. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of members unable to eat solid foods.

(2) Assistance with intravenous therapy which is 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 bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions 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.

d. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the person or agency that will provide the components of the attendant care services.

(2) Determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.46(2) Home and vehicle modification. Covered home and 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.
- (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 department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized,

competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

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 \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

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.

78.46(5) Transportation. Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) Consumer choices option. The consumer choices option 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. 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 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 physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) 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.

(4) 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. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6) "b"(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6) "b"(2) or the utilization adjustment factor in subparagraph 78.46(6) "b"(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case

manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) 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 or goods 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 service worker.

(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 service worker.

(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 78.46(6) "d." 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.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(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 78.46(6) "d." The savings plan shall meet the requirements in paragraph 78.46(6) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (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.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. 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 accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. 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 service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(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 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 shall be consistent with rates 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.
- (4) Authorize payment for waiver goods and services optional service components identified in the individual budget.
- (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. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (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 what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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 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) Enter the individual budget into the Web-based tracking system chosen by the department and enter 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.

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]

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 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

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.* Rescinded IAB 5/10/06, effective 7/1/06.
- 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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

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.* Rescinded IAB 5/10/06, effective 7/1/06.
- 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.

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 consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) General service standards. All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

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.

78.52(3) Family and community support services. Family and community support services shall support the consumer and the consumer'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 consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer 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 consumer's interdisciplinary team pursuant to 441—83.127(249A).

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 consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer 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 consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer'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 consumer 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 identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted 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.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)“a”(1).

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 consumer care.

f. A unit of family and community support services is one hour.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the consumer 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 consumer 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 the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

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 “usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

a. Respite care shall not 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.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. 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.

e. 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.

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11]

[Filed 3/11/70; amended 3/20/74]

[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]

[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]

[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]

[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]

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

[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]

[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]

[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]

[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]

[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]

[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]

- [Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]
- [Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
- [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
- [Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
- [Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
- [Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]
- [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
- [Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
- [Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
- [Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
- [Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
- [Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
- [Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
- [Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
- [Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 6/1/79]
- [Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 8/29/79]
- [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
- [Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
- [Filed emergency 9/6/79 after Notice 7/11/79—published 10/3/79, effective 10/1/79]
- [Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
- [Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
- [Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
- [Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
- [Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
- [Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
- [Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
- [Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
- [Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
- [Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
- [Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
- [Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
- [Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
- [Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
- [Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
- [Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
- [Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
- [Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
- [Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
- [Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
- [Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
- [Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
- [Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83][◇]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]

- [Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]◊
- [Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]◊
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
- [Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
- [Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
- [Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
- [Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
- [Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
- [Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
- [Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed 5/29/87, Notices 4/8/87, 4/22/87—published 6/17/87, effective 8/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 8/28/87, Notices 6/17/87, 7/15/87—published 9/23/87, effective 11/1/87]
- [Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88¹]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
- [Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
- [Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]

- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
- [Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]
- [Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90]²
- [Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
- [Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]
- [Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
- [Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]
- [Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]
- [Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]³
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]⁴
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
- [Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92][◇]
- [Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
- [Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]
- [Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]
- [Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]
- [Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]
- [Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]
- [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
- [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
- [Filed emergency 7/14/93—published 8/4/93, effective 8/1/93]

- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed 9/17/93, Notice 8/4/93—published 10/13/93, effective 12/1/93]
- [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
- [Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
- [Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]
- [Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]
- [Filed 9/15/94, Notices 7/6/94, 8/3/94—published 10/12/94, effective 12/1/94]
- [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/5/95]
- [Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]
- [Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]
- [Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95^o—published 12/6/95, effective 2/1/96]
- [Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
- [Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
- [Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 1/15/97, Notice 12/4/96—published 2/12/97, effective 4/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 7/9/97, Notice 5/21/97—published 7/30/97, effective 10/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notice 11/19/97—published 2/11/98, effective 4/1/98]
- [Filed 4/8/98, Notices 2/11/98, 2/25/98—published 5/6/98, effective 7/1/98]
- [Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
- [Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
- [Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 3/1/99]
- [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
- [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
- [Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 6/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 10/13/99, Notice 6/30/99—published 11/3/99, effective 1/1/00]
- [Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]

- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]
- [Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed 10/11/00, Notice 4/19/00—published 11/1/00, effective 1/1/01]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
- [Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 7/4/01]
- [Filed 5/9/01, Notices 1/24/01, 3/7/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01][◊]
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]
- [Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]
- [Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
- [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02][◊]
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02][◊]
- [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02⁵]
- [Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]
- [Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]
- [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
- [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
- [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
- [Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
- [Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
- [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
- [Filed emergency 8/15/02—published 9/4/02, effective 9/1/02]
- [Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
- [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
- [Filed emergency 11/18/02—published 12/11/02, effective 12/15/02][◊]
- [Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
- [Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]
- [Filed emergency 1/9/03—published 2/5/03, effective 2/1/03][◊]
- [Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]
- [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03][◊]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03][◊]
- [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
- [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
- [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04][◊]
- [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]
- [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 10/21/05—published 11/9/05, effective 11/1/05]

- [Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]^o
 - [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
 - [Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]
 - [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
 - [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
 - [Filed 5/12/06, Notice 3/15/06—published 6/7/06, effective 8/1/06]
 - [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
 - [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
 - [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
 - [Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
 - [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]
 - [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
 - [Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]
- [Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
 - [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
 - [Filed without Notice 7/20/07—published 8/15/07, effective 10/1/07]
 - [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
- [Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
- [Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]
 - [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
- [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
 - [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
 - [Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]
 - [Filed emergency 8/18/08—published 9/10/08, effective 9/1/08]
- [Filed emergency 8/18/08 after Notice 7/2/08—published 9/10/08, effective 10/1/08]
 - [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
- [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
 - [Filed 10/14/08, Notice 8/13/08—published 11/5/08, effective 1/1/09]
- [Filed emergency 11/12/08 after Notice 9/10/08—published 12/3/08, effective 12/1/08]
 - [Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
 - [Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09]
 - [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
- [Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
- [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]⁷
- [Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09]
 - [Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09]
 - [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
 - [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
- [Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10]
- [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
- [Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10]
- [Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10]

[Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
[Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10]
[Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
[Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11]
[Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11]
[Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11]
[Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]

- ◇ Two or more ARCs
- 1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
- 2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
- 3 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.
- 4 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.
- 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**.
- 6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- 7 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.

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.

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 Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Effective July 1, 2009, providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

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 retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred.

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 service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for 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.

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 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
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.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	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 FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or \$21.57 per half-day, \$42.93 per full day, or \$64.38 per extended day if no Veterans Administration contract. For intellectual disability waiver: County contract rate or, in the absence of a contract rate, \$28.73 per half-day, \$57.36 per full day, or \$73.13 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Initial one-time fee: \$48.29. Ongoing monthly fee: \$37.56.
Portable locator system	Fee schedule	One equipment purchase: \$300. Initial one-time fee: \$48.29. Ongoing monthly fee: \$37.56.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%. For intellectual disability waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of \$19.31 per hour.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver: \$80.85 per visit. For intellectual disability waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed \$80.85 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed \$296.94 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	\$32.91 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	\$17.56 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	\$32.91 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	\$17.56 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	\$12.79 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	\$12.79 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Adult day care	Fee schedule	\$12.79 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	\$12.79 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	\$12.79 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	\$12.79 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	\$12.79 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	\$7.52 per half hour.
8. Home-delivered meals	Fee schedule	\$7.52 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	For elderly waiver: \$1,010 lifetime maximum. For intellectual disability waiver: \$5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: \$6,060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	\$8.04 per unit.
13. Assistive devices	Fee schedule	\$107.30 per unit.
14. Senior companion	Fee schedule	\$6.44 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	\$19.70 per hour not to exceed the daily rate of \$113.80 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	For elderly waiver only: \$1,089.08 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed \$35.79 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, \$13.47 per hour not to exceed the daily rate of \$78.56 per day.
16. Counseling		
Individual:	Fee schedule	\$10.52 per unit.
Group:	Fee schedule	\$42.06 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)"d."	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	\$34.11 per hour, \$76.91 per day not to exceed the maximum daily ICF/MR per diem less 2.5%.
19. Supported employment: Activities to obtain a job:		

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Job development	Fee schedule	\$886.28 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$886.28 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of \$34.11 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of \$34.11 per hour for all activities other than personal care and services in an enclave setting. Maximum of \$19.31 per hour for personal care. Maximum of \$6.04 per hour for services in an enclave setting. Total not to exceed \$2,811.62 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	\$6,060 per year.
21. Behavioral programming	Fee schedule	\$10.52 per 15 minutes.
22. Family counseling and training	Fee schedule	\$42.06 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: \$47.01 per day, \$23.51 per half day, or \$12.88 per hour. For the intellectual disability waiver: County contract rate or, in absence of a contract rate, \$47.01 per day, \$23.51 per half day, or \$12.88 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Child development home or center	Fee schedule	\$12.79 per hour.
Supported community living provider	Retrospectively limited prospective rate	\$34.11 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR less 2.5%.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, \$12.88 per hour, \$31.35 per half-day, or \$62.68 per day.
27. Environmental modifications and adaptive devices	Fee schedule	\$6,060 per year.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	\$34.11 per hour.
29. In-home family therapy	Fee schedule	\$91.29 per hour.
30. Financial management services	Fee schedule	\$64.01 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	\$14.77 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour or \$105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	\$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	\$9.91 per hour, \$24.11 per half-day, or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of \$34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	\$6.19 per hour for services in an enclave setting; \$19.81 per hour for personal care; and \$34.98 per hour for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
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 11/30/09 less 5%.
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 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	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 11/30/09 less 5%.
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 11/30/09 less 5%.
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 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”(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	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
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>
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) "a"	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	\$4.34 dispensing fee. (See 79.1(8) "a," "b," and "e.")
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa less 5%.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; 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—88.14(249A)	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.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.

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 Web site. 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.

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.

“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.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

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) Rescinded IAB 7/6/05, effective 7/1/05.

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 \$16,000. 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.

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 and psychiatric units. 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) Rescinded IAB 5/12/93, effective 7/1/93.

(3) 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.

(4) 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.

(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 “y.”

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph “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 \$51 million and the actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise.

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 all hospitals 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. 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.

(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 \$8,210,006. 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. 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.

(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 \$14,415,396. 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.

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.

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.

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.

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.

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.

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.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

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 \$6,890,959. 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, is a voting member of the National Association of Children's Hospitals and Related Institutions, 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.

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 audits 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."

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. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph "g"; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph "g."

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph "g."

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph "g."

- (4) The submitted charge, representing the provider's usual and customary charge for the drug.
- b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:
- (1) The estimated acquisition cost, defined:
1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph "g"; or
2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph "g."
- (2) The submitted charge, representing the provider's usual and customary charge for the drug.
- c. No payment shall be made for sales tax.
- d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.
- e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph "a" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.
- f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.
- g. For services rendered on or after July 1, 2010, the professional dispensing fee is \$4.34 or the pharmacy's usual and customary fee, whichever is lower.
- h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."
- i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8) "a"(3) and 79.1(8) "c" and for the efficient operation of the pharmacy benefit.
- (1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.
- (2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.
- j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) HCBS consumer choices financial management.

a. *Monthly allocation.* A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13) "b," 78.37(16) "b," 78.38(9) "b," 78.41(15) "b," 78.43(15) "b," or 78.46(6) "b."

b. *Cost settlement.* The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall

perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

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 for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

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 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.

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 supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver 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 the waiver.

(4) Financial information shall be based on the agency'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. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) 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 noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) 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.

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, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) 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 "d."

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph "f."

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services rendered July 1, 2010, through June 30, 2011, revenues exceeding 100 percent of adjusted actual costs shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 100 percent of actual costs 30 days after notice is given by the department will have the revenues over 100 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

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.

“International classifications of diseases—fourth edition, ninth revision (ICD-9)” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“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 OPSS 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 (OPSS) 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.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

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 OPSS 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 OPSS 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 OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPSS 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 OPSS 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 OPSS APC or any other Medicaid payment system.</p>

F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
G	<p>Pass-through drugs and biologicals</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	<p>Pass-through device categories</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	<p>Non-pass-through drugs and biologicals</p> <p>Therapeutic radiopharmaceuticals</p>	<p>If covered by Iowa Medicaid, the item is:</p> <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. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	<p>Influenza vaccine</p> <p>Pneumococcal pneumonia vaccine</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	<p>Items and services not billable to the Medicare fiscal intermediary</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>

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>
V	Clinic or emergency department visit	<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>

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 that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(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) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

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. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

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. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

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 all 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. 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.

(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 \$2,776,336. 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. Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

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 Dental Terminology, Third Edition (CDT-3).

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 for inpatient and outpatient hospital services. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“Crossover claim” means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital 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 prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“Medicaid reimbursement” means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

“Medicare payment amount” means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(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 shall 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 shall be 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.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant

to paragraph “b” and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph “b.” The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) Reimbursement for remedial services. Reimbursement for remedial services 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.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, the department 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.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial 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. 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 case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)“d.” Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) Effective July 1, 2009, a unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member’s comprehensive service plan must identify and reflect the need for this amount of supervision. The provider’s documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. 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 that meets the requirement of paragraph 79.1(24) "b," the department 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) 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. 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.

79.1(25) Reimbursement for 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).

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, 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) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled into 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.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(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.

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]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient 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 withholding of all payments due a provider until the resolution of the matter in dispute between the provider 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 provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) Grounds for sanctioning providers. Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider’s peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers’ compensation, crippled children’s services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider’s patients.

79.2(3) Sanctions. The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective

on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

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

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

79.2(4) Imposition and extent of sanction.

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

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

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

79.2(5) Scope of sanction.

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

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

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

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

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

79.2(7) Notice of violation. Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements,

or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

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

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

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

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

79.3(1) *Financial (fiscal) records.*

- a. A provider of service shall maintain records as necessary to:
 - (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
 - (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

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

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. 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 and 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 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," or 441—paragraph 77.46(5) "i," or 441—subparagraph 78.9(10) "a"(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. 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.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(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 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). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services unit requests providers to submit records for review. (See paragraph 79.4(2) "b.")

- (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.
- (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.
- (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.
- (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.
- (25) Remedial services and rehabilitation services for adults with a chronic mental illness:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (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 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. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (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.
- (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. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.
 4. Prior authorization documentation.
 5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

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.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

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]

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 of the provider 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 surveillance and utilization review services 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, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
 Reviewer Name & Phone Number: _____
 Provider Name: _____
 Provider Number: _____
 Provider Type: _____

Please sign this form and return it with the information requested.
 Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number
-----------	-------	------------------

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

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

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

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

c. 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.

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.

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

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

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

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

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

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. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, 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 and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

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

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

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

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

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

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

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

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

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

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

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

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

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

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

e. The advice of an appropriate professional consultant.

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

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

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

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

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

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

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

- e.* Be eligible for federal financial participation unless specifically covered by state law or rule.
- f.* Be within the scope of the licensure of the provider.
- g.* Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may

request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

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

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

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

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

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

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

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

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

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

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

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

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

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

441—79.14(249A) Provider enrollment.

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

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Surveillance and Utilization Review Services 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.

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 Section 4201 of the ARRA, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. 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 July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate 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 July 28, 2010, eligible providers may elect to use either:

- (1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or
- (2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the “12-month period selected by the state” shall mean the state 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 following criteria:

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, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children’s hospital, defined as a separately certified children’s hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

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 covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume.

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 HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, 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 EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at <https://secureapp.dhs.state.ia.us/impa/>. The applicant shall use the Web site 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, the eligible provider 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 National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. 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 Web site. Providers shall access the Web site 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]

[Filed March 11, 1970]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]

[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]

[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]

[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]

[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]

[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]

- [Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
- [Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
- [Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
- [Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88¹]
- [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]^o
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
- [Filed 12/22/88, Notices 11/16/88^o—published 1/11/89, effective 3/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90²]
- [Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
- [Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
- [Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]
- [Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]

- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notices 7/11/90^o—published 9/5/90, effective 11/1/90]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
 - [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
 - [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
 - [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
 - [Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
 - [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91³]
 - [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
 - [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
 - [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
 - [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92⁴]
 - [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
 - [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
 - [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
 - [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
 - [Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]
 - [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
 - [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
 - [Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
 - [Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
 - [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]
 - [Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
 - [Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]
 - [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
 - [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
 - [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
 - [Filed 6/11/93, Notice 4/28/93—published 7/7/93, effective 9/1/93]
 - [Filed emergency 6/25/93—published 7/21/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
 - [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
 - [Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
 - [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
 - [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
 - [Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]
 - [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
 - [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed 3/10/94, Notices 1/19/94, 2/2/94—published 3/30/94, effective 6/1/94]^o
 - [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
 - [Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
 - [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]
 - [Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]

- [Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]◇
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]
- [Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]
- [Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
- [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
- [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
- [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
- [Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 6/10/99, Notice 5/5/99—published 6/30/99, effective 9/1/99]
- [Filed 7/15/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]
- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
- [Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
- [Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
- [Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]◇
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
- [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]◇

- [Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
 - [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02⁵]
 - [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
 - [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
 - [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
 - [Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]
 - [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02⁵]
 - [Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
 - [Filed 8/15/02, Notice 6/12/02—published 9/4/02, effective 11/1/02]
 - [Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 11/1/02]
 - [Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]
 - [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
 - [Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
 - [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
 - [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]◇
 - [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]◇
 - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◇
 - [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
 - [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
 - [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]◇
 - [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
- [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]◇
 - [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
 - [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
 - [Filed emergency 6/17/05—published 7/6/05, effective 6/25/05]
 - [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]◇
 - [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]
 - [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
 - [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
 - [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
 - [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
 - [Filed 6/16/06, Notice 4/26/06—published 7/5/06, effective 9/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
 - [Filed 8/10/06, Notice 2/15/06—published 8/30/06, effective 11/1/06]
 - [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
 - [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
 - [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
 - [Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
 - [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
 - [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed emergency 8/9/07 after Notice 7/4/07—published 8/29/07, effective 8/10/07]
 - [Filed 8/9/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]
 - [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
 - [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
 - [Filed emergency 10/10/07—published 11/7/07, effective 10/10/07]

- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
 [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
 [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
 [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
 [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
 [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
 [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
 [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
 [Filed ARC 7835B (Notice ARC 7627B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
 [Filed Emergency ARC 7937B, IAB 7/1/09, effective 7/1/09]
 [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]⁷
 [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
 [Filed ARC 8206B (Notice ARC 7938B, IAB 7/1/09), IAB 10/7/09, effective 11/11/09]
 [Filed ARC 8262B (Notice ARC 8084B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
 [Filed ARC 8263B (Notice ARC 8059B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
 [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
 [Filed Emergency ARC 8647B, IAB 4/7/10, effective 3/11/10]
 [Filed Emergency ARC 8649B, IAB 4/7/10, effective 3/11/10]
 [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
 [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]
 [Filed ARC 9176B (Notice ARC 8900B, IAB 6/30/10), IAB 11/3/10, effective 12/8/10]
 [Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]
 [Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
 [Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]

⁰ Two or more ARCs

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 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.

³ 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.

⁴ 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.

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**.

⁶ 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.

⁷ 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.

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

441—80.1(249A) The fiscal agent function in medical assistance. Rescinded IAB 5/25/05, effective 7/1/05.

441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

80.2(1) Electronic submission. Providers are encouraged to submit claims electronically whenever possible.

a. Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

b. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

c. Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

d. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-92, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

b. All other nursing facilities and intermediate care facilities for the mentally retarded shall file claims on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. Providers who send an Explanation of Medicare Benefits or a crossover claim for Medicare beneficiaries to the Iowa Medicaid enterprise are exempt from filing these forms for those beneficiaries.

80.2(3) Providers shall purchase or copy their supplies of forms CMS-1450 and CMS-1500 for use in billing.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11]

441—80.3(249A) Payment from other sources.

80.3(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.3(2) *Third-party liability.* When a third-party liability for medical expenses exists, this resource shall be utilized before the Medicaid program makes payment unless:

a. The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This “pay and chase” provision applies to claims for:

- (1) Prenatal care,
- (2) Preventive pediatric services, and
- (3) All services provided to a person for whom there is court-ordered medical support.

b. Otherwise authorized by the department.

80.3(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

This rule is intended to implement Iowa Code chapter 249A.
[ARC 7547B, IAB 2/11/09, effective 3/18/09]

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim where the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim.

80.4(2) Claim adjustments. A provider's 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 order to have the adjustment considered.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

441—80.5(249A) Authorization process.

80.5(1) Identification cards. The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to members for use in securing medical and health services available under the program except as provided in 441—76.6(249A).

a. The department shall issue the Medical Assistance Eligibility Card:

- (1) When the member's eligibility is initially determined.
- (2) Annually thereafter.
- (3) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.5(2) Third-party liability. Rescinded IAB 2/11/09, effective 3/18/09.
[ARC 7547B, IAB 2/11/09, effective 3/18/09]

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) Medical assistance corrective payments. Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

80.6(2) Assignment. Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) Business agent of provider. Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

- a.* Related to the cost of processing the billing.
- b.* Not related on a percentage or other basis to the amount that is billed or collected.
- c.* Not dependent upon the collection of the payment.

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

[Filed March 11, 1970; amended September 5, 1973]

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

[Filed 12/9/76, Notice 11/3/76—published 12/29/76, effective 2/2/77]

[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]

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

[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]

[Filed emergency 5/20/83—published 6/8/83, effective 6/1/83]

[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]

[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]

[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]

[Filed emergency 5/31/84 after Notice 4/11/84—published 6/20/84, effective 7/1/84]

[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]

[Filed 4/28/86, Notice 2/26/86—published 5/21/86, effective 7/1/86]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]

[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]

[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]

[Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]

[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]

- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]
- [Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
- [Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
- [Filed emergency 1/16/92 after Notice 11/29/91—published 2/5/92, effective 3/1/92]
- [Filed 3/12/92, Notice 2/5/92—published 4/1/92, effective 7/1/92]
- [Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01][◇]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
- [Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
- [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
- [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed ARC 7547B (Notice ARC 7355B, IAB 11/19/08), IAB 2/11/09, effective 3/18/09]
- [Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]

[◇] Two or more ARCs

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.

“*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.

“*Department’s accounting firm*” means the firm on contract with the department to calculate nursing facility rates and provide other accounting services as requested.

“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.

“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 Part 483, as amended to September 23, 1992, 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.

“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 \$1.5 million. The \$1.5 million 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 \$1.5 million threshold.

“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.

“*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).

“*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.

“*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 21 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.

“*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]

441—81.2 Rescinded, effective 11/21/79.

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 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. Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) *Skilled nursing care level of need.* Rescinded IAB 7/11/01, effective 7/1/01.

81.3(3) *Screening.* All persons, regardless of the source of payment, seeking admission to a nursing facility shall also be screened by the IME medical services unit to determine if mental illness, mental retardation, or a related condition is present. The Iowa Medicaid program will cover the cost of this screening through the managed mental health contractor.

a. Final approval for initial admissions and continued stay of persons with mental illness, mental retardation, or a related condition is determined by the department of human services, division of mental health and disability services.

b. Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the division of mental health and disability services that the person’s treatment needs will be or are being met.

81.3(4) *Special care level of need.* Rescinded IAB 3/20/91, effective 3/1/91.

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]

441—81.4(249A) Arrangements with residents.

81.4(1) *Resident care agreement.* Rescinded IAB 12/6/95, effective 2/1/96.

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 subrules 81.13(2) "a" and 81.13(6) "c.")

81.5(1) *Notice.* When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator shall promptly notify the local office of the department. This shall be done in sufficient time to permit a social service worker 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.

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 department's accounting firm. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report to the department's accounting firm. Costs for patient care services shall be reported, 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. The financial and statistical report shall be submitted in an electronic format approved by the department. 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 statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. 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.

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports to the department's accounting firm no later than three months after the close of the facility's established fiscal year. The Iowa Veterans Home shall submit the report to the department's accounting firm no later than three months after the close of each six-month period of the facility's established fiscal year. Failure to submit a report that meets the requirements of this rule within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

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 department's accounting firm 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.

(4) Rescinded IAB 9/8/10, effective 8/12/10.

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 public assistance recipients.* Census figures of public assistance recipients 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 are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

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) Each facility which supplies transportation services as defined in Iowa Code section 601J.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 601J and 820—[09,A] chapter 2 of the department of transportation rules at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division 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. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.

(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.

i. Management fees 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. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to 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. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

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 fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

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."

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. 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) Facility-requested rate adjustment. A facility may request a rate adjustment for a period of time no more than 18 months prior to the facility's rate effective date. The request for adjustment shall be made to the department's accounting firm.

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 department's accounting firm of the date its 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-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-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned 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. 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-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-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-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-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-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-operated 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-operated 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-operated 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-operated 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-operated nursing facility patient-day-weighted median.

(2) For non-state-operated 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-operated 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-operated 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-operated 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-operated 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-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-operated 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-operated 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-operated 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-operated 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-operated 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-operated 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-owned 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
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

Standard	Measurement Period	Value	Source
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
Subcategory: Resident Satisfaction			
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. 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.	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
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	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
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	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	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	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55% 10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

Standard	Measurement Period	Value	Source
<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
Subcategory: Nationally Reported Quality Measures			
<p>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.</p>	12-month period ending September 30 of the payment period	<p>3 points if one-half to one standard deviation below the mean percentage of occurrences</p> <p>5 points if one standard deviation or more below the mean percentage of occurrences</p>	IME medical services unit report based on MDS data as reported by CMS
<p>Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.</p>	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

Standard	Measurement Period	Value	Source
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
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 Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification 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.

(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 for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

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, 100 Army Post Road, 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.

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.

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).

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.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse nursing facilities for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph “*b*” and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph “*b*.” The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year or by a mutually acceptable schedule consistent with Medicare interim payment schedules.

d. Application of savings. Effective May 1, 2003, savings in Medicaid reimbursements attributable to the limits on nursing facility crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

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 \$10 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, Iowa Code chapter 249K, and 2009 Iowa Code Supplement chapter 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]

441—81.7(249A) Continued review. The IME medical services unit shall review Medicaid members' need of continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."
[ARC 8445B, IAB 1/13/10, effective 12/11/09]

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

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) Rescinded IAB 8/9/89, effective 10/1/89.

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. Effective December 1, 2009, 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, 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. In-state nursing facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care as determined by the peer review organization shall receive reimbursement for the care of these patients equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component

limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit factor pursuant to subparagraph 81.6(16)“f”(3). Facilities may continue to receive reimbursement at this rate for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled care criteria for those 30 days.

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 which 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, 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 except for those specified in 441—78.1(2)“f.”

(5) Fees charged by medical professionals for services requested by the facility which 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 which meet the Medicare definition of medical necessity and are provided by vendors enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Therapy services.

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances which 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.

81.10(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

81.10(7) *Comparative charges between private pay and Medicaid residents.* Rescinded IAB 2/6/02, effective 4/1/02.

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]

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 may be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039.

a. When payment is made, the facility will receive a copy of Form 470-0039, Iowa Medicaid Long-Term Care Claim. The white copy of the form shall be signed and returned to the Iowa Medicaid enterprise as a claim for the next month. If the claim is submitted electronically, the facility will receive remittance advice of the claims paid.

b. When there has been a new admission or a discharge, the facility shall submit Form 470-0039 with the changes noted. When a change is necessary to adjust a previously paid claim, the facility shall submit Form 470-0040, Credit/Adjustment Request. Adjustments to electronically 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."

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department 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 local office of the department.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

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.

k. Rescinded IAB 12/6/95, effective 2/1/96.

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. Rescinded IAB 2/3/93, effective 4/1/93.

b. Rescinded IAB 2/3/93, effective 4/1/93.

c. Rescinded IAB 2/3/93, effective 4/1/93.

d. Rescinded IAB 2/3/93, effective 4/1/93.

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.

f. Rescinded IAB 2/3/93, effective 4/1/93.

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, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release 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.

5. Rescinded IAB 3/4/92, effective 4/8/92.

i. Mail. The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, 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.

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 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 ASCII 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 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. Preadmission screening for mentally ill individuals and individuals with mental retardation.

(1) A nursing facility shall not admit a new resident with mental illness or mental retardation unless the division of mental health and disability services has approved the admission, based on an independent physical and mental health evaluation. This evaluation shall be reviewed by the IME medical services unit before admission to determine whether the individual requires the level of services provided by the facility because of the physical and mental condition of the individual. If the individual requires nursing facility level of services, the individual shall receive specialized services for mental illness or mental retardation.

(2) Definition. For purposes of this rule:

1. An individual is considered to have "mental illness" if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

2. An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition as described in 42 CFR 435.1009.

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 or hearing impairment 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 rehabilitative services.

a. Provision of services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, 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. Qualifications. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel.

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]

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. Field auditors of the department of inspections and appeals, or representatives 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. Field auditors of the department of inspections and appeals or representatives 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.

441—81.15(249A) Nurse aide training and testing programs. Rescinded IAB 12/9/92, effective 2/1/93.

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 training and competency evaluation approved by the department of inspections and appeals if the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

a. At least 60 hours were substituted for 75 hours; and

b. The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or

c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours' duration; or

d. 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

e. 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.

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).

(3) Rescinded IAB 10/7/98, effective 12/1/98.

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 testing 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 by the department of inspections and appeals, it shall, at a minimum:

(1) Consist of no less than 75 clock hours of training.

(2) Include at least the subjects specified in 81.16(3).

(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

(5) Meet the following requirements for 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 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 may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.

(6) Contain information regarding competency evaluation through written or oral and skills testing.

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) No 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 be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.
 - (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 not 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 aides for the course, books, and tests.
 2. Divide the total arrived at in No. 1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.
 3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the 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.

441—81.17(249A) Termination procedures. Rescinded IAB 5/10/95, effective 7/1/95.

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.

81.18(4) *Failure to meet requirements for participation.* Rescinded IAB 5/10/95, effective 7/1/95. This rule is intended to implement Iowa Code section 249A.4.

441—81.19(249A) Criteria related to the specific sanctions. Rescinded IAB 5/10/95, effective 7/1/95.

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. 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-operated 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.

81.20(4) Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8995B, IAB 8/11/10, effective 9/15/10]

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 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 date of eligibility is given on the Facility Card, Form 470-0371. 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.

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 Supplement section 249A.30A.

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.

81.52(4) *Penalties collected by the department.* Rescinded IAB 3/9/11, effective 4/1/11.
[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. Payment for the cost of relocating residents to other facilities;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents; and
4. Funding of projects to improve the quality of life or quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

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.

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

[Filed June 21, 1973; amended June 3, 1975]

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

[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 5/1/77]

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

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

[Filed 11/7/78, Notice 4/19/78—published 11/29/78, effective 1/3/79]

[Filed 6/5/79, Notice 4/4/79—published 6/27/79, effective 8/1/79]

[Filed 8/2/79, Notice 2/21/79—published 8/22/79, effective 9/26/79]

[Filed 9/27/79, Notice 7/25/79—published 10/17/79, effective 11/21/79]

[Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]

[Filed 10/24/79, Notice 9/5/79—published 11/14/79, effective 12/19/79]

[Filed 2/14/80, Notice 8/22/79—published 3/5/80, effective 4/9/80]

[Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]

[Filed 6/4/80, Notice 4/2/80—published 6/25/80, effective 7/30/80]

[Filed 7/3/80, Notice 4/16/80—published 7/23/80, effective 8/27/80]

[Filed 12/19/80, Notice 10/29/80—published 1/7/81, effective 2/11/81]

[Filed 2/12/81, Notice 1/7/81—published 3/4/81, effective 4/8/81]

[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]

[Filed 7/23/81, Notice 5/27/81—published 8/19/81, effective 9/23/81]

[Filed 11/20/81, Notice 10/14/81—published 12/9/81, effective 2/1/82]

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

[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]

[Filed 7/1/82, Notice 4/28/82—published 7/21/82, effective 9/1/82]

- [Filed 8/20/82, Notice 6/23/82—published 9/15/82, effective 10/20/82]
- [Filed 9/23/82, Notice 8/4/82—published 10/13/82, effective 12/1/82]
- [Filed emergency 1/14/83—published 2/2/83, effective 1/14/83]
- [Filed 3/25/83, Notice 1/19/83—published 4/13/83, effective 6/1/83]
- [Filed 5/20/83, Notice 4/13/83—published 6/8/83, effective 8/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed 9/19/83, Notice 4/27/83—published 10/12/83, effective 12/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 3/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
- [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed 6/14/85, Notice 5/8/85—published 7/3/85, effective 9/1/85]
- [Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed 10/18/85, Notice 8/28/85—published 11/6/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
- [Filed 12/22/86, Notice 10/22/86—published 1/14/87, effective 3/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 4/22/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
- [Filed 6/9/88, Notice 4/20/88—published 6/29/88, effective 9/1/88]
- [Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
- [Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
- [Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
- [Filed 3/16/90, Notice 11/15/90—published 4/4/90, effective 6/1/90]
- [Filed emergency 6/19/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notices 3/7/90, 5/30/90—published 8/8/90, effective 10/1/90¹]
- [Filed 8/16/90, Notice 6/27/90—published 9/5/90, effective 11/1/90]
- [Filed 9/28/90, Notices 7/11/90, 8/8/90—published 10/17/90, effective 12/1/90²]
- [Filed emergency 11/14/90—published 12/12/90, effective 12/1/90]
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91]
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 10/10/91, Notice 8/21/91—published 10/30/91, effective 1/1/92]
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
- [Filed without Notice 5/14/92—published 6/10/92, effective 7/15/92³]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]

- [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed 1/14/93, Notice 12/9/92—published 2/3/93, effective 4/1/93]
- [Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93⁴]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
- [Filed emergency 4/12/95—published 5/10/95, effective 4/12/95]
- [Filed 4/13/95, Notice 3/1/95—published 5/10/95, effective 7/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed 11/16/95, Notice 9/27/95—published 12/6/95, effective 2/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed emergency 5/13/98—published 6/3/98, effective 6/22/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
- [Filed 7/15/98, Notice 6/3/98—published 8/12/98, effective 10/1/98]
- [Filed emergency 8/12/98—published 9/9/98, effective 8/12/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/29/98—published 10/7/98, effective 12/1/98]
- [Filed 10/14/98, Notice 9/9/98—published 11/4/98, effective 1/1/99]
- [Filed 11/10/98, Notice 8/26/98—published 12/2/98, effective 2/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 8/12/99, Notices 5/5/99, 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
- [Filed 4/12/00, Notice 3/8/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]
- [Filed 1/9/02, Notice 10/31/01—published 2/6/02, effective 3/13/02]
- [Filed 1/9/02, Notice 11/28/01—published 2/6/02, effective 4/1/02]
- [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02⁵]
- [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
- [Filed 2/13/03, Notice 12/25/02—published 3/5/03, effective 5/1/03]
- [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
- [Filed emergency 11/19/03—published 12/10/03, effective 12/1/03]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
- [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
- [Filed emergency 5/12/06—published 6/7/06, effective 6/1/06]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]

[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]
 [Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
 [Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
 [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
 [Filed emergency 11/14/07 after Notice 9/26/07—published 12/5/07, effective 11/15/07]
 [Filed 4/10/08, Notice 1/30/08—published 5/7/08, effective 7/1/08]
 [Filed without Notice 7/9/08—published 7/30/08, effective 9/3/08]
 [Filed 10/14/08, Notice 7/30/08—published 11/5/08, effective 12/10/08]
 [Filed ARC 8258B (Notice ARC 8086B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]
 [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
 [Filed Emergency After Notice ARC 8445B (Notice ARC 8246B, IAB 10/21/09), IAB 1/13/10,
 effective 12/11/09]
 [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective
 3/11/10]
 [Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
 [Filed Without Notice ARC 8995B, IAB 8/11/10, effective 9/15/10]
 [Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]
 [Filed Emergency After Notice ARC 9402B (Notice ARC 9157B, IAB 10/20/10), IAB 3/9/11,
 effective 4/1/11]

- 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 165
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY PROGRAM
Rescinded IAB 9/8/10, effective 9/1/10

CHAPTER 166
QUALITY IMPROVEMENT INITIATIVE GRANTS

441—166.1(249A) Definitions.

“*Eligible entities*” means nursing facilities, state agencies, nursing facility advocacy groups, and other nursing facility stakeholder groups.

“*Nursing facility*” means a Medicaid-enrolled facility that is defined in 441—81.1(249A) as “facility.”

“*Quality improvement initiative*” or “*initiative*” means an innovative project that prevents noncompliance or promotes compliance with state or federal requirements for nursing facilities and that directly or indirectly benefits nursing facility residents by enhancing their quality of life or quality of care.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—166.2(249A) Availability of grants. At the beginning of each calendar year, the department shall set aside an annual amount from the civil money penalty fund established pursuant to Iowa Code section 249A.19 to be awarded in the form of grants to eligible entities for approved quality improvement initiatives. At no time shall the grant set-aside cause the civil money penalty fund to drop below \$1 million.

166.2(1) In any calendar year in which sufficient funds are available in the civil money penalty fund to support quality improvement initiative grants, the department shall issue a notice for applications for grants.

166.2(2) There is no entitlement to any funds available for grants awarded pursuant to this chapter. The department may award grants to the extent funds are available and, within its discretion, to the extent that applications are approved.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—166.3(249A) Requirements for applicants. Eligible entities wishing to apply for quality improvement initiative grants must meet the following requirements:

166.3(1) Eligible entities may submit an application on behalf of a specific facility, on behalf of a group of facilities, or on behalf of a stakeholder group. However, grant funds awarded shall be distributed to one distinct entity that shall be contractually responsible for the funds.

166.3(2) The applicant must demonstrate the capacity to carry out the initiative for which the grant is requested.

166.3(3) At the time of the application, a facility applicant must not have:

- a. Any pending enforcement actions that could result in the closure of the facility;
- b. Any outstanding sanctions by the Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services; or
- c. Any outstanding or unresolved Class I violations.

166.3(4) An applicant previously awarded a quality improvement initiative grant that failed to achieve that initiative’s intended goals or outcomes shall be ineligible to apply for a period of five years following that grant award. However, a grant may be considered if the applicant’s inability to complete the initiative was due to circumstances beyond the applicant’s control.

166.3(5) An applicant may receive a maximum of two grants within a five-year period.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—166.4(249A) Requirements for initiatives. Grants are available only for quality improvement initiatives that are outside the scope of normal operations for the nursing facility or other applicant. Grants cannot be used as replacement funding for goods or services that the applicant already offers.

166.4(1) The applicant must be able to identify:

- a. Areas in need of improvement, including staff education or training needs not available through current corporate or facility contract employment; and

b. Efficient uses of the quality improvement initiative grant to improve the quality of life or quality of care of nursing facility residents.

166.4(2) Grants may be awarded for:

- a.* Short-term quality improvement initiatives (three years or less), and
- b.* Initiatives with a longer term that involve collaborative efforts of state government and various stakeholders.

166.4(3) The applicant shall not submit a request for or receive a grant for the same type of initiative previously awarded a grant.

166.4(4) Except for a one-time initiative, grant awards shall be restricted to initiatives that will be self-sustaining once implemented. Costs to maintain the initiative may be considered allowable costs on the nursing facility's financial and statistical report, subject to 441—subrule 81.10(1) and rule 441—81.6(249A).

166.4(5) Quality improvement initiative grants are not available for the following:

- a.* General operations or administrative salaries.
- b.* Capital improvements, construction projects or other activities that would increase square footage or result in an increase in the assessed value of any property.
- c.* Facility maintenance activities intended to meet the minimum standards for nursing facilities set forth in 481—Chapter 61.
- d.* Goods or services for which the applicant or others are already obligated to pay.
- e.* Vendor payments and payroll obligations for a facility's normal operations or for fulfillment of state or federal requirements.
- f.* Costs related to travel, bonuses or other direct employee benefits.
- g.* Costs that are not specifically outlined in the applicant's grant application or are already included in the facility's cost report.
- h.* Projects, programs, goods or services that are unrelated to improving the quality of life or quality of care of nursing facility residents.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—166.5(249A) Applications. Eligible entities shall apply for quality improvement initiative grants using Form 470-4869, Grant Award Application. Applications may be accessed electronically through the Iowa Medicaid enterprise Web site, www.ime.state.ia.us/Providers.

166.5(1) Grant applications must be received by the Iowa Medicaid enterprise between February 1 and April 30 of any calendar year in which grant funds are available. Grant applications submitted before or after this period shall not be considered.

166.5(2) To be considered, each application must include, at a minimum, the following:

- a.* A description of the initiative's vision or goal. The application must identify how the grant will improve the quality of care or quality of life of nursing facility residents.
- b.* The objectives or expected outcomes of the initiative.
- c.* An implementation plan.
- d.* An education plan. For initiatives intended to provide education or training to stakeholders, the applicant shall submit a plan for the development and execution of the training curriculum.
- e.* A sustainability plan. The application shall describe how the initiative is a one-time initiative or will be self-sustaining once the grant implementation period has ended.
- f.* A budget, with competitive quotes. Applicants must include three quotes for the cost of equipment, construction and labor for the quality improvement initiative. The quotes shall be from businesses that comply with federal, state and local laws as required for the health and safety of the residents of the nursing facility.
- g.* A monitoring plan. The application shall describe how the applicant will monitor and evaluate ongoing progress toward meeting the initiative's stated goals.
- h.* The qualifications of professionals and other staff involved in the initiative.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—166.6(249A) Awarding of grants. Grants will be awarded beginning July 1 of each calendar year in which grant funds are available.

166.6(1) A grant award review committee shall be appointed by the state Medicaid director. The committee shall review and evaluate all complete grant applications submitted within the required time frame.

166.6(2) Applications shall be evaluated using the following criteria (indicated on Form 470-4869, Grant Award Application):

- a. Vision or goal: 5 points.
- b. Description of initiative: 20 points.
- c. Effect on quality of care or quality of life of residents: 20 points.
- d. Objectives and outcomes: 20 points.
- e. Implementation plan: 25 points.
- f. Education plan: 5 points.
- g. Sustainability: 5 points.

166.6(3) Each grant application must score at least 85 points on the evaluation criteria for the application to be recommended to the department director for an award.

166.6(4) The department shall comply with the Centers for Medicare and Medicaid Services (CMS) guidance on whether specific categories of civil money penalty use require federal approval. The department shall submit the project plan for each grant the department intends to award, along with any required documentation, to CMS to seek approval or denial of the proposed project.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—166.7(249A) Grant requirements. Grant awards are subject to the following general requirements.

166.7(1) Contract. Grants for approved applications shall be awarded through a contract entered into by the department and the applicant. Grant funds shall be distributed to grantees in quarterly increments.

166.7(2) Progress report. The grantee shall submit quarterly progress reports following the date of the award until completion of the initiative. A grantee that fails to submit a quarterly progress report shall forfeit any future grant award distributions.

166.7(3) Final report. The grantee must submit a final report to the bureau of long term care of the Iowa Medicaid enterprise within 60 days of completion of the initiative.

a. The report shall be submitted on Form 470-4950, Grant Award Final Report.
b. The final report must provide evidence of successful completion of the quality improvement initiative and must address the following:

- (1) The purpose of the grant,
- (2) The expected outcomes of the initiative,
- (3) The actual outcomes of the initiative,
- (4) The number of residents who benefited from the initiative,
- (5) The status of the action plan for sustainability if the initiative will continue beyond the grant funding.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

These rules are intended to implement Iowa Code section 249A.19.

[Filed Emergency After Notice ARC 9402B (Notice ARC 9157B, IAB 10/20/10), IAB 3/9/11, effective 4/1/11]

CHAPTER 11
PROCEDURE FOR CONTESTED CASES INVOLVING PERMITS
TO CARRY WEAPONS AND ACQUIRE FIREARMS

481—11.1(17A,724) Definitions.

“*Agency*” means the commissioner of public safety or the sheriff of the county in which the aggrieved party resides.

“*Applicant*” means a person who has applied for a permit to carry weapons or acquire firearms.

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5).

“*Division*” means the division of administrative hearings of the Iowa department of inspections and appeals.

“*Party*” means each person or agency named or admitted as a party.

“*Permittee*” means a person who has received a permit to carry weapons or acquire firearms.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.2(724) Appeals. An applicant or permittee may appeal a decision by an agency to deny an application for a permit to carry weapons or acquire firearms or to suspend or revoke a permit to carry weapons or acquire firearms.

11.2(1) *Written appeal.* The appeal shall be in writing and should state the reasons for rebutting the denial, suspension, or revocation.

11.2(2) *Filing of appeal.* Within 30 days of the applicant’s or permittee’s receipt of the agency’s decision, the applicant or permittee shall file the appeal, a copy of the agency’s written decision, and a fee of \$10 with the Iowa Department of Inspections and Appeals, Division of Administrative Hearings, 502 East 9th Street, Des Moines, Iowa 50319.

11.2(3) *Service on the agency.* The applicant or permittee shall serve a copy of the appeal on the agency at the time the appeal is filed with the division.

11.2(4) *Denial of appeal.* The division may deny any appeal that does not meet each of the requirements in subrules 11.2(1) to 11.2(3).

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.3(17A,724) Notice of hearing. The division shall prepare and serve the notice of hearing.

11.3(1) The notice of hearing shall contain the following information:

- a. A statement of the time, place, and nature of the hearing;
- b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the agency decision on appeal;
- d. Identification of the parties;
- e. Reference to the procedural rules governing the contested case proceeding;
- f. Identification of the administrative law judge, including the judge’s address and telephone number; and
- g. Notification that failure to appear and participate in the contested case proceeding may result in the entry of a default judgment.

11.3(2) Service of the notice of hearing shall be accomplished by first-class mail.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.4(17A,724) Agency record.

11.4(1) Upon receipt of a copy of the notice of hearing, the agency shall file with the division:

- a. A copy of all documents used by the agency in reaching the decision; and
- b. A form identifying the name, address, and telephone number of the agency’s contact person or attorney representative.

11.4(2) The agency shall provide to the applicant or permittee a copy of all documents used by the agency in reaching the decision.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.5(17A) Contested case hearing. The hearing shall be conducted pursuant to the standards established in Iowa Code chapter 17A for contested case hearings. The hearing shall be held by telephone conference call, unless a party to the proceeding requests an in-person hearing from the administrative law judge no later than five days before the hearing. All in-person hearings shall be held at the division's headquarters in Des Moines, Iowa. If the administrative law judge grants an in-person hearing, the administrative law judge may allow one party to appear by telephone.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.6(17A) Service and filing of documents.

11.6(1) When service is required. Every document filed in a contested case proceeding shall be served on each party of record. Service shall be made by delivering or mailing a copy to the party's last-known address.

11.6(2) Filing. All documents in the contested case proceeding shall be filed with the administrative law judge. A document is deemed filed at the time it is received by the division. A document is deemed to be served when mailed by first-class mail, so long as there is proof of mailing.

11.6(3) Proof of mailing. Proof of mailing includes a legible United States Postal Service postmark on the envelope and a certificate of service, a notarized affidavit, or certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of the state of Iowa, that on (date of mailing or hand-delivery), I mailed or hand-delivered copies (describe document(s)) addressed to (opposing party) by depositing the same in a United States post office mailbox with correct postage properly affixed, or I hand-delivered copies.

(Date)

(Signature)

11.6(4) Filing by electronic means. The administrative law judge may permit service or filing of particular documents by facsimile, electronic mail, or similar electronic means. When permitted, service by facsimile, electronic mail, or similar electronic means is complete upon transmission.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.7(17A) Witness lists and exhibits. No later than five days before the hearing, a party shall serve on all parties and the administrative law judge a witness list and a copy of any exhibit(s) the party intends to introduce into evidence during the contested case proceeding. If a party fails to serve on all parties and the administrative law judge a witness list or any exhibit five days before the hearing, the party may be precluded from calling the witness at hearing or introducing the exhibit(s) into the record at hearing.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.8(17A) Evidence. The administrative law judge shall rule on the admissibility of evidence and may take official notice of facts in accordance with applicable requirements of law. Evidence in the proceeding shall be confined to the issues for which the parties received notice prior to the hearing.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.9(17A) Withdrawals and dismissals. A request for withdrawal or dismissal of the appeal may be made with the division prior to the hearing. Either request must be in writing or secured on the record.

11.9(1) Withdrawals. An applicant or permittee who requested a contested case proceeding may request a withdrawal of the appeal. Upon receipt of a request for withdrawal of the appeal, the administrative law judge shall issue an order dismissing the appeal and closing the case.

11.9(2) Dismissals. An agency may request a dismissal of the appeal by agreeing to grant the entire relief sought by the applicant or permittee. The administrative law judge shall review a request for dismissal to determine whether it grants all relief requested in the appeal. If the request grants all relief requested in the appeal, the administrative law judge shall issue an order dismissing the appeal, ordering the agency to grant the relief requested, and closing the case.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.10(17A) Default. If a party fails to appear after proper service of notice, the administrative law judge may enter a default order against the party or may proceed with the hearing and make a decision in the absence of the party.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.11(10A) Costs. Costs of the contested case hearing shall be paid by the agency.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.12(724) Probable cause. Probable cause to deny an initial or renewal application for a permit to carry weapons or acquire firearms or to suspend or revoke a permit to carry weapons or acquire firearms means a reasonable ground exists for supposing that the basis for the denial, suspension or revocation is well-founded.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

481—11.13(724) Clear and convincing evidence. Clear and convincing evidence means there is no serious or substantial doubt about the correctness of the conclusion drawn from the evidence.

[ARC 9299B, IAB 12/29/10, effective 1/1/11; ARC 9400B, IAB 3/9/11, effective 4/13/11]

These rules are intended to implement Iowa Code section 724.21A.

[Filed Emergency ARC 9299B, IAB 12/29/10, effective 1/1/11]

[Filed ARC 9400B (Notice ARC 9298B, IAB 12/29/10), IAB 3/9/11, effective 4/13/11]

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.

CHAPTERS 1 to 3

Reserved

CHAPTER 4

BOARD ADMINISTRATIVE PROCESSES

- 4.1(17A) Definitions
- 4.2(17A) Purpose of board
- 4.3(17A,147,272C) Organization of board and proceedings
- 4.4(17A) Official communications
- 4.5(17A) Office hours
- 4.6(21) Public meetings
- 4.7(147) Licensure by reciprocal agreement
- 4.8(147) Duplicate certificate or wallet card
- 4.9(147) Reissued certificate or wallet card
- 4.10(17A,147,272C) License denial
- 4.11(272C) Audit of continuing education
- 4.12(272C,83GA,SF2325) Automatic exemption
- 4.13(272C) Grounds for disciplinary action
- 4.14(272C) Continuing education exemption for disability or illness
- 4.15(147,272C) Order for physical, mental, or clinical competency examination or alcohol or drug screening
- 4.16(252J,261,272D) Noncompliance rules regarding child support, loan repayment and nonpayment of state debt

CHAPTER 5

FEES

- 5.1(147,152D) Athletic training license fees
- 5.2(147,158) Barbering license fees
- 5.3(147,154D) Behavioral science license fees
- 5.4(151) Chiropractic license fees
- 5.5(147,157) Cosmetology arts and sciences license fees
- 5.6(147,152A) Dietetics license fees
- 5.7(147,154A) Hearing aid dispensers license fees
- 5.8(147) Massage therapy license fees
- 5.9(147,156) Mortuary science license fees
- 5.10(147,155) Nursing home administrators license fees
- 5.11(147,148B) Occupational therapy license fees
- 5.12(147,154) Optometry license fees
- 5.13(147,148A) Physical therapy license fees
- 5.14(148C) Physician assistants license fees
- 5.15(147,149) Podiatry license fees
- 5.16(147,154B) Psychology license fees
- 5.17(147,152B) Respiratory care license fees
- 5.18(147,154E) Sign language interpreters and transliterators license fees
- 5.19(147,154C) Social work license fees
- 5.20(147) Speech pathology and audiology license fees

CHAPTER 6
PETITIONS FOR RULE MAKING

- 6.1(17A) Petition for rule making
6.2(17A) Inquiries

CHAPTER 7
AGENCY PROCEDURE FOR RULE MAKING

- 7.1(17A) Adoption by reference

CHAPTER 8
DECLARATORY ORDERS
(Uniform Rules)

- 8.1(17A) Petition for declaratory order
8.2(17A) Notice of petition
8.3(17A) Intervention
8.5(17A) Inquiries

CHAPTER 9
COMPLAINTS AND INVESTIGATIONS

- 9.1(272C) Complaints
9.2(272C) Report of malpractice claims or actions or disciplinary actions
9.3(272C) Report of acts or omissions
9.4(272C) Investigation of complaints or reports
9.5(17A,272C) Issuance of investigatory subpoenas
9.6(272C) Peer review committees
9.7(17A) Appearance

CHAPTER 10
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

- 10.1(17A,22) Definitions
10.3(17A,22) Requests for access to records
10.5(17A,22) Request for treatment of a record as a confidential record and its withholding
from examination
10.6(17A,22) Procedures by which additions, dissents, or objections may be entered into certain
records
10.9(17A,22) Disclosures without the consent of the subject
10.10(17A,22) Routine use
10.11(17A,22) Consensual disclosure of confidential records
10.12(17A,22) Release to subject
10.13(17A,22) Availability of records
10.14(17A,22) Personally identifiable information
10.15(22) Other groups of records routinely available for public inspection
10.16(17A,22) Applicability

CHAPTER 11
CONTESTED CASES

- 11.1(17A) Scope and applicability
11.2(17A) Definitions
11.3(17A) Time requirements
11.4(17A) Probable cause
11.5(17A) Legal review
11.6(17A) Statement of charges and notice of hearing
11.7(17A,272C) Legal representation

11.8(17A,272C)	Presiding officer in a disciplinary contested case
11.9(17A)	Presiding officer in a nondisciplinary contested case
11.10(17A)	Disqualification
11.11(17A)	Consolidation—severance
11.12(17A)	Answer
11.13(17A)	Service and filing
11.14(17A)	Discovery
11.15(17A,272C)	Issuance of subpoenas in a contested case
11.16(17A)	Motions
11.17(17A)	Prehearing conferences
11.18(17A)	Continuances
11.19(17A,272C)	Hearing procedures
11.20(17A)	Evidence
11.21(17A)	Default
11.22(17A)	Ex parte communication
11.23(17A)	Recording costs
11.24(17A)	Interlocutory appeals
11.25(17A)	Applications for rehearing
11.26(17A)	Stays of agency actions
11.27(17A)	No factual dispute contested cases
11.28(17A)	Emergency adjudicative proceedings
11.29(17A)	Appeal
11.30(272C)	Publication of decisions
11.31(272C)	Reinstatement
11.32(17A,272C)	License denial

CHAPTER 12
INFORMAL SETTLEMENT

12.1(17A,272C)	Informal settlement
----------------	---------------------

CHAPTER 13
DISCIPLINE

13.1(272C)	Method of discipline
13.2(272C)	Discretion of board
13.3(272C)	Conduct of persons attending meetings

CHAPTERS 14 and 15
Reserved

CHAPTER 16
IMPAIRED PRACTITIONER REVIEW COMMITTEE

16.1(272C)	Definitions
16.2(272C)	Purpose
16.3(272C)	Composition of the committee
16.4(272C)	Organization of the committee
16.5(272)	Eligibility
16.6(272C)	Meetings
16.7(272C)	Terms of participation
16.8(272C)	Noncompliance
16.9(272C)	Practice restrictions
16.10(272C)	Limitations
16.11(272C)	Confidentiality

CHAPTER 17
MATERIALS FOR BOARD REVIEW

17.1(147) Materials for board review

CHAPTER 18
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

18.1(17A,147,272C) Definitions
 18.2(17A,147,272C) Scope of chapter
 18.3(17A,147,272C) Applicability of chapter
 18.4(17A,147,272C) Criteria for waiver or variance
 18.5(17A,147,272C) Filing of petition
 18.6(17A,147,272C) Content of petition
 18.7(17A,147,272C) Additional information
 18.8(17A,147,272C) Notice
 18.9(17A,147,272C) Hearing procedures
 18.10(17A,147,272C) Ruling
 18.11(17A,147,272C) Public availability
 18.12(17A,147,272C) Summary reports
 18.13(17A,147,272C) Cancellation of a waiver
 18.14(17A,147,272C) Violations
 18.15(17A,147,272C) Defense
 18.16(17A,147,272C) Judicial review

CHAPTERS 19 and 20
Reserved

BARBERS

CHAPTER 21
LICENSURE

21.1(158) Definitions
 21.2(158) Requirements for licensure
 21.3(158) Examination requirements for barbers and barber instructors
 21.4 Reserved
 21.5(158) Licensure by endorsement
 21.6 Reserved
 21.7(158) Temporary permits to practice barbering
 21.8(158) Demonstrator's permit
 21.9(158) License renewal
 21.10 Reserved
 21.11(158) Requirements for a barbershop license
 21.12(158) Barbershop license renewal
 21.13 to 21.15 Reserved
 21.16(17A,147,272C) License reactivation
 21.17(17A,147,272C) Reactivation of a barbershop license
 21.18(17A,147,272C) License reinstatement

CHAPTER 22
SANITATION

22.1(158) Definitions
 22.2(158) Posting of sanitation rules and inspection report
 22.3(147) Display of licenses
 22.4(158) Responsibilities of barbershop owner and supervisor
 22.5(158) Building standards

22.6(158)	Barbershops in residential buildings
22.7(158)	Barbershops adjacent to other businesses
22.8(142D,158)	Smoking
22.9(158)	Personal cleanliness
22.10(158)	Universal precautions
22.11(158)	Minimum equipment and supplies
22.12(158)	Disinfecting nonelectrical instruments and equipment
22.13(158)	Disinfecting electrical instruments
22.14(158)	Instruments and supplies that cannot be disinfected
22.15(158)	Semisolids, dusters, and styptics
22.16(158)	Disposal of materials
22.17(158)	Prohibited hazardous substances and use of products
22.18(158)	Proper protection of neck
22.19(158)	Proper laundering and storage
22.20(158)	Pets
22.21(158)	Records

CHAPTER 23 BARBER SCHOOLS

23.1(158)	Definitions
23.2(158)	Licensing for barber schools
23.3(158)	School license renewal
23.4(272C)	Inactive school license
23.5	Reserved
23.6(158)	Physical requirements for barber schools
23.7(158)	Minimum equipment requirements
23.8(158)	Course of study requirements
23.9(158)	Instructors
23.10(158)	Students
23.11(158)	Attendance requirements
23.12(158)	Graduate of a barber school
23.13(147)	Records requirements
23.14(158)	Public notice
23.15(158)	Apprenticeship

CHAPTER 24 CONTINUING EDUCATION FOR BARBERS

24.1(158)	Definitions
24.2(158)	Continuing education requirements
24.3(158,272C)	Standards

CHAPTER 25 DISCIPLINE FOR BARBERS, BARBER INSTRUCTORS, BARBERSHOPS AND BARBER SCHOOLS

25.1(158)	Definitions
25.2(272C)	Grounds for discipline
25.3(158,272C)	Method of discipline
25.4(272C)	Discretion of board

CHAPTERS 26 to 30 Reserved

BEHAVIORAL SCIENTISTS

CHAPTER 31

LICENSURE OF MARITAL AND FAMILY THERAPISTS
AND MENTAL HEALTH COUNSELORS

31.1(154D)	Definitions
31.2(154D)	Requirements for permanent and temporary licensure
31.3(154D)	Examination requirements
31.4(154D)	Educational qualifications for marital and family therapists
31.5(154D)	Clinical experience requirements for marital and family therapists
31.6(154D)	Educational qualifications for mental health counselors
31.7(154D)	Clinical experience requirements for mental health counselors
31.8(154D)	Licensure by endorsement
31.9	Reserved
31.10(147)	License renewal
31.11	Reserved
31.12(147)	Licensee record keeping
31.13 to 31.15	Reserved
31.16(17A,147,272C)	License reactivation
31.17(17A,147,272C)	License reinstatement
31.18(154D)	Marital and family therapy and mental health counselor services subject to regulation

CHAPTER 32

CONTINUING EDUCATION FOR MARITAL AND
FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

32.1(272C)	Definitions
32.2(272C)	Continuing education requirements
32.3(154D,272C)	Standards
32.4(154D,272C)	Audit of continuing education report

CHAPTER 33

DISCIPLINE FOR MARITAL AND FAMILY THERAPISTS
AND MENTAL HEALTH COUNSELORS

33.1(154D)	Definitions
33.2(154D,272C)	Grounds for discipline
33.3(147,272C)	Method of discipline
33.4(272C)	Discretion of board

CHAPTERS 34 to 40

Reserved

CHIROPRACTIC

CHAPTER 41

LICENSURE OF CHIROPRACTIC PHYSICIANS

41.1(151)	Definitions
41.2(151)	Requirements for licensure
41.3(151)	Examination requirements
41.4(151)	Educational qualifications
41.5(151)	Temporary certificate
41.6(151)	Licensure by endorsement
41.7	Reserved
41.8(151)	License renewal

- 41.9 to 41.13 Reserved
 41.14(17A,147,272C) License reactivation
 41.15(17A,147,272C) License reinstatement

CHAPTER 42

COLLEGES FOR CHIROPRACTIC PHYSICIANS

- 42.1(151) Definitions
 42.2(151) Board-approved chiropractic colleges
 42.3(151) Practice by chiropractic interns and chiropractic residents
 42.4(151) Approved chiropractic preceptorship program
 42.5(151) Approved chiropractic physician preceptors
 42.6(151) Termination of preceptorship

CHAPTER 43

PRACTICE OF CHIROPRACTIC PHYSICIANS

- 43.1(151) Definitions
 43.2(147,272C) Principles of chiropractic ethics
 43.3(514F) Utilization and cost control review
 43.4(151) Chiropractic insurance consultant
 43.5(151) Acupuncture
 43.6 Reserved
 43.7(151) Adjunctive procedures
 43.8(151) Physical examination
 43.9(151) Gonad shielding
 43.10(151) Record keeping
 43.11(151) Billing procedures
 43.12(151) Chiropractic assistants

CHAPTER 44

CONTINUING EDUCATION FOR CHIROPRACTIC PHYSICIANS

- 44.1(151) Definitions
 44.2(272C) Continuing education requirements
 44.3(151,272C) Standards

CHAPTER 45

DISCIPLINE FOR CHIROPRACTIC PHYSICIANS

- 45.1(151) Definitions
 45.2(151,272C) Grounds for discipline
 45.3(147,272C) Method of discipline
 45.4(272C) Discretion of board

CHAPTERS 46 to 59

Reserved

COSMETOLOGISTS

CHAPTER 60

LICENSURE OF COSMETOLOGISTS, ELECTROLOGISTS, ESTHETICIANS,
 MANICURISTS, NAIL TECHNOLOGISTS, AND INSTRUCTORS
 OF COSMETOLOGY ARTS AND SCIENCES

- 60.1(157) Definitions
 60.2(157) Requirements for licensure
 60.3(157) Criteria for licensure in specific practice disciplines
 60.4(157) Practice-specific training requirements

60.5(157)	Licensure restrictions relating to practice
60.6(157)	Consent form requirements
60.7(157)	Licensure by endorsement
60.8(157)	License renewal
60.9(157)	Temporary permits
60.10 to 60.16	Reserved
60.17(17A,147,272C)	License reactivation
60.18(17A,147,272C)	License reinstatement

CHAPTER 61

LICENSURE OF SALONS AND SCHOOLS
OF COSMETOLOGY ARTS AND SCIENCES

61.1(157)	Definitions
61.2(157)	Salon licensing
61.3(157)	Salon license renewal
61.4(272C)	Inactive salon license
61.5(157)	Display requirements for salons
61.6(147)	Duplicate certificate or wallet card for salons
61.7(157)	Licensure for schools of cosmetology arts and sciences
61.8(157)	School license renewal
61.9(272C)	Inactive school license
61.10(157)	Display requirements for schools
61.11	Reserved
61.12(157)	Physical requirements for schools of cosmetology arts and sciences
61.13(157)	Minimum equipment requirements
61.14(157)	Course of study requirements
61.15(157)	Instructors
61.16(157)	Student instructors
61.17(157)	Students
61.18(157)	Attendance requirements
61.19(157)	Accelerated learning
61.20(157)	Mentoring program
61.21(157)	Graduate of a school of cosmetology arts and sciences
61.22(157)	Records requirements
61.23(157)	Classrooms used for other educational purposes
61.24(157)	Public notice

CHAPTER 62

Reserved

CHAPTER 63

SANITATION FOR SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

63.1(157)	Definitions
63.2(157)	Posting of sanitation rules and inspection report
63.3(157)	Responsibilities of salon owners
63.4(157)	Responsibilities of licensees
63.5(157)	Joint responsibility
63.6(157)	Building standards
63.7(157)	Salons in residential buildings
63.8(157)	Salons adjacent to other businesses
63.9(157)	Smoking
63.10(157)	Personal cleanliness
63.11(157)	Universal precautions

63.12(157)	Blood spill procedures
63.13(157)	Disinfecting instruments and equipment
63.14(157)	Instruments and supplies that cannot be disinfected
63.15(157)	Sterilizing instruments
63.16(157)	Sanitary methods for creams, cosmetics and applicators
63.17	Reserved
63.18(157)	Prohibited hazardous substances and use of products and equipment
63.19(157)	Proper protection of neck
63.20(157)	Proper laundering and storage
63.21(157)	Pets
63.22(157)	General maintenance
63.23(157)	Records
63.24(157)	Salons and schools providing electrology or esthetics
63.25(157)	Cleaning and disinfecting circulating and noncirculating tubs, bowls, and spas
63.26(157)	Paraffin wax

CHAPTER 64

CONTINUING EDUCATION FOR COSMETOLOGY ARTS AND SCIENCES

64.1(157)	Definitions
64.2(157)	Continuing education requirements
64.3(157,272C)	Standards

CHAPTER 65

DISCIPLINE FOR COSMETOLOGY ARTS AND SCIENCES LICENSEES,
INSTRUCTORS, SALONS, AND SCHOOLS

65.1(157,272C)	Definitions
65.2(157,272C)	Grounds for discipline
65.3(157,272C)	Method of discipline
65.4(272C)	Discretion of board
65.5(157)	Civil penalties against nonlicensees

CHAPTERS 66 to 80

Reserved

DIETITIANS

CHAPTER 81

LICENSURE OF DIETITIANS

81.1(152A)	Definitions
81.2(152A)	Nutrition care
81.3(152A,272C)	Principles
81.4(152A)	Requirements for licensure
81.5(152A)	Educational qualifications
81.6(152A)	Supervised experience
81.7(152A)	Licensure by endorsement
81.8	Reserved
81.9(152A)	License renewal
81.10 to 81.14	Reserved
81.15(17A,147,272C)	License reactivation
81.16(17A,147,272C)	License reinstatement

CHAPTER 82
CONTINUING EDUCATION FOR DIETITIANS

- 82.1(152A) Definitions
82.2(152A) Continuing education requirements
82.3(152A,272C) Standards

CHAPTER 83
DISCIPLINE FOR DIETITIANS

- 83.1(152A) Definitions
83.2(152A,272C) Grounds for discipline
83.3(152A,272C) Method of discipline
83.4(272C) Discretion of board

CHAPTERS 84 to 99
Reserved

FUNERAL DIRECTORS

CHAPTER 100
PRACTICE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS,
AND CREMATION ESTABLISHMENTS

- 100.1(156) Definitions
100.2(156) Funeral director duties
100.3(156) Permanent identification tag
100.4(142,156) Removal and transfer of dead human remains and fetuses
100.5(135,144) Burial transit permits
100.6(156) Prepreparation and embalming activities
100.7(156) Arranging and directing funeral and memorial ceremonies
100.8(142,156) Unclaimed dead human remains for scientific use
100.9(144) Disinterments
100.10(156) Cremation of human remains and fetuses

CHAPTER 101
LICENSURE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS, AND
CREMATION ESTABLISHMENTS

- 101.1(156) Definitions
101.2(156) Requirements for licensure
101.3(156) Educational qualifications
101.4(156) Examination requirements
101.5(147,156) Internship and preceptorship
101.6(156) Student practicum
101.7(156) Funeral establishment license or cremation establishment license or both establishment licenses
101.8(156) Licensure by endorsement
101.9 Reserved
101.10(156) License renewal
101.11 and 101.12 Reserved
101.13(272C) Renewal of a funeral establishment license or cremation establishment license or both establishment licenses
101.14(272C) Inactive funeral establishment license or cremation establishment license or both establishment licenses
101.15(17A,147,272C) License reinstatement
101.16 and 101.17 Reserved

- 101.18(17A,147,272C) License reactivation
- 101.19(17A,147,272C) License reinstatement

CHAPTER 102

CONTINUING EDUCATION FOR FUNERAL DIRECTORS

- 102.1(272C) Definitions
- 102.2(272C) Continuing education requirements
- 102.3(156,272C) Standards
- 102.4 Reserved
- 102.5(83GA,SF2325) Automatic exemption

CHAPTER 103

DISCIPLINARY PROCEEDINGS

- 103.1(156) Definitions
- 103.2(17A,147,156,272C) Disciplinary authority
- 103.3(17A,147,156,272C) Grounds for discipline against funeral directors
- 103.4(17A,147,156,272C) Grounds for discipline against funeral establishments and cremation establishments
- 103.5(17A,147,156,272C) Method of discipline
- 103.6(17A,147,156,272C) Board discretion in imposing disciplinary sanctions
- 103.7(156) Order for mental, physical, or clinical competency examination or alcohol or drug screening
- 103.8(17A,147,156,272C) Informal discussion

CHAPTER 104

ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

- 104.1(156) Civil penalties against nonlicensees
- 104.2(156) Unlawful practices
- 104.3(156) Investigations
- 104.4(156) Subpoenas
- 104.5(156) Notice of intent to impose civil penalties
- 104.6(156) Requests for hearings
- 104.7(156) Factors to consider
- 104.8(156) Enforcement options

CHAPTERS 105 to 120

Reserved

HEARING AID DISPENSERS

CHAPTER 121

LICENSURE OF HEARING AID DISPENSERS

- 121.1(154A) Definitions
- 121.2(154A) Temporary permits
- 121.3(154A) Supervision requirements
- 121.4(154A) Requirements for initial licensure
- 121.5(154A) Examination requirements
- 121.6(154A) Licensure by endorsement
- 121.7 Reserved
- 121.8(154A) Display of license
- 121.9(154A) License renewal
- 121.10 to 121.13 Reserved
- 121.14(17A,147,272C) License reactivation
- 121.15(17A,147,272C) License reinstatement

CHAPTER 122
CONTINUING EDUCATION FOR HEARING AID DISPENSERS

- 122.1(154A) Definitions
- 122.2(154A) Continuing education requirements
- 122.3(154A,272C) Standards

CHAPTER 123
PRACTICE OF HEARING AID DISPENSING

- 123.1(154A) Definitions
- 123.2(154A) Requirements prior to sale of a hearing aid
- 123.3(154A) Requirements for sales receipt
- 123.4(154A) Requirements for record keeping

CHAPTER 124
DISCIPLINE FOR HEARING AID DISPENSERS

- 124.1(154A,272C) Definitions
- 124.2(154A,272C) Grounds for discipline
- 124.3(154A,272C) Method of discipline
- 124.4(272C) Discretion of board

CHAPTERS 125 to 130
Reserved

MASSAGE THERAPISTS

CHAPTER 131
LICENSURE OF MASSAGE THERAPISTS

- 131.1(152C) Definitions
- 131.2(152C) Requirements for licensure
- 131.3(152C) Educational qualifications
- 131.4(152C) Examination requirements
- 131.5(152C) Temporary licensure of a licensee from another state
- 131.6(152C) Licensure by endorsement
- 131.7 Reserved
- 131.8(152C) License renewal
- 131.9 to 131.13 Reserved
- 131.14(17A,147,272C) License reactivation
- 131.15(17A,147,272C) License reinstatement

CHAPTER 132
MASSAGE THERAPY EDUCATION CURRICULUM

- 132.1(152C) Definitions
- 132.2(152C) Application for approval of massage therapy education curriculum
- 132.3(152C) Curriculum requirements
- 132.4(152C) Student clinical practicum standards
- 132.5(152C) School certificate or diploma
- 132.6(152C) School records retention
- 132.7(152C) Massage school curriculum compliance
- 132.8(152C) Denial or withdrawal of approval

CHAPTER 133

CONTINUING EDUCATION FOR MASSAGE THERAPISTS

- 133.1(152C) Definitions
- 133.2(152C) Continuing education requirements
- 133.3(152C,272C) Continuing education criteria

CHAPTER 134

DISCIPLINE FOR MASSAGE THERAPISTS

- 134.1(152C) Definitions
- 134.2(152C,272C) Grounds for discipline
- 134.3(147,272C) Method of discipline
- 134.4(272C) Discretion of board
- 134.5(152C) Civil penalties

CHAPTERS 135 to 140

Reserved

NURSING HOME ADMINISTRATORS

CHAPTER 141

LICENSURE OF NURSING HOME ADMINISTRATORS

- 141.1(155) Definitions
- 141.2(155) Requirements for licensure
- 141.3(147,155) Examination requirements
- 141.4(155) Educational qualifications
- 141.5(155) Practicum experience
- 141.6(155) Provisional administrator
- 141.7(155) Licensure by endorsement
- 141.8(147,155) Licensure by reciprocal agreement
- 141.9(147,155) License renewal
- 141.10 to 141.14 Reserved
- 141.15(17A,147,272C) License reactivation
- 141.16(17A,147,272C) License reinstatement

CHAPTER 142

Reserved

CHAPTER 143

CONTINUING EDUCATION FOR NURSING HOME ADMINISTRATION

- 143.1(272C) Definitions
- 143.2(272C) Continuing education requirements
- 143.3(155,272C) Standards
- 143.4(155,272C) Audit of continuing education report
- 143.5(155,272C) Automatic exemption
- 143.6(272C) Continuing education exemption for disability or illness
- 143.7(155,272C) Grounds for disciplinary action

CHAPTER 144

DISCIPLINE FOR NURSING HOME ADMINISTRATORS

- 144.1(155) Definitions
- 144.2(155,272C) Grounds for discipline
- 144.3(155,272C) Method of discipline

- 144.4(272C) Discretion of board
 144.5(155) Order for mental, physical, or clinical competency examination or alcohol or drug screening

CHAPTERS 145 to 179

Reserved

OPTOMETRISTS

CHAPTER 180

LICENSURE OF OPTOMETRISTS

- 180.1(154) Definitions
 180.2(154) Requirements for licensure
 180.3(154) Licensure by endorsement
 180.4 Reserved
 180.5(154) License renewal
 180.6 to 180.10 Reserved
 180.11(17A,147,272C) License reactivation
 180.12(17A,147,272C) License reinstatement

CHAPTER 181

CONTINUING EDUCATION FOR OPTOMETRISTS

- 181.1(154) Definitions
 181.2(154) Continuing education requirements
 181.3(154,272C) Standards

CHAPTER 182

PRACTICE OF OPTOMETRISTS

- 182.1(154) Code of ethics
 182.2(154,272C) Record keeping
 182.3(154) Furnishing prescriptions
 182.4(155A) Prescription drug orders

CHAPTER 183

DISCIPLINE FOR OPTOMETRISTS

- 183.1(154) Definitions
 183.2(154,272C) Grounds for discipline
 183.3(147,272C) Method of discipline
 183.4(272C) Discretion of board

CHAPTERS 184 to 199

Reserved

PHYSICAL AND OCCUPATIONAL THERAPISTS

CHAPTER 200

LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

- 200.1(147) Definitions
 200.2(147) Requirements for licensure
 200.3 Reserved
 200.4(147) Examination requirements for physical therapists and physical therapist assistants
 200.5(147) Educational qualifications
 200.6(272C) Supervision requirements
 200.7(147) Licensure by endorsement
 200.8 Reserved

- 200.9(147) License renewal
- 200.10 to 200.14 Reserved
- 200.15(17A,147,272C) License reactivation
- 200.16(17A,147,272C) License reinstatement

CHAPTER 201

PRACTICE OF PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

- 201.1(148A,272C) Code of ethics for physical therapists and physical therapist assistants
- 201.2(147) Record keeping

CHAPTER 202

DISCIPLINE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

- 202.1(148A) Definitions
- 202.2(272C) Grounds for discipline
- 202.3(147,272C) Method of discipline
- 202.4(272C) Discretion of board

CHAPTER 203

CONTINUING EDUCATION FOR PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

- 203.1(272C) Definitions
- 203.2(148A) Continuing education requirements
- 203.3(148A,272C) Standards

CHAPTERS 204 and 205

Reserved

CHAPTER 206

LICENSURE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 206.1(147) Definitions
- 206.2(147) Requirements for licensure
- 206.3(147) Limited permit to practice pending licensure
- 206.4(147) Applicant occupational therapist and occupational therapy assistant
- 206.5(147) Practice of occupational therapy limited permit holders and endorsement applicants prior to licensure
- 206.6(147) Examination requirements
- 206.7(147) Educational qualifications
- 206.8(272C) Supervision requirements
- 206.9(147) Occupational therapy assistant responsibilities
- 206.10(147) Licensure by endorsement
- 206.11 Reserved
- 206.12(147) License renewal
- 206.13 to 206.17 Reserved
- 206.18(17A,147,272C) License reactivation
- 206.19(17A,147,272C) License reinstatement

CHAPTER 207

CONTINUING EDUCATION FOR OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 207.1(148B) Definitions
- 207.2(272C) Continuing education requirements
- 207.3(148B,272C) Standards

CHAPTER 208
PRACTICE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 208.1(148B,272C) Code of ethics for occupational therapists and occupational therapy assistants
208.2(147) Record keeping

CHAPTER 209
DISCIPLINE FOR OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 209.1(148B) Definitions
209.2(272C) Grounds for discipline
209.3(147,272C) Method of discipline
209.4(272C) Discretion of board

CHAPTERS 210 to 219
Reserved

PODIATRISTS

CHAPTER 220
LICENSURE OF PODIATRISTS

- 220.1(149) Definitions
220.2(149) Requirements for licensure
220.3(149) Written examinations
220.4(149) Educational qualifications
220.5(149) Title designations
220.6(147,149) Temporary license
220.7(149) Licensure by endorsement
220.8 Reserved
220.9(149) License renewal
220.10 to 220.14 Reserved
220.15(17A,147,272C) License reactivation
220.16(17A,147,272C) License reinstatement

CHAPTER 221
Reserved

CHAPTER 222
CONTINUING EDUCATION FOR PODIATRISTS

- 222.1(149,272C) Definitions
222.2(149,272C) Continuing education requirements
222.3(149,272C) Standards

CHAPTER 223
PRACTICE OF PODIATRY

- 223.1(149) Definitions
223.2(149) Requirements for administering conscious sedation
223.3(139A) Preventing HIV and HBV transmission
223.4(149) Unlicensed graduate of a podiatric college

CHAPTER 224
DISCIPLINE FOR PODIATRISTS

- 224.1(149) Definitions
224.2(149,272C) Grounds for discipline

- 224.3(147,272C) Method of discipline
 224.4(272C) Discretion of board

CHAPTERS 225 to 239

Reserved

PSYCHOLOGISTS

CHAPTER 240

LICENSURE OF PSYCHOLOGISTS

- 240.1(154B) Definitions
 240.2(154B) Requirements for licensure
 240.3(154B) Educational qualifications
 240.4(154B) Examination requirements
 240.5(154B) Title designations
 240.6(154B) Supervised professional experience
 240.7(154B) Certified health service provider in psychology
 240.8(154B) Exemption to licensure
 240.9(154B) Psychologists' supervision of unlicensed persons in a practice setting
 240.10(147) Licensure by endorsement
 240.11(147) Licensure by reciprocal agreement
 240.12(147) License renewal
 240.13 to 240.17 Reserved
 240.18(17A,147,272C) License reactivation
 240.19(17A,147,272C) License reinstatement

CHAPTER 241

CONTINUING EDUCATION FOR PSYCHOLOGISTS

- 241.1(272C) Definitions
 241.2(272C) Continuing education requirements
 241.3(154B,272C) Standards

CHAPTER 242

DISCIPLINE FOR PSYCHOLOGISTS

- 242.1(154B) Definitions
 242.2(147,272C) Grounds for discipline
 242.3(147,272C) Method of discipline
 242.4(272C) Discretion of board
 242.5(154B) Order for mental, physical, or clinical competency examination or alcohol or drug screening

CHAPTERS 243 to 260

Reserved

RESPIRATORY CARE PRACTITIONERS

CHAPTER 261

LICENSURE OF RESPIRATORY CARE PRACTITIONERS

- 261.1(152B) Definitions
 261.2(152B) Requirements for licensure
 261.3(152B) Educational qualifications
 261.4(152B) Examination requirements
 261.5(152B) Students
 261.6(152B) Licensure by endorsement
 261.7 Reserved

- 261.8(152B) License renewal
- 261.9 to 261.13 Reserved
- 261.14(17A,147,272C) License reactivation
- 261.15(17A,147,272C) License reinstatement

CHAPTER 262

CONTINUING EDUCATION FOR RESPIRATORY CARE PRACTITIONERS

- 262.1(152B,272C) Definitions
- 262.2(152B,272C) Continuing education requirements
- 262.3(152B,272C) Standards
- 262.4(152B,272C) Audit of continuing education report
- 262.5(152B,272C) Automatic exemption
- 262.6(152B,272C) Grounds for disciplinary action
- 262.7(152B,272C) Continuing education exemption for disability or illness

CHAPTER 263

DISCIPLINE FOR RESPIRATORY CARE PRACTITIONERS

- 263.1(152B) Definitions
- 263.2(152B,272C) Grounds for discipline
- 263.3(147,272C) Method of discipline
- 263.4(272C) Discretion of board

CHAPTER 264

Reserved

CHAPTER 265

PRACTICE OF RESPIRATORY CARE PRACTITIONERS

- 265.1(152B,272C) Code of ethics
- 265.2(152B,272C) Intravenous administration

CHAPTERS 266 to 279

Reserved

SOCIAL WORKERS

CHAPTER 280

LICENSURE OF SOCIAL WORKERS

- 280.1(154C) Definitions
- 280.2(154C) Social work services subject to regulation
- 280.3(154C) Requirements for licensure
- 280.4(154C) Written examination
- 280.5(154C) Educational qualifications
- 280.6(154C) Supervised professional practice for the LISW
- 280.7(154C) Licensure by endorsement
- 280.8 Reserved
- 280.9(154C) License renewal
- 280.10 to 280.13 Reserved
- 280.14(17A,147,272C) License reactivation
- 280.15(17A,147,272C) License reinstatement

CHAPTER 281

CONTINUING EDUCATION FOR SOCIAL WORKERS

- 281.1(154C) Definitions
- 281.2(154C) Continuing education requirements
- 281.3(154C,272C) Standards

CHAPTER 282
PRACTICE OF SOCIAL WORKERS

- 282.1(154C) Definitions
282.2(154C) Rules of conduct

CHAPTER 283
DISCIPLINE FOR SOCIAL WORKERS

- 283.1(154B) Definitions
283.2(272C) Grounds for discipline
283.3(147,272C) Method of discipline
283.4(272C) Discretion of board

CHAPTERS 284 to 299

Reserved

SPEECH PATHOLOGISTS AND AUDIOLOGISTS

CHAPTER 300
LICENSURE OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

- 300.1(147) Definitions
300.2(147) Speech pathology and audiology services subject to regulation
300.3(147) Requirements for licensure
300.4(147) Educational qualifications
300.5(147) Examination requirements
300.6(147) Temporary clinical license
300.7(147) Temporary permit
300.8(147) Use of assistants
300.9(147) Licensure by endorsement
300.10 Reserved
300.11(147) License renewal
300.12 to 300.16 Reserved
300.17(17A,147,272C) License reactivation
300.18(17A,147,272C) License reinstatement

CHAPTERS 301 and 302

Reserved

CHAPTER 303
CONTINUING EDUCATION FOR SPEECH PATHOLOGISTS
AND AUDIOLOGISTS

- 303.1(147) Definitions
303.2(147) Continuing education requirements
303.3(147,272C) Standards

CHAPTER 304
DISCIPLINE FOR SPEECH PATHOLOGISTS AND AUDIOLOGISTS

- 304.1(147) Definitions
304.2(272C) Grounds for discipline
304.3(272C) Method of discipline
304.4(272C) Discretion of board

CHAPTERS 305 to 325

Reserved

PHYSICIAN ASSISTANTS

CHAPTER 326

LICENSURE OF PHYSICIAN ASSISTANTS

326.1(148C)	Definitions
326.2(148C)	Requirements for licensure
326.3(148C)	Temporary licensure
326.4(148C)	Licensure by endorsement
326.5	Reserved
326.6(148C)	Examination requirements
326.7(148C)	Educational qualifications
326.8(148C)	Supervision requirements
326.9(148C)	License renewal
326.10 to 326.14	Reserved
326.15(148C)	Use of title
326.16(148C)	Address change
326.17(148C)	Student physician assistant
326.18(148C)	Recognition of an approved program
326.19(17A,147,272C)	License reactivation
326.20(17A,147,272C)	License reinstatement

CHAPTER 327

PRACTICE OF PHYSICIAN ASSISTANTS

327.1(148C)	Duties
327.2(148C)	Prohibition
327.3	Reserved
327.4(148C)	Remote medical site
327.5(147)	Identification as a physician assistant
327.6(147)	Prescription requirements
327.7(147)	Supplying—requirements for containers, labeling, and records

CHAPTER 328

CONTINUING EDUCATION FOR PHYSICIAN ASSISTANTS

328.1(148C)	Definitions
328.2(148C)	Continuing education requirements
328.3(148C,272C)	Standards

CHAPTER 329

DISCIPLINE FOR PHYSICIAN ASSISTANTS

329.1(148C)	Definitions
329.2(148C,272C)	Grounds for discipline
329.3(147,272C)	Method of discipline
329.4(272C)	Discretion of board

CHAPTERS 330 to 350

Reserved

ATHLETIC TRAINERS

CHAPTER 351

LICENSURE OF ATHLETIC TRAINERS

351.1(152D)	Definitions
351.2(152D)	Requirements for licensure
351.3(152D)	Educational qualifications

351.4(152D)	Examination requirements
351.5(152D)	Documentation of physician direction
351.6(152D)	Athletic training plan for direct service
351.7(152D)	Licensure by endorsement
351.8	Reserved
351.9(147)	License renewal
351.10(272C)	Exemptions for inactive practitioners
351.11 and 351.12	Reserved
351.13(272C)	Lapsed licenses
351.14	Reserved
351.15(17A,147,272C)	License reactivation
351.16(17A,147,272C)	License reinstatement

CHAPTER 352

CONTINUING EDUCATION FOR ATHLETIC TRAINERS

352.1(272C)	Definitions
352.2(152D)	Continuing education requirements
352.3(152D,272C)	Standards
352.4(152D,272C)	Audit of continuing education report
352.5 and 352.6	Reserved
352.7(152D,272C)	Continuing education waiver for active practitioners
352.8(152D,272C)	Continuing education exemption for inactive practitioners
352.9	Reserved
352.10(152D,272C)	Reinstatement of inactive practitioners
352.11(272C)	Hearings

CHAPTER 353

DISCIPLINE FOR ATHLETIC TRAINERS

353.1(152D)	Definitions
353.2(152D,272C)	Grounds for discipline
353.3(152D,272C)	Method of discipline
353.4(272C)	Discretion of board

CHAPTERS 354 to 360

Reserved

SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

CHAPTER 361

LICENSURE OF SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

361.1(154E)	Definitions
361.2(154E)	Requirements for licensure
361.3(154E)	Licensure by endorsement
361.4	Reserved
361.5(154E)	License renewal
361.6 to 361.8	Reserved
361.9(17A,147,272C)	License reactivation
361.10(17A,147,272C)	License reinstatement

CHAPTER 362
CONTINUING EDUCATION FOR SIGN LANGUAGE INTERPRETERS AND
TRANSLITERATORS

- 362.1(154E,272C) Definitions
- 362.2(154E,272C) Continuing education requirements
- 362.3(154E,272C) Standards

CHAPTER 363
DISCIPLINE FOR SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

- 363.1(154E) Definitions
- 363.2(154E,272C) Grounds for discipline
- 363.3(147,272C) Method of discipline
- 363.4(272C) Discretion of board

HEARING AID DISPENSERS

CHAPTER 121	LICENSURE OF HEARING AID DISPENSERS
CHAPTER 122	CONTINUING EDUCATION FOR HEARING AID DISPENSERS
CHAPTER 123	PRACTICE OF HEARING AID DISPENSING
CHAPTER 124	DISCIPLINE FOR HEARING AID DISPENSERS

CHAPTER 121

LICENSURE OF HEARING AID DISPENSERS

[Prior to 5/29/02, see 645—120.2(154A) to 120.6(154A) and 120.10(154A)]

645—121.1(154A) Definitions. For purposes of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Board*” means the board of hearing aid dispensers.

“*Department*” means the department of public health.

“*Dispense*” or “*sell*” means a transfer of title or of the right to use by lease, bailment, or any other means, but excludes a wholesale transaction with a distributor or dispenser, and excludes the temporary, charitable loan or educational loan of a hearing aid without remuneration.

“*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.

“*Hearing aid dispenser*” means any person engaged in the fitting, dispensing and the sale of hearing aids and providing hearing aid services or maintenance by means of procedures stipulated by Iowa Code chapter 154A or the board.

“*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.

“*License*” means a license issued by the state to hearing aid dispensers.

“*Licensee*” means any person licensed to practice as a hearing aid dispenser in the state of Iowa.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice as a hearing aid dispenser to an applicant who is or has been licensed in another state.

“*National examination*” means the written licensing examination of the International Hearing Society or its successor organization.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 121.14(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice as a hearing aid dispenser to an applicant who is currently licensed in another state that has a mutual agreement with the Iowa board of hearing aid dispensers to license persons who have the same or similar qualifications to those required in Iowa.

“*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.

“*Temporary permit*” means a permit issued while the applicant is in training to become a licensed hearing aid dispenser.

“*Trainee*” means the holder of a temporary permit.

645—121.2(154A) Temporary permits.

121.2(1) An applicant shall send a completed application and fee to the board office. The application must be accompanied by a statement from the employer, which includes the following information:

- a. The type of supervision which shall be provided to the trainee;
- b. A list of the subjects to be covered;

- c. The books and other training materials to be used for training; and
- d. An outline of the training program to be followed in preparing the trainee for examination.

121.2(2) A temporary permit is valid for one year and shall not be renewable.

121.2(3) The board reserves the right to deny an application for a temporary permit or rescind a temporary permit once issued.

121.2(4) The licensed hearing aid dispenser employing the holder of a temporary permit shall be responsible for the following:

- a. Training of the temporary permit holder;
- b. Evaluating the audiograms and determining which hearing aid and ear mold will best compensate for hearing loss of a particular person; and
- c. Notifying the board within 15 days of the termination of the holder of a temporary permit.
- d. Submitting a report on a board-approved form verifying completion of the supervision and training requirements in accordance with 121.2(1).

645—121.3(154A) Supervision requirements. The supervisor's report must provide assurance of completion of training pursuant to 121.2(1).

121.3(1) Supervision of temporary permit holders. The supervisor(s) shall:

- a. Have a current hearing aid dispenser license that has been valid for the immediately preceding 24 months;
- b. Have two years of actual experience in testing, fitting, and dispensing of hearing aids;
- c. Supervise not more than three trainees with temporary permits at the same time;
- d. For the first 90 days, provide a minimum of 20 hours of direct supervision per week in the physical presence of the trainee;
- e. Provide direct supervision of the trainee before completion of the first 90 days for any client activity that would require dispensing of hearing aids, including evaluation, selection, fitting or selling of hearing aids; and
- f. Cosign all audiometric evaluations and contracts processed by the trainee for the duration of the temporary permit.
- g. Submit, on a board-approved form, a supervision report for trainees prior to taking the board-approved examination. A supervision report is required each time the temporary permit holder submits a request to take the examination.

121.3(2) A trainee with a temporary permit must notify the board in writing within ten days of an interruption of training due to loss of supervision. The trainee shall, within 30 days, obtain a replacement supervisor for continuance of the training period and shall obtain and submit to the board a statement signed by the replacement supervisor, which states that the training program will be maintained.

121.3(3) If a statement by the replacement supervisor is not submitted, the trainee shall revert to new trainee status.

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—121.4(154A) Requirements for initial licensure. The following criteria shall apply to licensure:

121.4(1) The applicant shall complete a board-approved application packet. Application forms may be obtained from the board's Web site (<http://www.idph.state.ia.us/licensure>) or directly from the board office. All applications shall be sent to Board of Hearing Aid Dispensers, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

121.4(2) The 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.

121.4(3) Each application shall be accompanied by the appropriate fees, which include the following:

- a. Application fee payable to the Board of Hearing Aid Dispensers; and
- b. Examination fee payable to the International Hearing Society.

121.4(4) Examination score results must be received from the testing service.

121.4(5) Each applicant must successfully pass the national examination.

121.4(6) Examination candidates who hold a temporary permit are required to submit a supervisory report in accordance with paragraph 121.3(1)“g.”

121.4(7) Licensees who were issued their licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal month two years later.

121.4(8) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

121.4(9) Notification of eligibility for licensure shall be sent to the licensee by the board.

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—121.5(154A) Examination requirements.

121.5(1) The following criteria shall apply to the written examination:

a. The supporting data and documentation must be received at least ten business days prior to the examination with check or money order made payable to the International Hearing Society in the amount specified in the application for the examination fee;

b. Applicants must pass the national examination. The passing score is set by the International Hearing Society.

121.5(2) Applicants who fail the national examination three times must apply to the board to retake the examination.

645—121.6(154A) Licensure by endorsement. An applicant who has been a licensed hearing aid dispenser under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

121.6(1) Submits to the board a completed application;

121.6(2) Pays the licensure fee;

121.6(3) Shows evidence of licensure requirements that are similar to those required in Iowa;

121.6(4) Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) 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.

121.6(5) Provides official verification of one of the following:

a. A passing score on the national examination. For the ten-part examination, the passing score is 70 percent on each subject or 75 percent overall. The International Hearing Society sets the passing score for the five-part competency examination;

b. A passing score on an examination that the board determines is equivalent to the national examination; or

c. Current certification from the National Board for Certification in Hearing Instrument Sciences; and

121.6(6) Provides evidence of:

a. Completing a minimum of 32 continuing education hours within the 24 months prior to application; or

b. Continuing education certificates that verify that the minimum hours of continuing education required by a state(s) in which the licensee is currently licensed have been met; or

c. Current certification from the National Board for Certification in Hearing Instrument Sciences.

645—121.7(154A) Licensure by reciprocal agreement. Rescinded IAB 1/14/09, effective 2/18/09.

645—121.8(154A) Display of license. Persons licensed as hearing aid dispensers shall display their original licenses in a conspicuous public place at the primary site of practice.

645—121.9(154A) License renewal.

121.9(1) The biennial license renewal period for a license to dispense hearing aids shall begin on January 1 of each odd-numbered year and end on December 31 of the next even-numbered year. All licensees shall renew on a biennial basis. The licensee is responsible for renewing the license prior to its expiration.

121.9(2) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—122.2(154A) and the mandatory reporting requirements of subrule 121.9(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.

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 next renewal two years later.

121.9(3) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 125.1(5). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

121.9(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 in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "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 two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

c. A licensee who, in the scope of professional practice or in the course of employment, examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e." Training may be completed through separate courses as identified in paragraphs "a" and "b" or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs "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 645—Chapter 122.

f. The board may select licensees for audit of compliance with the requirements in paragraphs "a" to "e."

121.9(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. 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.

121.9(6) 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 hearing aid dispenser in Iowa until the license is reactivated. A licensee who practices as a hearing aid dispenser 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 9424B, IAB 3/9/11, effective 4/13/11]

645—121.10(272C) Exemptions for inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—121.11(272C) Lapsed licenses. Rescinded IAB 8/31/05, effective 10/5/05.

645—121.12(154A,147) Duplicate certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—121.13(272C) License denial. Rescinded IAB 1/14/09, effective 2/18/09.

645—121.14(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

121.14(1) Submit a reactivation application on a form provided by the board.

121.14(2) Pay the reactivation fee that is due as specified in 645—subrule 125.1(6).

121.14(3) Provide verification of current competence to practice as a hearing aid dispenser by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 32 hours of continuing education within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 64 hours of continuing education within two years of application for reactivation.

645—121.15(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 121.14(17A,147,272C) prior to practicing as a hearing aid dispenser in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 154A and 272C.

[Filed 5/8/02, Notice 3/6/02—published 5/29/02, effective 7/3/02]

[Filed 8/14/03, Notice 5/28/03—published 9/3/03, effective 10/8/03]

[Filed 8/5/05, Notice 5/25/05—published 8/31/05, effective 10/5/05][◇]

[Filed 12/11/08, Notice 9/24/08—published 1/14/09, effective 2/18/09]

[Filed ARC 9424B (Notice ARC 9317B, IAB 12/29/10), IAB 3/9/11, effective 4/13/11]

[◇] Two or more ARCs

CHAPTER 122
CONTINUING EDUCATION FOR HEARING AID DISPENSERS

645—122.1(154A) 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 hearing aid dispensers.

“*Continuing education*” means planned, organized learning acts acquired during initial licensure 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.

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice as a hearing aid dispenser in the state of Iowa.
[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—122.2(154A) Continuing education requirements.

122.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on January 1 of each odd-numbered year and ending on December 31 of the next even-numbered year. Each biennium, each person who is licensed to practice as a hearing aid dispenser in this state shall be required to complete a minimum of 32 hours of continuing education approved by the board. For the 2011-2012 compliance period for license renewal on January 1, 2013, and every renewal biennium thereafter, a minimum of 2 hours shall be in the content areas of Iowa hearing aid dispenser law and rules, or ethics.

122.2(2) Requirements for 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 32 hours of continuing education per biennium for each subsequent license renewal.

122.2(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.

122.2(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.

122.2(5) It is the responsibility of each licensee to finance the cost of continuing education.
[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—122.3(154A,272C) Standards.

122.3(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 the presenters;

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date, place, 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.

122.3(2) *Specific criteria.* Continuing education hours of credit may be obtained by completing the following:

a. Academic coursework if the coursework is offered by an accredited postsecondary educational institution. The maximum number of continuing education hours of credit for academic coursework per biennium is 15 hours with:

1 academic semester hour = 15 continuing education hours; and

1 academic quarter hour = 10 continuing education hours.

b. A maximum of 8 hours of credit may be obtained by independent study, including on-line instruction. Independent study hours are subject to the requirements stated in the rules in this chapter and in 645—Chapter 4.

c. Attending programs, conferences, or business, technical, or professional seminars which enhance a licensee's ability to provide quality hearing health care services.

d. Mandatory reporter training, as specified in 645—subrule 121.9(4). Hours reported for credit shall not exceed the hours required for compliance.

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—122.4(154A,272C) Audit of continuing education report. Rescinded IAB 1/14/09, effective 2/18/09.

645—122.5(154A,272C) Automatic exemption. Rescinded IAB 1/14/09, effective 2/18/09.

645—122.6(154A,272C) Continuing education exemption for disability or illness. Rescinded IAB 1/14/09, effective 2/18/09.

645—122.7(154A,272C) Grounds for disciplinary action. Rescinded IAB 1/14/09, effective 2/18/09.

645—122.8(154A,272C) Continuing education waiver for inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—122.9(154A,272C) Continuing education exemption for disability or illness. Rescinded IAB 8/31/05, effective 10/5/05.

645—122.10(154A,272C) Reinstatement of inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—122.11(272C) Hearings. Rescinded IAB 8/31/05, effective 10/5/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 154A.

[Filed 8/18/00, Notice 5/17/00—published 9/6/00, effective 10/11/00]

[Filed 5/8/02, Notice 3/6/02—published 5/29/02, effective 7/3/02]

[Filed 8/5/05, Notice 5/25/05—published 8/31/05, effective 10/5/05][◇]

[Filed 12/11/08, Notice 9/24/08—published 1/14/09, effective 2/18/09]

[Filed ARC 9424B (Notice ARC 9317B, IAB 12/29/10), IAB 3/9/11, effective 4/13/11]

[◇] Two or more ARCs

CHAPTER 123
PRACTICE OF HEARING AID DISPENSING

645—123.1(154A) Definitions. For the purposes of these rules, the following definitions apply:

“Health history” means a series of questions pertaining to all of the following: client hearing needs and expectations; communication issues; otological conditions; medications; and previous amplification.

“Hearing aid fitting” means any of the following: the measurement of human hearing by any means for the purpose of selections, adaptations, and sales of hearing aids, and the instruction and counseling pertaining thereto, and demonstration of techniques in the use of hearing aids, and the making of earmold impressions as part of the fitting of hearing aids.

“Sales receipt” means a written record that is provided to a person who purchases a hearing aid, that complies with these rules, and that is signed by the purchaser and the licensed hearing aid dispenser. The requirements for the sales receipt may be found in rule 645—123.3(154A).

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—123.2(154A) Requirements prior to sale of a hearing aid.

123.2(1) No hearing aid shall be sold to an individual 18 years of age or older unless the individual:

a. Provides a health history to a licensed hearing aid dispenser who is responsible for reducing the history to written form;

b. Presents a physician statement verifying that a medical evaluation, preferably by a physician specializing in diseases of the ear, has been done within the previous six months and stating the individual’s hearing loss and that the individual may benefit from a hearing aid. In lieu of this requirement, the individual may verify in writing that the individual has been informed that it is in the individual’s best health interests to obtain a medical evaluation by a licensed physician specializing in diseases of the ear, or if no such licensed physician is available in the community, then a duly licensed physician, and that the individual chooses to waive said evaluation; and

c. Is given a hearing examination that utilizes appropriate established procedures and instrumentation for the measurement of hearing and the fitting of hearing aids and that includes, but is not limited to, an assessment of the following: air conduction; bone conduction; masking capability; speech reception thresholds; speech discrimination; uncomfortable loudness levels (UCL) and most comfortable levels (MCL). An examination that includes these procedures within the past 12 months shall be an exception to this requirement if the procedures and results are documented in the client record.

123.2(2) Whenever any of the following conditions are found to exist either from observations by the licensed hearing aid dispenser or person holding a temporary permit or on the basis of information furnished by a prospective hearing aid user, the hearing aid dispenser or person holding a temporary permit shall, prior to fitting and selling a hearing aid to any individual, suggest to that individual in writing that the individual’s best interests would be served if the individual would consult a licensed physician specializing in diseases of the ear, or if no such licensed physician is available in the community, then a duly licensed physician:

a. Visible congenital or traumatic deformity of the ear.

b. History of, or active drainage from the ear within the previous 90 days.

c. History of sudden or rapidly progressive hearing loss within the previous 90 days.

d. Acute or chronic dizziness.

e. Unilateral hearing loss of sudden or recent onset within the previous 90 days.

f. Significant air-bone gap (greater than or equal to 15dB ANSI 500, 1000 and 2000 Hz. average).

g. Obstruction of the ear canal, by structures of undetermined origin, such as foreign bodies, impacted cerumen, redness, swelling, or tenderness from localized infections of the otherwise normal ear canal.

123.2(3) Testing shall not be required in cases in which replacement hearing aids of the same make or model are sold within one year of the original sale.

123.2(4) Except as otherwise provided in these rules, for individuals younger than 18 years of age, all of the requirements stated in these rules are applicable. In addition, the following are required:

a. Written authorization of a parent or legal guardian consenting to the services covered in these rules, and

b. An original signature on all documents required by law or these rules to be signed, including but not limited to, all sales transactions and receipts, required notifications, and warranty agreements.

123.2(5) For individuals 12 years of age or younger, all of the requirements stated in these rules are applicable. In addition, the parent or legal guardian must first present a written, signed recommendation for a hearing aid from a licensed physician specializing in otolaryngology. The recommendation must have been made within the preceding six months. A replacement of an identical hearing aid within one year shall be an exception to this requirement.

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—123.3(154A) Requirements for sales receipt. Upon sale of a hearing aid device, the licensee shall provide to the person a sales receipt, which shall include the following:

1. Licensee's signature.
2. Licensee's business address.
3. Licensee's license number.
4. Client signature and address.
5. Make, model, and serial number of the hearing aid furnished.
6. Statement to the effect that the aid or aids delivered to the purchaser are used or reconditioned, if that is the fact.

7. Full terms of sale, including:

- The date of sale;
- Specific warranty terms, including whether any extended warranty is available through the manufacturer;

- Specific return policy; and
- Whether any trial period is available.

8. The following statement in type no smaller than the largest used in the body copy portion of the receipt: "The purchaser has been advised that any examination or representation made by a licensed hearing aid dispenser in connection with the fitting or selection and selling of this hearing aid is not an examination, diagnosis, or prescription by a person licensed to practice medicine in this state and therefore, must not be regarded as medical opinion or advice."

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

645—123.4(154A) Requirements for record keeping. A licensee shall keep and maintain records in the licensee's office or place of business for a seven-year period.

123.4(1) The records for each person shall include:

- a.* A complete record of each test performed and the results of the test.
- b.* A copy of any written recommendations.
- c.* A copy of medical clearances or waivers.
- d.* A copy of the written sales receipt.
- e.* A copy of terms of sale, including any warranty.
- f.* A written record of any adjustments or services provided on the hearing aid device, including whether such services were provided under warranty or other agreement.

123.4(2) No less than 30 days prior to closure of a licensee's business, the licensee shall provide written notification to clients of the location at which records will be maintained for a period of no less than 30 days following closure and the procedure to obtain those records. The licensee may arrange the transfer of records to another licensee for the purpose of maintenance of the records, provided that all contractual agreements have been satisfied.

[ARC 9424B, IAB 3/9/11, effective 4/13/11]

These rules are intended to implement Iowa Code chapter 154A.

[Filed ARC 9424B (Notice ARC 9317B, IAB 12/29/10), IAB 3/9/11, effective 4/13/11]

CHAPTER 124
DISCIPLINE FOR HEARING AID DISPENSERS
[Prior to 5/29/02, see 645—120.11(272C)]

645—124.1(154A,272C) Definitions.

“*Board*” means the board of hearing aid dispensers.

“*Discipline*” means any sanction the board may impose upon licensees.

“*Licensee*” means a person licensed to practice as a hearing aid dispenser in Iowa.

645—124.2(154A,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—124.3(154A,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

124.2(1) Failure to comply with the current Code of Ethics of the International Hearing Society. The board hereby adopts by reference the current Code of Ethics of the International Hearing Society, available at <http://www.ihinfo.org>.

124.2(2) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, the following:

a. An intentional perversion of the truth in making application for a license to practice in this state;

b. 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

c. 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.

124.2(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 hearing aid dispensers 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 hearing aid dispenser acting in the same or similar circumstances;

d. Failure to conform to the minimal standard of acceptable and prevailing practice of licensed hearing aid dispensers in this state.

124.2(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of hearing aid dispensing or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

124.2(5) Advertising that hearing testing or hearing screening is for the purpose of detection or diagnosis of medical problems or medical screening for referral to a physician.

124.2(6) Failure to place all of the following in an advertisement relating to hearing aids:

a. Hearing aid dispenser’s name.

b. Hearing aid dispenser’s office address.

c. Hearing aid dispenser’s telephone number.

d. The qualifying words in the same size type as the title of the business: “for the purpose of fitting, selection, adaption, and sale of hearing aids.” However, the qualifying words are not required if the advertisement includes the words “hearing test,” “hearing evaluation,” “free hearing test,” “free hearing evaluation,” “hearing measurement,” or “free hearing measurement,” and the title of the business which is advertising appears in the advertisement and includes the words “hearing aid.”

124.2(7) Practice outside the scope of the profession.

124.2(8) The use of untruthful or improbable statements in advertisements. The use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

124.2(9) Except in cases of selling replacement hearing aids of the same make or model within one year of the original sale, a hearing aid shall not be sold without adequate diagnostic testing and evaluation using established procedures to assess hearing needs as defined in 645—Chapter 123. Instruments shall be calibrated to current standards at least annually or more often if necessary. The distributor shall keep with the instruments a certificate indicating the date of calibration.

124.2(10) 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.

124.2(11) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

124.2(12) Falsification of client records.

124.2(13) Acceptance of any fee by fraud or misrepresentation.

124.2(14) Misappropriation of funds.

124.2(15) 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 improper 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.

124.2(16) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice as a hearing aid dispenser. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

124.2(17) Violation of a regulation, rule, or law of this state, another state, or the United States, which relates to the practice of hearing aid dispensing.

124.2(18) 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.

124.2(19) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the individual's practice as a hearing aid dispenser in another state, district, territory or country.

124.2(20) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

124.2(21) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

124.2(22) Engaging in any conduct that subverts or attempts to subvert a board investigation.

124.2(23) Failure to comply with a subpoena issued by the board or failure to cooperate with an investigation of the board.

124.2(24) Failure to respond within 30 days of receipt of communication from the board which was sent by registered or certified mail.

124.2(25) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

124.2(26) Failure to pay costs assessed in any disciplinary action.

124.2(27) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

124.2(28) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

124.2(29) Knowingly aiding, assisting, or advising a person to unlawfully practice as a hearing aid dispenser.

124.2(30) Failure to report a change of name or address within 30 days after the occurrence.

124.2(31) Representing oneself as a licensed hearing aid dispenser when one's license has been suspended or revoked, or when one's license is on inactive status.

124.2(32) Permitting another person to use the licensee's license for any purpose.

124.2(33) Permitting an unlicensed employee or person under the licensee's control to perform activities that require a license.

124.2(34) 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, client, or coworker.
- 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. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
- e. Being adjudged mentally incompetent by a court of competent jurisdiction.

124.2(35) 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.

124.2(36) 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 9424B, IAB 3/9/11, effective 4/13/11]

645—124.3(154A,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—124.4(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.

645—124.5(154A) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 1/14/09, effective 2/18/09.

These rules are intended to implement Iowa Code chapters 147, 154A and 272C.

[Filed 5/8/02, Notice 3/6/02—published 5/29/02, effective 7/3/02]

[Filed 8/14/03, Notice 5/28/03—published 9/3/03, effective 10/8/03]

[Filed 8/5/05, Notice 5/25/05—published 8/31/05, effective 10/5/05]

[Filed 10/31/05, Notice 8/31/05—published 11/23/05, effective 12/28/05]

[Filed 4/25/06, Notice 3/1/06—published 5/24/06, effective 6/28/06]

[Filed 12/11/08, Notice 9/24/08—published 1/14/09, effective 2/18/09]

[Filed ARC 9424B (Notice ARC 9317B, IAB 12/29/10), IAB 3/9/11, effective 4/13/11]

PHARMACY BOARD[657]

[Prior to 2/10/88, see Pharmacy Examiners, Board of [620], renamed Pharmacy Examiners Board[657]
under the “umbrella” of Public Health Department by 1986 Iowa Acts, ch 1245; renamed by 2007 Iowa Acts, Senate File 74]

CHAPTER 1

PURPOSE AND ORGANIZATION

- 1.1(17A) Board mission
- 1.2(17A,147,272C) Description and organization of board
- 1.3(17A,272C) Responsibilities
- 1.4(17A,272C) Submission of complaints and requests
- 1.5(17A,21) Meetings
- 1.6(124,147,155A) Fee for returned check
- 1.7(124,124B,147,155A) Overpayment of fees

CHAPTER 2

PHARMACIST LICENSES

- 2.1(147,155A) Licensure by examination
- 2.2(155A) Application for examination—requirements
- 2.3(147,155A) Examination fee
- 2.4(155A) Internship requirements
- 2.5(155A) College graduate certification
- 2.6(147) Reexamination applications and fees
- 2.7(147) Examination results
- 2.8(155A) Transfer of examination scores
- 2.9(147,155A) Licensure by license transfer/reciprocity
- 2.10(155A) Foreign pharmacy graduates
- 2.11(147,155A) License expiration and renewal
- 2.12(272C) Continuing education requirements
- 2.13(272C) Active and inactive license status
- 2.14(155A) Fees for additional license certificates
- 2.15(155A) Notifications to the board
- 2.16(235B,272C) Mandatory training for identifying and reporting abuse

CHAPTER 3

PHARMACY TECHNICIANS

- 3.1(155A) Definitions
- 3.2(155A) Purpose of registration
- 3.3(155A) Registration required
- 3.4 Reserved
- 3.5(155A) Certification of pharmacy technicians
- 3.6(155A) Extension of deadline for national certification
- 3.7 Reserved
- 3.8(155A) Application form
- 3.9(155A) Registration term and renewal
- 3.10(155A) Registration fee
- 3.11(155A) Late applications and fees
- 3.12(155A) Registration certificates
- 3.13(155A) Notifications to the board
- 3.14 to 3.16 Reserved
- 3.17(155A) Training and utilization of pharmacy technicians
- 3.18(147,155A) Identification of pharmacy technician
- 3.19 Reserved

3.20(155A)	Responsibility of supervising pharmacist
3.21(155A)	Delegation of functions
3.22(155A)	Technical functions
3.23(155A)	Tasks a pharmacy technician shall not perform
3.24(155A)	New prescription drug orders or medication orders
3.25 to 3.27	Reserved
3.28(147,155A)	Unethical conduct or practice
3.29(155A)	Denial of registration
3.30(155A)	Discipline of pharmacy technicians

CHAPTER 4 PHARMACIST-INTERNS

4.1(155A)	Definitions
4.2(155A)	Goal and objectives of internship
4.3(155A)	1500-hour requirements
4.4(155A)	Iowa colleges of pharmacy clinical internship programs
4.5(155A)	Out-of-state internship programs
4.6(155A)	Registration, reporting, and authorized functions
4.7(155A)	Foreign pharmacy graduates
4.8(155A)	Fees
4.9(155A)	Preceptor requirements
4.10(155A)	Denial of pharmacist-intern registration
4.11(155A)	Discipline of pharmacist-interns

CHAPTER 5 PHARMACY SUPPORT PERSONS

5.1(155A)	Definitions
5.2(155A)	Purpose of registration
5.3	Reserved
5.4(155A)	Registration required
5.5(155A)	Exempt from registration
5.6	Reserved
5.7(155A)	Registration application form
5.8	Reserved
5.9(155A)	Registration fee
5.10(155A)	Registration renewal
5.11(155A)	Late application
5.12	Reserved
5.13(155A)	Registration certificates
5.14(155A)	Notifications to the board
5.15(155A)	Identification of pharmacy support person
5.16	Reserved
5.17(155A)	Tasks a pharmacy support person shall not perform
5.18(155A)	Nontechnical pharmacy support tasks
5.19	Reserved
5.20(155A)	Training and utilization of pharmacy support persons
5.21(155A)	Responsibility of supervising pharmacist
5.22(155A)	Delegation of nontechnical functions
5.23	Reserved
5.24(155A)	Denial of registration
5.25(147,155A)	Unethical conduct or practice
5.26(155A)	Discipline of pharmacy support persons

CHAPTER 6
GENERAL PHARMACY PRACTICE

6.1(155A)	Purpose and scope
6.2(155A)	Pharmacist in charge
6.3(155A)	Reference library
6.4(155A)	Exemption from duplicate requirements
6.5 and 6.6	Reserved
6.7(124,155A)	Security
6.8(124,155A)	Prescription processing documentation
6.9(124,155A)	Transfer of prescription
6.10(126,155A)	Prescription label requirements
6.11 and 6.12	Reserved
6.13(155A)	Patient record system
6.14(155A)	Patient counseling and instruction
6.15(124,126)	Return of drugs and other items
6.16(124,155A)	Records

CHAPTER 7
HOSPITAL PHARMACY PRACTICE

7.1(155A)	Purpose and scope
7.2(155A)	Pharmacist in charge
7.3(155A)	Reference library
7.4 and 7.5	Reserved
7.6(124,155A)	Security
7.7(155A)	Verification by pharmacist when pharmacy is closed
7.8(124,126,155A)	Drug distribution and control
7.9(124,155A)	Drug information
7.10(124,155A)	Ensuring rational drug therapy
7.11(124,126,155A)	Outpatient services
7.12(124,126,155A)	Drugs in the emergency department
7.13(124,155A)	Records

CHAPTER 8
UNIVERSAL PRACTICE STANDARDS

8.1(155A)	Purpose and scope
8.2(155A)	Pharmaceutical care
8.3(155A)	Responsibility
8.4(155A)	Pharmacist identification and staff logs
8.5(155A)	Environment and equipment requirements
8.6(155A)	Health of personnel
8.7(155A)	Procurement, storage, and recall of drugs and devices
8.8(124,155A)	Out-of-date drugs or devices
8.9(124,155A)	Records
8.10	Reserved
8.11(147,155A)	Unethical conduct or practice
8.12(126,147)	Advertising
8.13(135C,155A)	Personnel histories
8.14(155A)	Training and utilization of pharmacy technicians or pharmacy support persons
8.15(155A)	Delivery of prescription drugs and devices
8.16(124,155A)	Confidential information
8.17 and 8.18	Reserved
8.19(124,126,155A)	Manner of issuance of a prescription drug or medication order

8.20(155A)	Valid prescriber/patient relationship
8.21(155A)	Prospective drug use review
8.22 to 8.25	Reserved
8.26(155A)	Continuous quality improvement program
8.27 to 8.31	Reserved
8.32(124,155A)	Individuals qualified to administer
8.33(147,155A)	Supervision of pharmacists who administer adult immunizations
8.34(155A)	Collaborative drug therapy management
8.35(155A)	Pharmacy license

CHAPTER 9
AUTOMATED MEDICATION DISTRIBUTION SYSTEMS AND
TELEPHARMACY SERVICES

9.1(155A)	Purpose and scope
9.2(147,155A)	Definitions
9.3(147,155A)	Pharmacist in charge responsibilities
9.4	Reserved
9.5(124,155A)	General requirements for telepharmacy
9.6(155A)	Duties of pharmacist in telepharmacy practice
9.7 to 9.9	Reserved
9.10(147,155A)	Quality assurance and performance improvement
9.11(147,155A)	Policies and procedures
9.12(147,155A)	System, site, and process requirements
9.13(147,155A)	Records
9.14	Reserved
9.15(147,155A)	Decentralized unit dose AMDS
9.16(147,155A)	Centralized unit dose AMDS
9.17(147,155A)	Outpatient AMDS
9.18(124,155A)	Remote dispensing site operations
9.19	Reserved
9.20(124,155A)	Drugs at a remote dispensing site
9.21(124,155A)	Record keeping

CHAPTER 10
CONTROLLED SUBSTANCES

10.1(124)	Who shall register
10.2(124)	Application forms
10.3(124)	Registration and renewal
10.4(124)	Exemptions—registration fee
10.5(124)	Separate registration for independent activities; coincident activities
10.6(124)	Separate registrations for separate locations; exemption from registration
10.7 to 10.9	Reserved
10.10(124,147,155A)	Inspection
10.11(124)	Modification or termination of registration
10.12(124)	Denial, modification, suspension, or revocation of registration
10.13 and 10.14	Reserved
10.15(124,155A)	Security requirements
10.16(124)	Report of theft or loss
10.17(124)	Accountability of stock supply
10.18(124)	Disposal
10.19 and 10.20	Reserved
10.21(124,126,155A)	Prescription requirements

10.22(124)	Schedule II emergency prescriptions
10.23(124)	Schedule II prescriptions—partial filling
10.24(124)	Schedule II medication order
10.25(124)	Schedule II—issuing multiple prescriptions
10.26	Reserved
10.27(124,155A)	Facsimile transmission of a controlled substance prescription
10.28(124,155A)	Schedule III, IV, or V refills
10.29(124,155A)	Schedule III, IV, or V partial fills
10.30(124,155A)	Schedule III, IV, and V medication order
10.31(124,155A)	Dispensing Schedule V controlled substances without a prescription
10.32(124,155A)	Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine without a prescription
10.33(124,155A)	Schedule II perpetual inventory in pharmacy
10.34(124,155A)	Records
10.35(124,155A)	Physical count and record of inventory
10.36(124)	Samples and other complimentary packages—records
10.37(124,126)	Revision of controlled substances schedules
10.38(124)	Temporary designation of controlled substances
10.39(124,126)	Excluded substances
10.40(124,126)	Anabolic steroid defined
10.41(124A)	Designation of imitation controlled substances

CHAPTER 11

DRUGS IN EMERGENCY MEDICAL SERVICE PROGRAMS

11.1(124,147A,155A)	Definitions
11.2(124,147A,155A)	Ownership of drugs—options
11.3(124,147A,155A)	General requirements
11.4(124,147A,155A)	Procurement and storage
11.5(124,147A,155A)	Records
11.6(124,147A,155A)	Inspections
11.7(124,147A,155A)	Security and control

CHAPTER 12

PRECURSOR SUBSTANCES

12.1(124B)	Precursor substance identified
12.2(124B)	Reports required
12.3(124B)	Form of reports
12.4(124B)	Monthly reporting option
12.5(124B)	Exemptions
12.6(124B)	Identification of purchaser or other recipient
12.7(124B)	Permits
12.8(124B)	Denial, modification, suspension, or revocation of permit

CHAPTER 13

STERILE COMPOUNDING PRACTICES

13.1(124,126,155A)	Purpose and scope
13.2(124,126,155A)	Definitions
13.3(155A)	Responsibilities
13.4	Reserved
13.5(155A)	References required
13.6(126,155A)	Policies and procedures
13.7(126,155A)	Labeling requirements
13.8 and 13.9	Reserved

13.10(126,155A)	Microbial contamination risk levels
13.11(155A)	Low-risk preparations and low-risk preparations with 12-hour or less beyond-use date
13.12(155A)	Medium-risk preparations
13.13(155A)	High-risk preparations
13.14(155A)	Immediate-use preparations
13.15(155A)	Utilization of single-dose and multiple-dose containers
13.16(155A)	Utilization of proprietary bag and vial systems
13.17 to 13.19	Reserved
13.20(124,155A)	Sterile preparation of hazardous drugs
13.21 and 13.22	Reserved
13.23(124,155A)	Verification of compounding accuracy and sterility
13.24(124,155A)	Sterilization methods
13.25(155A)	Media-fill testing by personnel
13.26	Reserved
13.27(124,126,155A)	Physical environment requirements
13.28(155A)	Cleaning, maintenance, and supplies
13.29(126,155A)	Environmental monitoring requirements
13.30	Reserved
13.31(155A)	Quality assurance (QA)
13.32(155A)	Patient or caregiver education and training
13.33(124,155A)	Storage and delivery of sterile preparations

CHAPTER 14

PUBLIC INFORMATION AND INSPECTION OF RECORDS

14.1(22,124,155A)	Definitions
14.2(22,124,155A)	Purpose and scope
14.3(22,124,155A)	Requests for access to records
14.4(22,124,155A)	Access to confidential records
14.5(22,124,155A)	Requests for treatment of a record as a confidential record and its withholding from examination
14.6(22,124,155A)	Procedure by which additions, dissents, or objections may be entered into certain records
14.7(22,124,155A)	Consent to disclosure by the subject of a confidential record
14.8(22,124,155A)	Notice to suppliers of information
14.9(22,124,155A)	Disclosures without the consent of the subject
14.10(22,124,155A)	Routine use
14.11(22,124,155A)	Consensual disclosure of confidential records
14.12(22,124,155A)	Release to subject
14.13(22,124,155A)	Availability of records
14.14(22,124,155A)	Personally identifiable information
14.15(22,124,155A)	Other groups of records
14.16(22,124,155A)	Computer

CHAPTER 15

CORRECTIONAL PHARMACY PRACTICE

15.1(155A)	Purpose and scope
15.2(126,155A)	Definitions
15.3(155A)	Pharmacist in charge
15.4(155A)	Reference library
15.5(124,155A)	Security
15.6	Reserved

- 15.7(124,126,155A) Training and utilization of pharmacy technicians or pharmacy support persons
- 15.8(124,126,155A) Drug distribution and dispensing controls
- 15.9 Reserved
- 15.10(124,126,155A) Policies and procedures

CHAPTER 16

NUCLEAR PHARMACY PRACTICE

- 16.1(155A) Purpose and scope
- 16.2(155A) Definitions
- 16.3(155A) General requirements for qualified nuclear pharmacist
- 16.4(155A) General requirements for pharmacies providing radiopharmaceutical services
- 16.5(155A) Library
- 16.6(155A) Minimum equipment requirements
- 16.7(155A) Training and utilization of pharmacy support persons

CHAPTER 17

WHOLESALE DRUG LICENSES

- 17.1(155A) Definitions
- 17.2 Reserved
- 17.3(155A) Wholesale drug license
- 17.4(155A) Minimum qualifications
- 17.5(155A) Personnel
- 17.6(155A) Responsibility for conduct
- 17.7(124,155A) Distribution to authorized licensees
- 17.8(124,155A) Written policies and procedures
- 17.9(155A) Facilities
- 17.10(124,155A) Security
- 17.11(155A) Storage
- 17.12 Reserved
- 17.13(155A) Drugs in possession of representatives
- 17.14(155A) Examination of materials
- 17.15(155A) Returned, damaged, and outdated prescription drugs
- 17.16(124,155A) Record keeping
- 17.17(124,155A) Compliance with federal, state, and local laws
- 17.18(155A) Discipline

CHAPTER 18

CENTRALIZED PRESCRIPTION FILLING AND PROCESSING

- 18.1(155A) Purpose and scope
- 18.2(155A) Definitions
- 18.3(155A) General requirements
- 18.4 Reserved
- 18.5(155A) Patient notification and authorization
- 18.6 to 18.9 Reserved
- 18.10(155A) Policy and procedures
- 18.11 to 18.14 Reserved
- 18.15(155A) Records

CHAPTER 19

NONRESIDENT PHARMACY PRACTICE

- 19.1(155A) Definitions
- 19.2(155A) Application and license requirements
- 19.3(124,155A) Applicability of board rules

19.4 to 19.6	Reserved
19.7(155A)	Confidential data
19.8(124,155A)	Storage and shipment of drugs and devices
19.9(155A)	Patient record system, prospective drug use review, and patient counseling
19.10(155A)	Discipline

CHAPTER 20

PHARMACY COMPOUNDING PRACTICES

20.1(124,126,155A)	Purpose and scope
20.2(124,126,155A)	Definitions
20.3(124,126,155A)	General requirements
20.4(126,155A)	Organization and personnel
20.5(126,155A)	Drug compounding facilities
20.6(126,155A)	Sterile products and radiopharmaceuticals
20.7	Reserved
20.8(126,155A)	Equipment
20.9(126,155A)	Control of bulk drug substances, components, containers, and closures
20.10(124,126,155A)	Drug compounding controls
20.11(126)	Bulk compounding
20.12(124,126,155A)	Records

CHAPTER 21

ELECTRONIC DATA IN PHARMACY PRACTICE

21.1(124,155A)	Definitions
21.2(124,155A)	System security and safeguards
21.3(124,155A)	Verifying authenticity of an electronically transmitted prescription
21.4(124,155A)	Automated data processing system
21.5(124,155A)	Pharmacist verification of controlled substance refills—daily printout or logbook
21.6	Reserved
21.7(124,155A)	Electronically prepared prescriptions
21.8(124,155A)	Computer-to-computer transmission of a prescription
21.9(124,155A)	Facsimile transmission (fax) of a prescription
21.10 and 21.11	Reserved
21.12(124,155A)	Prescription drug orders for Schedule II controlled substances
21.13(124,155A)	Prescription drug orders for Schedule II controlled substances—emergency situations
21.14(124,155A)	Facsimile transmission of a prescription for Schedule II narcotic substances—parenteral
21.15(124,155A)	Facsimile transmission of Schedule II controlled substances—long-term care facility patients
21.16(124,155A)	Facsimile transmission of Schedule II controlled substances—hospice patients

CHAPTER 22

UNIT DOSE, ALTERNATIVE PACKAGING, AND EMERGENCY BOXES

22.1(155A)	Unit dose dispensing systems
22.2	Reserved
22.3(126)	Prepackaging
22.4	Reserved
22.5(126,155A)	Patient med paks
22.6	Reserved
22.7(124,155A)	Emergency/first dose drug supply
22.8	Reserved
22.9(155A)	Home health agency/hospice emergency drugs

CHAPTER 23
LONG-TERM CARE PHARMACY PRACTICE

23.1(155A)	Definitions
23.2(124,155A)	Applicability of rules
23.3(124,155A)	Freedom of choice
23.4(124,155A)	Pharmacy responsibilities
23.5(124,155A)	Emergency drugs
23.6(124,155A)	Space, equipment, and supplies
23.7(124,155A)	Policies and procedures
23.8	Reserved
23.9(124,155A)	Medication orders
23.10(124,155A)	Stop orders
23.11(124,155A)	Drugs dispensed—general requirements
23.12	Reserved
23.13(124,155A)	Labeling drugs under special circumstances
23.14(124,155A)	Labeling of biologicals and other injectables supplied to a facility
23.15(124,155A)	Return and reuse of drugs and devices
23.16(124,155A)	Destruction of outdated and improperly labeled drugs
23.17(124,155A)	Accountability of controlled substances
23.18(124,155A)	Schedule II orders
23.19(124,155A)	Dispensing Schedule II controlled substances
23.20(124,155A)	Partial filling of Schedule II controlled substances
23.21(124,155A)	Destruction of controlled substances

CHAPTER 24
Reserved

CHAPTER 25
CHILD SUPPORT NONCOMPLIANCE

25.1(252J)	Definitions
25.2(252J)	Issuance or renewal of license—denial
25.3(252J)	Suspension or revocation of a license
25.4(17A,22,252J)	Share information

CHAPTER 26
PETITIONS FOR RULE MAKING
(Uniform Rules)

26.1(17A)	Petition for rule making
26.2(17A)	Briefs
26.3(17A)	Inquiries
26.4(17A)	Board consideration

CHAPTER 27
DECLARATORY ORDERS
(Uniform Rules)

27.1(17A)	Petition for declaratory order
27.2(17A)	Notice of petition
27.3(17A)	Intervention
27.4(17A)	Briefs
27.5(17A)	Inquiries
27.6(17A)	Service and filing of petitions and other papers
27.7(17A)	Consideration
27.8(17A)	Action on petition
27.9(17A)	Refusal to issue order

- 27.10(17A) Contents of declaratory order—effective date
- 27.11(17A) Copies of orders
- 27.12(17A) Effect of a declaratory order

CHAPTER 28

AGENCY PROCEDURE FOR RULE MAKING

(Uniform Rules)

- 28.1(17A) Applicability
- 28.2(17A) Advice on possible rules before notice of proposed rule adoption
- 28.3(17A) Public rule-making docket
- 28.4(17A) Notice of proposed rule making
- 28.5(17A) Public participation
- 28.6(17A) Regulatory analysis
- 28.7(17A,25B) Fiscal impact statement
- 28.8(17A) Time and manner of rule adoption
- 28.9(17A) Variance between adopted rule and published notice of proposed rule adoption
- 28.10(17A) Exemptions from public rule-making procedures
- 28.11(17A) Concise statement of reasons
- 28.12(17A) Contents, style, and form of rule
- 28.13(17A) Board rule-making record
- 28.14(17A) Filing of rules
- 28.15(17A) Effectiveness of rules prior to publication
- 28.16(17A) General statements of policy
- 28.17(17A) Review by board of rules

CHAPTER 29

SALES OF GOODS AND SERVICES

- 29.1(68B) Selling of goods or services by members of the board
- 29.2(68B) Conditions of consent for board members
- 29.3(68B) Authorized sales
- 29.4(68B) Application for consent
- 29.5(68B) Limitation of consent

CHAPTER 30

IMPAIRED PHARMACY PROFESSIONAL AND TECHNICIAN RECOVERY PROGRAM

- 30.1(155A) Definitions
- 30.2(155A) Purpose, function, and responsibilities
- 30.3(155A) Program committee and personnel; confidentiality; liability
- 30.4(155A) Identification and referral of impaired professionals and technicians
- 30.5(155A) Recovery contract requirements
- 30.6(155A) Program provider contract
- 30.7(155A) Disclosure of information
- 30.8(155A) Program funds

CHAPTER 31

STUDENT LOAN DEFAULT OR NONCOMPLIANCE WITH AGREEMENT FOR PAYMENT OF OBLIGATION

- 31.1(261) Definitions
- 31.2(261) Issuance or renewal of a license—denial
- 31.3(261) Suspension or revocation of a license
- 31.4(17A,22,261) Share information

CHAPTER 32
NONPAYMENT OF STATE DEBT

- 32.1(272D) Definitions
- 32.2(272D) Issuance or renewal of a license—denial
- 32.3(272D) Suspension or revocation of a license
- 32.4(17A,22,272D) Share information

CHAPTER 33
Reserved

CHAPTER 34
RULES FOR WAIVERS AND VARIANCES

- 34.1(17A) Definition
- 34.2(17A,124,126,147,155A,205,272C) Scope of chapter
- 34.3(17A,124,126,147,155A,205,272C) Applicability of chapter
- 34.4(17A) Criteria for waiver or variance
- 34.5(17A,124,126,147,155A,205,272C) Filing of petition
- 34.6(17A) Content of petition
- 34.7(17A) Additional information
- 34.8(17A) Notice
- 34.9(17A) Hearing procedures
- 34.10(17A) Ruling
- 34.11(17A,22) Public availability
- 34.12(17A) Summary reports
- 34.13(17A) Cancellation of a waiver
- 34.14(17A,124,126,147,155A,205,272C) Violations
- 34.15(17A,124,126,147,155A,205,272C) Defense
- 34.16(17A) Judicial review

CHAPTER 35
CONTESTED CASES

- 35.1(17A,124,124B,126,147,155A,205,272C) Scope and applicability
- 35.2(17A,272C) Definitions
- 35.3(17A) Time requirements
- 35.4 Reserved
- 35.5(17A,124B,126,147,155A,205,272C) Notice of hearing
- 35.6(17A,272C) Presiding officer for nondisciplinary hearings
- 35.7(17A,124B,147,155A,272C) Waiver of procedures
- 35.8(17A,272C) Telephone or network proceedings
- 35.9(17A) Disqualification
- 35.10(17A,272C) Consolidation—severance
- 35.11(17A,272C) Service and filing of pleadings and other papers
- 35.12(17A,272C) Discovery
- 35.13(17A,272C) Subpoenas
- 35.14(17A,272C) Motions
- 35.15(17A,272C) Prehearing conference
- 35.16(17A,272C) Continuances
- 35.17(17A) Withdrawals
- 35.18 Reserved
- 35.19(17A,124B,126,147,155A,205,272C) Hearing procedures in contested cases
- 35.20(17A,272C) Evidence
- 35.21(17A,272C) Default
- 35.22(17A,272C) Ex parte communication

- 35.23(17A,272C) Recording costs
- 35.24(17A,272C) Interlocutory appeals
- 35.25(17A) Final decision
- 35.26(17A,124B,126,147,155A,205,272C) Appeals and review
- 35.27(17A,124B,126,147,155A,205,272C) Applications for rehearing
- 35.28(17A,272C) Stays of board actions
- 35.29(17A,272C) No factual dispute contested cases
- 35.30(17A,124B,126,147,155A,205,272C) Emergency adjudicative proceedings

CHAPTER 36

DISCIPLINE

- 36.1(147,155A,272C) Authority and grounds for discipline
- 36.2(155A,272C) Investigations
- 36.3(147,272C) Peer review committees
- 36.4(17A,124,124B,126,147,155A,272C) Disciplinary proceedings
- 36.5(17A,124,124B,126,147,155A,272C) Notice of disciplinary hearing
- 36.6(17A,124B,147,155A,272C) Informal settlement
- 36.7(272C) Appearance
- 36.8(17A,124B,147,155A,272C) Order of proceedings
- 36.9(272C) Confidentiality
- 36.10(17A,272C) Notification of decision
- 36.11(272C) Board decision
- 36.12(17A,272C) Publication of decisions
- 36.13(17A,124B,147,155A,272C) Reinstatement
- 36.14(17A,124B,147,155A,272C) Informal reinstatement conference
- 36.15(17A,124B,147,155A,272C) Voluntary surrender of a license, permit, or registration
- 36.16(17A,124B,147,155A,272C) License, permit, or registration denial
- 36.17(155A,272C) Order for mental or physical examination
- 36.18(272C) Disciplinary hearings—fees and costs

CHAPTER 37

IOWA PRESCRIPTION MONITORING PROGRAM

- 37.1(124) Purpose
- 37.2(124) Definitions
- 37.3(124) Requirements for the PMP
- 37.4(124) Access to database information
- 37.5(124) Fees
- 37.6(124) PMP information retained
- 37.7(124) Information errors
- 37.8(124) Dispenser and practitioner records
- 37.9(124) Prohibited acts

CHAPTERS 38 to 99

Reserved

CHAPTER 100

IOWA REAL-TIME ELECTRONIC PSEUDOEPHEDRINE
TRACKING SYSTEM

- 100.1(124) Purpose and scope
- 100.2(124) Definitions
- 100.3(124) Electronic pseudoephedrine tracking system (PTS)
- 100.4(124) Access to database information and confidentiality
- 100.5(124) Violations

CHAPTER 2
PHARMACIST LICENSES

[Prior to 2/10/88, see Pharmacy Examiners[620] Chs 1, 5]

657—2.1(147,155A) Licensure by examination. The board of pharmacy, in conjunction with the National Association of Boards of Pharmacy (NABP), shall provide for the administration of pharmacist licensure examinations.

2.1(1) Components. Applicants shall take and pass the following components: the North American Pharmacist Licensure Examination (NAPLEX); the Multistate Pharmacy Jurisprudence Examination (MPJE), Iowa Edition. A total scaled score of no less than 75 is required to pass each examination.

2.1(2) Timeliness. To be eligible for a license by examination, the candidate shall pass all components in Iowa within a period of one year beginning with the date the candidate passed an initial component. A candidate may request waiver or variance from this deadline pursuant to the procedures and requirements of 657—Chapter 34.

657—2.2(155A) Application for examination—requirements. Application for examination shall be on forms provided by the board, and all requested information shall be provided on or with such application. An applicant shall complete the NABP Computerized Examination Registration Form to apply for registration to take the NAPLEX. An applicant shall complete an additional registration form to apply for registration to take the MPJE, Iowa Edition.

2.2(1) Required information. The application for examination shall require that the applicant provide, at a minimum, the following: name; address; telephone number; date of birth; social security number; name and location of college of pharmacy and date of graduation; one current photograph of a quality at least similar to a passport photograph; and internship experience. Each applicant shall also declare the following: history of prior pharmacist licensure examinations and record of offenses including but not limited to charges, convictions, and fines which relate to the profession or that may affect the licensee's ability to practice pharmacy.

2.2(2) Sworn statement. The application for examination shall be made as a sworn statement before a notary public, and the notary public shall witness the signature of the applicant.

657—2.3(147,155A) Examination fee. The fee for examination shall consist of the biennial license fee, a processing fee, administration fees, and examination registration fees.

2.3(1) Fees to the board. The biennial license fee shall be the fee established by rule 2.11(147,155A), including surcharge. The processing fee shall be \$80. No refunds of the processing fee shall be made for cancellation or withdrawal of applications. The license fee and processing fee shall be payable to the Iowa Board of Pharmacy and may be remitted in the form of personal check, money order, or certified check. No refund of fees shall be made for failure to complete all licensure requirements within the period specified in subrule 2.1(2).

2.3(2) Fees to NABP. The examination registration and administration fees shall be amounts determined by NABP, shall be payable to the National Association of Boards of Pharmacy, and shall be in the form of a certified check or money order. Refunds of fees paid to NABP shall be at the discretion of NABP.

2.3(3) Submission of forms and fees. The biennial license fee including surcharge, the processing fee, the administration fees, and the examination registration fees shall accompany the applications and registration forms and shall be submitted to the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688, or as otherwise directed by the board.

657—2.4(155A) Internship requirements. Each applicant shall furnish to the board evidence certifying completion of satisfactory internship experience. The board will not certify an applicant eligible to take any of the examination components prior to receipt of evidence of satisfactory completion of internship experience. Internship experience shall comply with the requirements in 657—Chapter 4. Internship experience completed in compliance with the requirements in 657—Chapter 4 shall be valid for application for licensure in Iowa by examination or score transfer for a period of three years

following graduation from an approved college of pharmacy or as otherwise approved by the board on a case-by-case basis.

657—2.5(155A) College graduate certification. Each applicant shall furnish a certificate from a recognized college of pharmacy stating that the applicant has successfully graduated from a school or college of pharmacy with either a bachelor of science degree in pharmacy or a doctor of pharmacy (Pharm.D.) degree. Certification shall be completed by an individual authorized by the college on a form provided by the board. A recognized college of pharmacy is a United States institution that meets the minimum standards of the American Council on Pharmaceutical Education and appears on its list of accredited colleges of pharmacy published by the council as of July 1 of each year.

657—2.6(147) Reexamination applications and fees. A candidate who fails to pass the NAPLEX once shall be allowed to schedule a time to retake the examination no less than 91 days following administration of the failed examination. A candidate who fails to pass the MPJE, Iowa Edition, once shall be allowed to schedule a time to retake the examination no less than 30 days following administration of the failed examination. A candidate who fails to pass either examination following a second or subsequent examination may petition the board for permission to take the examination again. Determination of a candidate's eligibility to take an examination more than two times shall be at the discretion of the board.

Each applicant for reexamination shall file an application on forms provided by the board. Processing fees of \$40 each will be charged to take NAPLEX or MPJE, Iowa Edition, and shall be paid to the board as provided in subrule 2.3(1). In addition, candidates will be required to complete the appropriate examination registration application as provided in rule 2.2(155A) and to pay to NABP the registration and administration fees for each examination as provided in subrule 2.3(2). All applications, registration forms, and fees shall be submitted as provided in subrules 2.3(2) and 2.3(3).

657—2.7(147) Examination results. Examination scores and original license certificates shall be provided to each new licensee as soon after the examinations as possible.

657—2.8(155A) Transfer of examination scores. The board of pharmacy participates in the NAPLEX score transfer program offered by NABP. This program allows candidates for pharmacist licensure to take the standardized NAPLEX in one state and have the score from that examination transferred to other participant states in which the candidate is seeking licensure. MPJE scores cannot be transferred.

2.8(1) Score transfer application. The NAPLEX Score Transfer Form must be completed and submitted with the proper fee to NABP prior to, or postmarked no later than, the date on which the candidate takes the NAPLEX. The fee to NABP for score transfer is determined by NABP. Payment shall be made in the form of a money order or certified check payable to the National Association of Boards of Pharmacy. NABP makes no refunds of score transfer fees.

2.8(2) Requirements and deadline. Score transfer candidates shall meet the requirements established in rules 2.1(147,155A) through 2.5(155A) within 12 months of the date of transfer. No refund of fees paid to the board will be made for failure to complete all licensure requirements within this one-year period.

2.8(3) Fees. In addition to the score transfer fee identified in subrule 2.8(1), fees for licensure pursuant to the NABP score transfer program shall consist of the fees identified in rule 2.3(147,155A) excluding the NAPLEX examination registration and administration fees.

657—2.9(147,155A) Licensure by license transfer/reciprocity. An applicant for license transfer/reciprocity must be a pharmacist licensed by examination in a state or territory of the United States with which Iowa has a reciprocal agreement, and the license by examination must be in good standing at the time of the application. All candidates shall take and pass the MPJE, Iowa Edition, as provided in subrule 2.1(1). Any candidate who fails to pass the examination shall be eligible for reexamination as provided in rule 2.6(147).

2.9(1) Eligibility. Each applicant for license transfer to this state who obtains the applicant's original license after January 1, 1980, must have passed the NABP Licensure Examination (NABPLEX), the NAPLEX, or an equivalent examination as determined by NABP.

a. Preliminary application. Each applicant for license transfer/reciprocity to Iowa shall complete and submit to NABP, with the appropriate fee as indicated on the application, the NABP Preliminary Application for Transfer of Pharmaceutical Licensure. Refunds of fees paid to NABP shall be at the discretion of NABP.

b. Foreign pharmacy graduates. If the applicant is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board, proof of qualifications shall include certification from the FPGEC pursuant to subrule 2.10(1).

2.9(2) Application requirements. Application to the board shall consist of the final application for license transfer prepared by NABP pursuant to the NABP license transfer program. A foreign pharmacy graduate shall submit certification from the FPGEC as provided in subrule 2.10(1). Applications, together with other required information and fees, shall be submitted as provided in subrule 2.3(3).

2.9(3) MPJE required. An applicant shall also be required to submit the registration application for MPJE, Iowa Edition, as provided in rule 2.2(155A). The form and fees shall be submitted as provided in subrules 2.3(2) and 2.3(3).

2.9(4) Fees. The fee for license transfer shall consist of the biennial license fee established by rule 2.11(147,155A) including surcharge and a processing fee of \$100. No refunds of the processing fee shall be made for cancellation or withdrawal of an application. The license fee and processing fee shall be payable to the Iowa Board of Pharmacy and may be remitted in the form of personal check, money order, or certified check.

2.9(5) Timeliness. A final application for license transfer is valid for 12 months following the date of issuance by NABP. A candidate for license transfer shall complete, within that one-year period, all licensure requirements established by this rule. No refund of fees will be made for failure to complete all licensure requirements within this one-year period.

657—2.10(155A) Foreign pharmacy graduates.

2.10(1) Education equivalency. Any applicant who is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board shall be deemed to have satisfied the requirements of Iowa Code section 155A.8, subsection 1, by certification by the Foreign Pharmacy Graduate Examination Committee (FPGEC). Each applicant shall have successfully passed the Foreign Pharmacy Graduate Equivalency Examination (FPGEE) given by the FPGEC established by the NABP. The FPGEE is hereby recognized and approved by the board. Each applicant shall also demonstrate proficiency in written English by passing the Test of English as a Foreign Language (TOEFL) and proficiency in spoken English by passing the Test of Spoken English (TSE) or proficiency in basic English language skills by passing the Internet Based TOEFL (TOEFL iBT). The TOEFL, TOEFL iBT, and TSE are hereby recognized and approved by the board. Certification by the FPGEC shall be evidence of the applicant's successfully passing the FPGEE, TSE, and TOEFL, or the FPGEE and TOEFL iBT, and certification is a prerequisite to taking the licensure examinations required in subrule 2.1(1).

2.10(2) Internship. A foreign pharmacy graduate applicant shall also be required to obtain internship experience in one or more board-licensed community or hospital pharmacies as provided in rule 657—4.7(155A). Internship requirements shall, in all other aspects, meet the requirements established in 657—Chapter 4.

657—2.11(147,155A) License expiration and renewal. A license to practice pharmacy shall expire on the second thirtieth day of June following the date of issuance of the license, with the exception that a new pharmacist license issued between April 1 and June 29 shall expire on the third thirtieth day of June following the date of issuance. The license renewal certificate shall be issued upon completion of the renewal application and timely payment of a \$200 fee plus applicable surcharge pursuant to 657—30.8(155A).

2.11(1) *Late payment penalty.* Failure to renew the license before July 1 following expiration shall require payment of the renewal fee, a penalty fee of \$200, and applicable surcharge pursuant to 657—30.8(155A). Failure to renew the license before August 1 following expiration shall require payment of the renewal fee, a penalty fee of \$300, and applicable surcharge pursuant to 657—30.8(155A). Failure to renew the license before September 1 following expiration shall require payment of the renewal fee, a penalty fee of \$400, and applicable surcharge pursuant to 657—30.8(155A). Failure to renew the license before October 1 following expiration may require an appearance before the board and shall require payment of the renewal fee, a penalty fee of \$500, and applicable surcharge pursuant to 657—30.8(155A). In no event shall the combined fee and penalty fee for late renewal of the license exceed \$700 plus applicable surcharge pursuant to 657—30.8(155A). The provisions of Iowa Code section 147.11 shall apply to a license that is not renewed within five months of the expiration date.

2.11(2) *Delinquent license.* If a license is not renewed before its expiration date, the license is delinquent and the licensee may not practice pharmacy in the state of Iowa until the licensee reactivates the delinquent license. Reactivation of a delinquent license shall include submission of a completed application and appropriate fees and may include requirements relating to the reactivation of an inactive license pursuant to subrule 2.13(2). A pharmacist who continues to practice pharmacy in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.1(4).

657—2.12(272C) Continuing education requirements. Pharmacists shall complete continuing education for license renewal pursuant to the requirements of this rule. For purposes of this rule, “continuing education” means a structured educational activity that is applicable to the practice of pharmacy, that promotes problem solving and critical thinking, and that is designed or intended to support the continuing development of pharmacists to maintain and enhance their competence.

2.12(1) *Continuing education activity attendance.* Continuing education activities that carry the seal of an Accreditation Council for Pharmacy Education (ACPE)-accredited provider will automatically qualify for continuing education credit. Attendance is mandated in order for a pharmacist to receive credit unless the activity is an ACPE-accredited correspondence course.

a. Non-ACPE provider activity. A maximum of 50 percent of the total continuing education credits required pursuant to subrule 2.12(4) may be obtained through completion of non-ACPE provider activities if such activities are provided by an accredited health-professional continuing education provider, such as a continuing medical education (CME) provider, and if the activity content directly relates to the pharmacist’s professional practice.

b. Exemption for health-related graduate studies. A pharmacist who is continuing formal education in health-related graduate programs, including participation in a pharmacy residency program, may be exempted from meeting the continuing education requirements during the period of such enrollment or participation. An applicant for this exemption shall petition the board, as soon as possible following enrollment in the qualifying graduate program or commencement of the pharmacy residency program and prior to completion of the qualifying program, on forms provided by the board office. At the discretion of the board, exemption during part-time or short-term enrollment in a health-related graduate program may be prorated for the actual period of such enrollment.

2.12(2) *Continuing education unit required.* The nationally accepted measurement of continuing education is referred to as CEU (continuing education unit), and the board of pharmacy employs that measurement. Ten contact hours of approved continuing education are equivalent to one CEU. The board of pharmacy will require 3.0 CEUs each renewal period. For purposes of this rule, “renewal period” means the 27-month period commencing April 1 prior to the previous license expiration and ending June 30, the date of current license expiration. A pharmacist who fails to complete the required CEUs within the renewal period shall be required to complete one and one-half times the number of delinquent CEUs prior to reactivation of the license. CEUs that are used to satisfy the continuing education requirement for one renewal period shall not be used to satisfy the requirement for a subsequent renewal period.

2.12(3) Continuing education activity statement of credit.

a. An accredited provider will be required to make available to an individual pharmacist a statement of credit that indicates successful completion of and participation in a continuing education activity. The statement of credit will carry the following information:

- (1) Pharmacist's full name.
- (2) Number of contact hours or CEUs awarded for activity completion.
- (3) Date of live activity or date of completion of home study activity.
- (4) Name of accredited provider.
- (5) Activity title and universal activity number.

b. A pharmacist must retain statements of credit in the pharmacist's personal files for four years.

2.12(4) Continuing education activity topics. Each pharmacist is required to obtain a minimum of 50 percent of the pharmacist's required 3.0 CEUs in ACPE-accredited courses dealing with drug therapy. Activities qualifying for the drug therapy requirement will include the ACPE topic designator "01" or "02" in the last two digits of the universal activity number.

2.12(5) New license holders licensed by examination. After the initial license is issued by examination, the new license holder is exempt from meeting continuing education requirements for the first license renewal. However, if the licensee qualifies as a mandatory abuse reporter, the licensee shall not be exempt from mandatory training for identifying and reporting abuse pursuant to rule 2.16(235B,272C). Regardless of when the license is first issued, the new license holder will be required to obtain, prior to the second renewal, 30 contact hours (3.0 CEUs) of continuing education pursuant to subrules 2.12(1) through 2.12(4).

2.12(6) New license holders licensed by license transfer/reciprocity. After the initial license is issued by license transfer, the new license holder will be required to obtain, prior to the first license renewal, 30 contact hours (3.0 CEUs) of continuing education credits pursuant to subrules 2.12(1) through 2.12(4).

2.12(7) Reporting continuing education credits.

a. A pharmacist shall submit on or with the renewal application form documentation that the continuing education requirements have been met. Documentation shall be in a format that includes the following:

- (1) The total number of credits accumulated for the renewal period;
- (2) The individual activities completed, including activity title and universal activity number;
- (3) The dates of completion;
- (4) The credits awarded for each activity;
- (5) The name of the provider of each activity; and
- (6) Identification of the activities completed to comply with the drug therapy requirements in subrule 2.12(4).

b. The board may require a pharmacist to submit the activity statements of credit that document successful completion of the activities included with or on the renewal application.

c. Failure to receive the renewal application shall not relieve the pharmacist of the responsibility of meeting continuing education requirements.

2.12(8) Relicensure examination. Nothing in these rules precludes the board from requiring an applicant for renewal to submit to a relicensure examination.

2.12(9) Physical disability or illness. The board may, in individual cases involving physical disability or illness, grant waivers of the minimum continuing education requirements or extensions of time within which to fulfill the same or make the required reports. No waiver or extension of time shall be granted unless written application is made and signed by the licensee and the licensee's physician. The board may grant waivers of the minimum continuing education requirements for physical disability or illness for any period of time not to exceed one renewal period. In the event that the physical disability or illness upon which a waiver has been granted continues beyond the period of the waiver, the licensee must reapply for an extension of the waiver. The board may, as a condition of any waiver granted, require the licensee to make up all or any portion of the waived continuing education requirements by any method prescribed by the board.

[ARC 8672B, IAB 4/7/10, effective 5/12/10; ARC 9406B, IAB 3/9/11, effective 4/13/11]

657—2.13(272C) Active and inactive license status.

2.13(1) *Active license.* Active license status applies to a pharmacist who has submitted the renewal application and fee and has met Iowa requirements for continuing education. Active license status also applies to a pharmacist who has submitted the renewal application and fee and who is a resident of another state, is licensed to practice pharmacy in that state, and has met the continuing education requirements of that state. A pharmacist who meets the continuing education requirements of another state shall provide documentation on the renewal application of the pharmacist's license status in that state. An Iowa licensee actively practicing in a state that does not require continuing education for license renewal shall be required to meet Iowa continuing education requirements.

2.13(2) *Inactive license.* Failure of a pharmacist to comply with the continuing education requirements during the renewal period will result in the issuance of a renewal card marked “inactive” upon submission of the renewal application and fee. Reactivation of an inactive pharmacist license shall be accomplished by the appropriate method described below. Internship, in each instance where internship is mentioned below, shall be in a pharmacy approved by the board. The pharmacist will be issued an intern registration certificate.

a. An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in any state or states which required continuing education during that five-year period shall submit proof of continued licensure in good standing in the state or states of such practice.

b. An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in a state which does not require continuing education shall submit proof of continued licensure in good standing in the state or states of such practice. The pharmacist shall also complete one of the following options:

- (1) Take and successfully pass the MPJE, Iowa Edition, as provided in subrule 2.1(1);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours); or
- (3) Obtain one and one-half times the number of continuing education credits required under 2.12(2) for each renewal period the pharmacist was inactive.

c. An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy during the past five years, and whose license has been inactive for not more than five years, shall complete one of the following options:

- (1) Successfully pass all components of the licensure examination as required in rule 2.1(147,155A);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status; or
- (3) Obtain one and one-half times the number of continuing education credits required under 2.12(2) for each renewal period the pharmacist was inactive.

d. An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy for more than five years shall petition the board for reactivation of the license to practice pharmacy under one or more of the following options:

- (1) Successfully pass all components of the licensure examination as required in rule 2.1(147,155A);
- (2) Complete 160 hours internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours); or
- (3) Obtain one and one-half times the number of continuing education credits required under 2.12(2) for each renewal period the pharmacist was inactive.

657—2.14(155A) Fees for additional license certificates. Only original license certificates issued by the board of pharmacy for licensed pharmacists are valid. Additional original license certificates for licensed pharmacists may be obtained from the board of pharmacy for a prepaid fee of \$20 each. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

657—2.15(155A) Notifications to the board. A pharmacist shall report to the board within ten days a change of the pharmacist's name, address, or pharmacy employment.

657—2.16(235B,272C) Mandatory training for identifying and reporting abuse. “Mandatory training for identifying and reporting abuse” means training on identifying and reporting child abuse or dependent adult abuse required of a pharmacist who qualifies as a mandatory abuse reporter under Iowa Code section 232.69 or 235B.16. A licensed pharmacist shall be responsible for determining whether or not, by virtue of the pharmacist's practice or employment, the pharmacist qualifies as a mandatory abuse reporter under either or both of these sections.

2.16(1) Training required. A licensed pharmacist who qualifies as a mandatory abuse reporter shall have completed approved abuse education training as follows.

a. Mandatory reporter of child abuse. A pharmacist who qualifies as a mandatory reporter of child abuse shall have completed two hours of training in child abuse identification and reporting within the previous five years.

b. Mandatory reporter of dependent adult abuse. A pharmacist who qualifies as a mandatory reporter of dependent adult abuse shall have completed two hours of training in dependent adult abuse identification and reporting within the previous five years.

c. Mandatory reporter of child abuse and dependent adult abuse. A pharmacist who qualifies as a mandatory reporter of child abuse and dependent adult abuse may complete separate courses pursuant to paragraphs “a” and “b” or may complete, within the previous five years, one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse.

2.16(2) Persons exempt from training requirements. The requirements of this rule shall not apply to a pharmacist during periods that the pharmacist serves honorably on active duty in the military or during periods that the pharmacist resides outside Iowa and does not practice pharmacy in Iowa.

2.16(3) Mandatory training records. A pharmacist subject to the requirements of this rule shall maintain documentation of completion of the mandatory training for identifying and reporting abuse, including dates, subjects, duration of programs, and proof of participation, for five years following the date of the training. The board may audit this information at any time within the five-year period.

2.16(4) Approved programs. “Approved abuse education training” means a training program using a curriculum approved by the abuse education review panel of the Iowa department of public health.

These rules are intended to implement Iowa Code sections 147.10, 147.36, 147.94, 147.96, 155A.8, 155A.9, 155A.11, 155A.39, and 272C.2.

[Filed 4/11/68; amended 11/14/73]

[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]

[Filed 1/30/80, Notice 12/26/79—published 2/20/80, effective 6/1/80]

[Filed 9/24/80, Notice 6/25/80—published 10/15/80, effective 11/19/80]

[Filed 12/1/80, Notice 9/3/80—published 12/24/80, effective 1/28/81]

[Filed 2/12/81, Notice 9/3/80—published 3/4/81, effective 4/8/81]

[Filed 6/16/83, Notice 5/11/83—published 7/6/83, effective 8/10/83]

[Filed 11/14/85, Notice 8/28/85—published 12/4/85, effective 1/8/86]

[Filed 5/14/86, Notice 4/9/86—published 6/4/86, effective 7/9/86]

[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]

[Filed 8/5/87, Notice 6/3/87—published 8/26/87, effective 9/30/87]

[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]

[Filed 4/26/88, Notice 3/9/88—published 5/18/88, effective 6/22/88]

[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]

[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]

[Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]

[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]

[Filed 2/27/97, Notices 8/28/96, 1/1/97—published 3/26/97, effective 4/30/97]

[Filed 6/23/97, Notice 4/9/97—published 7/16/97, effective 8/20/97]

[Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]

[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 10/15/98]
[Filed 9/8/99, Notice 6/2/99—published 10/6/99, effective 11/10/99]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 7/15/03, Notice 4/16/03—published 8/6/03, effective 9/10/03]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed 11/24/08, Notice 10/8/08—published 12/17/08, effective 1/21/09]
[Filed ARC 8672B (Notice ARC 8412B, IAB 12/30/09), IAB 4/7/10, effective 5/12/10]
[Filed ARC 9406B (Notice ARC 9192B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

CHAPTER 3
PHARMACY TECHNICIANS

[Prior to 9/4/02, see 657—Ch 22]

657—3.1(155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

“*Board*” means the Iowa board of pharmacy.

“*Cashier*” means a person whose duties within the pharmacy are limited to accessing finished, packaged prescription orders and processing payments for and delivering such orders to the patient or the patient’s representative.

“*Certified pharmacy technician*” or “*certified technician*” means an individual who holds a valid current national certification and who has registered with the board as a certified pharmacy technician. The term includes an individual registered with the board who voluntarily acquired certification as provided in subrule 3.5(2).

“*Delivery*” means the transport and conveyance of a finished, securely packaged prescription order to the patient or the patient’s caregiver.

“*Nationally accredited program*” means a program and examination for the certification of pharmacy technicians that is accredited by the NCCA.

“*NCCA*” means the National Commission for Certifying Agencies.

“*Pharmacy support person*” means a person, other than a licensed pharmacist, a registered pharmacist-intern, or a registered pharmacy technician, who may perform nontechnical duties assigned by the pharmacist under the pharmacist’s responsibility and supervision pursuant to 657—Chapter 5.

“*Pharmacy technician*” or “*technician*” means a person who is employed in Iowa by a licensed pharmacy under the responsibility of an Iowa-licensed pharmacist to assist in the technical functions of the practice of pharmacy, as provided in rules 657—3.22(155A) through 657—3.24(155A), and includes a certified pharmacy technician, a pharmacy technician trainee, and an uncertified pharmacy technician.

“*Pharmacy technician certification*” or “*national certification*” means a certificate issued by a national pharmacy technician certification authority accredited by the NCCA attesting that the technician has successfully completed the requirements of the certification program. The term includes evidence of renewal of the national certification.

“*Pharmacy technician trainee*” or “*technician trainee*” means an individual who is in training to become a pharmacy technician and who is in the process of acquiring national certification as a pharmacy technician as provided in rule 657—3.5(155A).

“*Pharmacy technician training*” or “*technician training*” means education or experience acquired for the purpose of qualifying for and preparing for national certification.

“*Supervising pharmacist*” means an Iowa-licensed pharmacist who is on duty in an Iowa-licensed pharmacy and who is responsible for the actions of a pharmacy technician or other supportive personnel.

“*Uncertified pharmacy technician*” or “*uncertified technician*” means a pharmacy technician who has not attained national certification and who qualifies for the time extension to attain national certification as provided in rule 657—3.6(155A).

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.2(155A) Purpose of registration. A registration program for pharmacy technicians is established for the purposes of determining the competency of a pharmacy technician or of an applicant for registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician and for the purposes of identification, tracking, and disciplinary action for violations of federal or state pharmacy or drug laws or regulations.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.3(155A) Registration required. Any person employed in Iowa as a pharmacy technician, except a pharmacist-intern whose pharmacist-intern registration is in good standing with the board, shall obtain and maintain during such employment a current registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician pursuant to these rules. An individual accepting employment as a pharmacy technician in Iowa who fails to register as a certified pharmacy

technician, technician trainee, or uncertified technician as provided by these rules may be subject to disciplinary sanctions. A certified pharmacy technician accepting employment as a certified pharmacy technician in Iowa who fails to register as a certified pharmacy technician or who fails to maintain national certification may be subject to disciplinary sanctions.

3.3(1) *Licensed health care provider.* Except as provided in this rule, a licensed health care provider whose registration or license is in good standing with and not subject to current disciplinary sanctions or practice restrictions imposed by the licensee's professional licensing board and who assists in the technical functions of the practice of pharmacy shall be required to register as a certified pharmacy technician, technician trainee, or uncertified technician pursuant to these rules.

3.3(2) *Original application required.* Any person not currently registered with the board as a pharmacy technician shall complete the appropriate application for registration within 30 days of accepting employment in an Iowa pharmacy as a pharmacy technician. Such application shall be received in the board office before the expiration of this 30-day period.

3.3(3) *Technician training.* A person who is enrolled in a college-based or American Society of Health-System Pharmacists (ASHP)-accredited technician training program shall obtain a pharmacy technician trainee registration prior to beginning on-site practical experience. A person who is employed in a pharmacy and who is receiving pharmacy technician training through work experience shall obtain a pharmacy technician trainee registration within 30 days of the commencement of pharmacy technician training.

3.3(4) *Registration number.* Each pharmacy technician registered with the board will be assigned a unique registration number.

[ARC 9009B, IAB 8/11/10, effective 7/23/10; ARC 9407B, IAB 3/9/11, effective 4/13/11]

657—3.4 Reserved.

657—3.5(155A) Certification of pharmacy technicians. Except as provided in rule 657—3.6(155A) or subrule 3.5(3), effective July 1, 2010, all pharmacy technicians shall be required to be nationally certified as provided by this rule. National certification does not replace the need for licensed pharmacist control over the performance of delegated functions, nor does national certification exempt the pharmacy technician from registration pursuant to these rules. A certified pharmacy technician shall maintain the technician's national certification, in addition to the technician's Iowa registration, during any period of employment in an Iowa pharmacy as a certified pharmacy technician.

3.5(1) *Certification prior to July 1, 2010.* An individual who holds a valid current national certification from the Institute for the Certification of Pharmacy Technicians (ICPT) or the Pharmacy Technician Certification Board (PTCB) and who acquired such certification prior to July 1, 2010, shall be deemed to have met the requirement for national certification beginning July 1, 2010, provided the certification is maintained in current standing.

3.5(2) *Required certification effective July 1, 2010.* Beginning July 1, 2010, national certification acquired through successful completion of any NCCA-accredited pharmacy technician certification program and examination fulfills the requirement for national certification.

3.5(3) *Pharmacy technician trainee.* Except as provided in rule 657—3.6(155A), effective July 1, 2009, a person who is in the process of acquiring national certification as a pharmacy technician shall register with the board as a pharmacy technician trainee. The registration shall be issued for a period of one year and shall not be renewed.

3.5(4) *Certified pharmacy technician.* Beginning July 1, 2010, all applicants for a new pharmacy technician registration except as provided by subrule 3.5(3), and all applicants for renewal of a pharmacy technician registration except as provided in rule 657—3.6(155A), shall provide proof of current national pharmacy technician certification and shall complete the application for certified pharmacy technician registration.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9009B, IAB 8/11/10, effective 7/23/10; ARC 9407B, IAB 3/9/11, effective 4/13/11]

657—3.6(155A) Extension of deadline for national certification. A pharmacy technician who meets all of the criteria identified in this rule shall not be required to acquire national certification prior to

December 31, 2013. The pharmacy technician shall register with the board as an uncertified pharmacy technician and shall maintain that registration during all periods of employment as a pharmacy technician. To qualify for this extension, the uncertified pharmacy technician shall meet all of the following criteria:

3.6(1) *Prior registration.* The pharmacy technician shall have registered as a pharmacy technician prior to January 1, 2010;

3.6(2) *Minimum prior employment.* The pharmacy technician shall have worked as a pharmacy technician for at least 2,000 hours in the 18-month period immediately before submission of the application for renewal of the pharmacy technician's registration as evidenced by one or more affidavits as provided in paragraph 3.8(5) "d"; and

3.6(3) *Minimum continued employment.* The pharmacy technician shall continue to work as a pharmacy technician for at least 2,000 hours during any 18-month period between January 1, 2010, and December 31, 2013, or until the pharmacy technician attains national certification.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.7 Reserved.

657—3.8(155A) Application form.

3.8(1) *Required information.* The application for a certified pharmacy technician registration, pharmacy technician trainee registration, or uncertified pharmacy technician registration shall include the following:

- a. Information sufficient to identify the applicant including, but not limited to, name, address, date of birth, gender, and social security number;
- b. Educational background;
- c. Work experience;
- d. Current place or places of employment;
- e. Any other information deemed necessary by the board and as provided by this rule.

3.8(2) *Declaration of current impairment or limitations.* The applicant shall declare any current use of drugs, alcohol, or other chemical substances that in any way impairs or limits the applicant's ability to perform the duties of a pharmacy technician with reasonable skill and safety.

3.8(3) *History of felony or misdemeanor crimes.* The applicant shall declare any history of being charged, convicted, found guilty of, or entering a plea of guilty or no contest to a felony or misdemeanor crime (other than minor traffic violations with fines under \$100).

3.8(4) *History of disciplinary actions.* The applicant shall declare any history of disciplinary actions or practice restrictions imposed by a state health care professional or technician licensure or registration authority.

3.8(5) *Additional information.* The following additional information shall be required from an applicant for the specified registration.

a. *Technician trainee.* The applicant for technician trainee registration shall identify the source of technician training, the anticipated date of completion of training, and the anticipated date of national certification.

b. *Certified pharmacy technician.* The applicant for certified technician registration shall provide proof of current pharmacy technician certification. The applicant shall also identify all current pharmacy employers including pharmacy name, license number, address, and average hours worked per week.

c. *Licensed health care provider.* In addition to the additional information required by paragraph "a," "b" or "d" as applicable, a licensed health care provider shall provide evidence that the licensee's professional license or registration is current and in good standing and is not subject to current disciplinary sanctions or practice restrictions imposed by the licensee's professional licensing authority.

d. *Uncertified pharmacy technician.* The applicant for uncertified pharmacy technician registration shall submit with the application for registration renewal one or more affidavits signed by the pharmacists in charge of one or more Iowa pharmacies where the applicant practiced as a pharmacy

technician during the 18 months prior to submission of the application for registration. Affidavits shall be on a form provided by the board office.

3.8(6) Sworn signature. The applicant shall sign the application under penalty of perjury and shall submit the application to the board with the appropriate fees pursuant to rule 657—3.10(155A).
[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.9(155A) Registration term and renewal. A pharmacy technician registration shall expire as provided in this rule for the specified registration. The board shall not require continuing education for renewal of a pharmacy technician registration.

3.9(1) Certified pharmacy technician registration. A certified pharmacy technician registration shall expire on the second last day of the birth month following initial registration, with the exception that a new certified pharmacy technician registration issued within the two months immediately preceding the applicant's birth month shall expire on the third last day of the birth month following initial registration.

3.9(2) Pharmacy technician trainee registration. Beginning July 1, 2009, a registration for a pharmacy technician who is in the process of acquiring national certification (technician trainee) shall expire on the last day of the registration month 12 months following the date of registration or 12 months following the date registration was required pursuant to subrule 3.3(3).

a. National certification completed. When the registered technician trainee completes national certification, and no later than the date of expiration of the technician trainee registration, the pharmacy technician trainee shall complete and submit an application for certified pharmacy technician registration. A successful application shall result in issuance of a new certified pharmacy technician registration as provided in subrule 3.9(1).

b. Voluntary cancellation of registration. A registered technician trainee who fails to complete national certification prior to expiration of the technician trainee registration shall notify the board that the pharmacy technician trainee registration should be canceled and that the individual has ceased practice as a pharmacy technician.

c. Failure to notify the board. If a pharmacy technician trainee fails to notify the board prior to the expiration date of the technician trainee registration regarding the individual's intentions as provided in paragraph "a" or "b," the technician trainee registration shall be canceled and the individual shall cease practice as a pharmacy technician.

3.9(3) Uncertified pharmacy technician registration. Beginning June 1, 2010, a registration for a pharmacy technician who qualifies for the time extension for certification as provided by rule 657—3.6(155A) shall expire the second last day of the birth month following the latest scheduled registration renewal. In no case shall a registration for an uncertified pharmacy technician expire later than December 31, 2013, unless the pharmacy technician attains national certification as provided in subrule 3.5(2) and is reclassified as a certified pharmacy technician.
[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.10(155A) Registration fee. The following fees for initial registration and registration renewal shall apply to the specified registration applications filed within the following time frames. The appropriate fee shall be submitted with the registration application in the form of a personal check, certified check or cashier's check, or a money order payable to the Iowa Board of Pharmacy.

3.10(1) Certified or uncertified pharmacy technician registration. The fee for obtaining an initial certified pharmacy technician registration or for biennial renewal of a certified pharmacy technician registration or an uncertified pharmacy technician registration shall be \$50 plus applicable surcharge pursuant to rule 657—30.8(155A).

3.10(2) Technician trainee registration. The fee for a one-year pharmacy technician trainee registration shall be \$20 plus applicable surcharge pursuant to rule 657—30.8(155A).
[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.11(155A) Late applications and fees.

3.11(1) Initial registration. An application for initial registration that is not received within the applicable period specified in subrule 3.3(2) or 3.3(3) shall be delinquent, and the applicant shall be

assessed a late payment fee. The late payment fee shall be equal to the amount of the fee for initial registration. A delinquent initial registration shall include payment of the initial registration fee, applicable surcharge pursuant to rule 657—30.8(155A), and late payment fee.

3.11(2) *Registration renewal.* A technician registration that is not renewed before its expiration date shall be delinquent, and the registrant shall not continue employment as a pharmacy technician until the registration is reactivated. An individual who continues employment as a pharmacy technician without a current registration, in addition to the pharmacy and the pharmacist in charge that allow the individual to continue practice as a pharmacy technician, may be subject to disciplinary sanctions.

a. A person who is required to renew a registration pursuant to these rules and who fails to renew the registration before the first day of the month following expiration shall pay the renewal fee, a penalty fee equal to the amount of the renewal fee, plus the applicable surcharge pursuant to rule 657—30.8(155A).

b. A person who is required to renew a registration pursuant to these rules and who fails to renew the registration before the first day of the second month following expiration shall pay the renewal fee, a penalty fee equal to the amount of the renewal fee, the applicable surcharge pursuant to rule 657—30.8(155A), plus an additional penalty fee of \$10 for each additional month, not to exceed three additional months, that the registration is delinquent. The maximum combined fee payment for reactivation of a delinquent registration shall not exceed an amount equal to twice the renewal fee plus \$30 plus the applicable surcharge pursuant to rule 657—30.8(155A).

657—3.12(155A) Registration certificates. The certificate of technician registration issued by the board to a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician is the property of and shall be maintained by the registered technician. The certificate or a copy of the certificate shall be maintained in each pharmacy where the pharmacy technician works. Each pharmacy utilizing pharmacy technicians shall be responsible for verifying that all pharmacy technicians working in the pharmacy are registered, that technician registrations remain current and active, and that a certified pharmacy technician's national certification remains current and active.

[ARC 9009B, IAB 8/11/10, effective 7/23/10; ARC 9407B, IAB 3/9/11, effective 4/13/11]

657—3.13(155A) Notifications to the board. A pharmacy technician shall report to the board within ten days a change of the technician's name, address, or pharmacy employment status.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.14 to 3.16 Reserved.

657—3.17(155A) Training and utilization of pharmacy technicians. All Iowa-licensed pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians appropriate to the practice of pharmacy. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection and copying by the board or an agent of the board.

657—3.18(147,155A) Identification of pharmacy technician.

3.18(1) *Identification badge.* A pharmacy technician shall wear a visible identification badge while on duty that clearly identifies the person as a pharmacy technician and that includes at least the technician's first name.

3.18(2) *Misrepresentation prohibited.* A pharmacy technician shall not represent himself or herself in any manner as a pharmacist or pharmacist-intern. A pharmacy technician shall not represent himself or herself in any manner as a certified pharmacy technician unless the technician has attained national pharmacy technician certification.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.19 Reserved.

657—3.20(155A) Responsibility of supervising pharmacist. The ultimate responsibility for the actions of a pharmacy technician shall remain with the supervising pharmacist.
[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.21(155A) Delegation of functions.

3.21(1) Technical dispensing functions. A pharmacist may delegate technical dispensing functions to an appropriately trained and registered pharmacy technician, but only if the pharmacist is on site and available to supervise the pharmacy technician when delegated functions are performed, except as provided in 657—subrule 6.7(2) or 657—subrule 7.6(2), as appropriate, or as provided for telepharmacy in 657—Chapter 9. The pharmacist shall provide and document the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative. A pharmacy technician shall not delegate technical functions to a pharmacy support person.

3.21(2) Nontechnical functions. A pharmacist may delegate nontechnical functions to a pharmacy technician or a pharmacy support person only if the pharmacist is present to supervise the pharmacy technician or pharmacy support person when delegated nontechnical functions are performed, except as provided in 657—subrule 6.7(2) or 657—subrule 7.6(2), as appropriate, or as provided for telepharmacy in 657—Chapter 9.
[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—3.22(155A) Technical functions. At the discretion of the supervising pharmacist, the following technical functions may be delegated to a pharmacy technician as specified in the following subrules.

3.22(1) Certified pharmacy technician. Under the supervision of a pharmacist, a certified pharmacy technician may perform technical functions delegated by the supervising pharmacist including, but not limited to, the following:

- a. Perform packaging, manipulative, or repetitive tasks relating to the processing of a prescription or medication order in a licensed pharmacy.
- b. Accept prescription refill authorizations communicated to a pharmacy by a prescriber or by the prescriber's office.
- c. Contact prescribers to obtain prescription refill authorizations.
- d. Process pertinent patient information, including information regarding allergies and disease state.
- e. Enter prescription and patient information into the pharmacy computer system.
- f. Inspect drug supplies provided and controlled by an Iowa-licensed pharmacy but located or maintained outside the pharmacy department, including but not limited to drug supplies maintained in an ambulance or other emergency medical service vehicle, a long-term care facility, a hospital patient care unit, or a hospice facility.
- g. Affix required prescription labels upon any container of drugs sold or dispensed pursuant to the prescription of an authorized prescriber.
- h. Prepackage or label multidose and single-dose packages of drugs, including dose picks for unit dose cart or AMDS fills for hospital or long-term care facility patients.
- i. Perform drug compounding processes for nonsterile compounding as provided in 657—Chapter 20.
- j. Perform drug compounding processes for sterile compounding as provided in 657—Chapter 13.
- k. As provided in rule 657—3.24(155A), accept new prescription drug orders or medication orders communicated to the pharmacy by a prescriber or by the prescriber's agent.

3.22(2) Pharmacy technician trainee. Under the supervision of a pharmacist, a pharmacy technician trainee may perform only the following technical functions delegated by the supervising pharmacist:

- a. Perform packaging, manipulative, or repetitive tasks relating to the processing of a prescription or medication order in a licensed pharmacy.
- b. Accept prescription refill authorizations communicated to a pharmacy by a prescriber or by the prescriber's office.

- c. Contact prescribers to obtain prescription refill authorizations.
- d. Process pertinent patient information, including information regarding allergies and disease state.
- e. Enter prescription and patient information into the pharmacy computer system.
- f. Affix required prescription labels upon any container of drugs sold or dispensed pursuant to the prescription of an authorized prescriber.
- g. Prepackage or label multidose and single-dose packages of drugs, including dose picks for unit dose cart or AMDS fills for hospital or long-term care facility patients.
- h. Under the supervision of a pharmacist who provides training and evaluates and monitors trainee competence in the compounding processes, perform drug compounding processes for nonsterile compounding as provided in 657—Chapter 20.
- i. Under the supervision of a pharmacist who provides training and evaluates and monitors trainees, and contingent on successful completion of appropriate media fill testing processes, perform drug compounding processes for sterile compounding as provided in 657—Chapter 13.

3.22(3) [See **Objection at end of chapter**] *Uncertified pharmacy technician.* Under the supervision of a pharmacist, an uncertified pharmacy technician may perform technical functions delegated by the supervising pharmacist limited to the following:

- a. Select the appropriate stock supply of a prescription drug from the pharmacy drug supply shelves to process a prescription drug order.
- b. Count dosage forms of prescription drugs into appropriate prescription vials or containers pursuant to prescription drug orders. Uncertified pharmacy technicians shall not prepackage or label multidose and single-dose packages of drugs, including dose picks for unit dose cart or AMDS fills for hospital or long-term care facility patients.
- c. Affix required prescription labels upon any container of drugs sold or dispensed pursuant to the prescription of an authorized prescriber.
- d. Return or place stock supplies of prescription drugs in the appropriate locations on the pharmacy drug supply shelves.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.23(155A) Tasks a pharmacy technician shall not perform. A pharmacy technician shall not be authorized to perform any of the following judgmental tasks:

1. Provide the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order;
2. Conduct prospective drug use review or evaluate a patient's medication record for purposes identified in rule 657—8.21(155A);
3. Provide patient counseling, consultation, or patient-specific drug information, tender an offer of patient counseling on behalf of a pharmacist, or accept a refusal of patient counseling from a patient or patient's agent;
4. Make decisions that require a pharmacist's professional judgment, such as interpreting prescription drug orders or applying information;
5. Transfer a prescription drug order to another pharmacy or receive the transfer of a prescription drug order from another pharmacy;
6. Delegate technical functions to a pharmacy support person.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.24(155A) New prescription drug orders or medication orders. At the discretion of the supervising pharmacist, a certified pharmacy technician may be allowed to accept new prescription drug orders or medication orders communicated to the pharmacy by a prescriber or by the prescriber's agent if the certified pharmacy technician has received appropriate training pursuant to the pharmacy's policies and procedures. The supervising pharmacist shall remain responsible for ensuring the accuracy, validity, and completeness of the information received by the certified pharmacy technician. The pharmacist shall contact the prescriber to resolve any questions, inconsistencies, or other issues relating

to the information received by the certified pharmacy technician that involve a pharmacist's professional judgment.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.25(155A) Delegation of nontechnical functions. Rescinded IAB 4/7/10, effective 6/1/10.

657—3.26 and 3.27 Reserved.

657—3.28(147,155A) Unethical conduct or practice. Violation by a pharmacy technician of any of the provisions of this rule shall constitute unethical conduct or practice and may be grounds for disciplinary action as provided in rule 657—3.30(155A).

3.28(1) Misrepresentative deeds. A pharmacy technician shall not make any statement tending to deceive, misrepresent, or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

3.28(2) Confidentiality. In the absence of express written authorization from the patient or written order or direction of a court, except where the best interests of the patient require, a pharmacy technician shall not divulge or reveal to any person other than the patient or the patient's authorized representative, the prescriber or other licensed practitioner then caring for the patient, a licensed pharmacist, a person duly authorized by law to receive such information, or as otherwise provided in rule 657—8.16(124,155A), any of the following:

a. A patient's name, address, social security number, or any information that could be used to identify a patient;

b. The contents of any prescription drug order or medication order or the therapeutic effect thereof, or the nature of professional pharmaceutical services rendered to a patient;

c. The nature, extent, or degree of illness suffered by any patient; or

d. Any medical information furnished by the prescriber or the patient.

3.28(3) Discrimination. It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

3.28(4) Unethical conduct or behavior. A pharmacy technician shall not exhibit unethical behavior in connection with the technician's pharmacy employment. Unethical behavior shall include, but is not limited to, the following acts: verbal or physical abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.29(155A) Denial of registration. The executive director or designee may deny an application for registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205 or any rule of the board.

An individual whose application for registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician is denied pursuant to this rule may, within 30 days after issuance of the notice of denial, appeal to the board for reconsideration of the application.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

657—3.30(155A) Discipline of pharmacy technicians.

3.30(1) Violations. The board may impose discipline for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs, or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205 or any rule of the board.

3.30(2) Sanctions. The board may impose the following disciplinary sanctions:

- a. Revocation of a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician registration.
- b. Suspension of a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician registration until further order of the board or for a specified period.
- c. Nonrenewal of a certified pharmacy technician or uncertified pharmacy technician registration.
- d. Prohibition, permanently, until further order of the board, or for a specified period, from engaging in specified procedures, methods, or acts.
- e. Probation.
- f. The ordering of a physical or mental examination.
- g. The imposition of civil penalties not to exceed \$25,000.
- h. Issuance of a citation and warning.
- i. Such other sanctions allowed by law as may be appropriate.

[ARC 9009B, IAB 8/11/10, effective 7/23/10]

These rules are intended to implement Iowa Code sections 147.72, 155A.23, 155A.33, and 155A.39 and Iowa Code section 155A.6A as amended by 2010 Iowa Acts, House File 2531, section 112.

[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]

[Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]

[Filed 2/22/99, Notice 10/21/98—published 3/10/99, effective 4/14/99]

[Filed 9/8/99, Notice 6/2/99—published 10/6/99, effective 11/10/99]

[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]

[Filed 3/11/04, Notice 8/6/03—published 3/31/04, effective 5/5/04]

[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]

[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]

[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]

[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]

[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]

[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]

[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]

[Filed 3/5/08, Notice 12/19/07—published 3/26/08, effective 4/30/08¹]

[Filed emergency 6/9/08—published 7/2/08, effective 7/9/08]

[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]

[Filed Emergency ARC 9009B, IAB 8/11/10, effective 7/23/10]

[Editorial change: IAC Supplement 10/6/10]

[Filed ARC 9407B (Notice ARC 9193B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

¹ April 30, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.

OBJECTION

At its September 14, 2010 meeting the Administrative Rules Review Committee voted to object to a specific provision of **ARC 9009B**: subrule 3.22(3) relating to the functions that may be performed by an uncertified pharmacy technician. The filing appears in IAB Vol. XXXIII, No. 03 (08/11/10). The committee takes this action pursuant to the authority of §17A.4(5).

The committee objects to subrule 3.22(3) on the grounds that it is beyond the authority delegated to the agency. The head note to **ARC 9009B** cites 2010 Iowa Acts, House File 2531, section 112, as the authority for the filing. That provision relates only to extending the timeframe for certain pharmacy technicians or pharmacy technician trainees to obtain national certification. The provisions of subrule 3.22(3) do not relate to national certification and exceed the scope of **ARC 9009B**.

Objection filed September 21, 2010

CHAPTER 7
HOSPITAL PHARMACY PRACTICE
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 12]

657—7.1(155A) Purpose and scope. Hospital pharmacy means and includes a pharmacy licensed by the board and located within any hospital, health system, institution, or establishment which maintains and operates organized facilities for the diagnosis, care, and treatment of human illnesses to which persons may or may not be admitted for overnight stay at the facility. A hospital is a facility licensed pursuant to Iowa Code chapter 135B. This chapter does not apply to a pharmacy located within such a facility for the purpose of providing outpatient prescriptions. A pharmacy providing outpatient prescriptions is and shall be licensed as a general pharmacy subject to the requirements of 657—Chapter 6. The requirements of these rules for hospital pharmacy practice apply to all hospitals, regardless of size or type, and are in addition to the requirements of 657—Chapter 8 and other rules of the board relating to services provided by the pharmacy.

657—7.2(155A) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall be responsible for, at a minimum, the items identified in this rule. A part-time pharmacist in charge has the same obligations and responsibilities as a full-time pharmacist in charge. Where 24-hour operation of the pharmacy is not feasible, a pharmacist shall be available on an “on call” basis. The pharmacist in charge, at a minimum, shall be responsible for:

1. Ensuring that the pharmacy utilizes an ongoing, systematic program for achieving performance improvement and ensuring the quality of pharmaceutical services.
2. Ensuring that the pharmacy employs an adequate number of qualified personnel commensurate with the size and scope of services provided by the pharmacy and sufficient to ensure adequate levels of quality patient care services. Drug dispensing by nonpharmacists shall be minimized and eliminated wherever possible.
3. Ensuring the availability of any equipment and references necessary for the particular practice of pharmacy.
4. Ensuring that a pharmacist performs therapeutic drug monitoring and drug use evaluation.
5. Ensuring that a pharmacist provides drug information to other health professionals and to patients.
6. Dispensing drugs to patients, including the packaging, preparation, compounding, and labeling functions performed by pharmacy personnel.
7. Delivering drugs to the patient or the patient’s agent.
8. Ensuring that patient medication records are maintained as specified in rule 657—7.10(124,155A).
9. Training pharmacy technicians and pharmacy support persons.
10. Ensuring adequate and appropriate pharmacist oversight and supervision of pharmacy technicians and pharmacy support persons.
11. Procuring and storing prescription drugs and devices and other products dispensed from the pharmacy.
12. Distributing and disposing of drugs from the pharmacy.
13. Maintaining records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all drugs as required by applicable state and federal laws, rules, and regulations.
14. Establishing and maintaining effective controls against the theft or diversion of prescription drugs, controlled substances, and records for such drugs.
15. Preparing a written operations manual governing pharmacy functions; periodically reviewing and revising those policies and procedures to reflect changes in processes, organization, and other pharmacy functions; and ensuring that all pharmacy personnel are familiar with the contents of the manual.

16. Ensuring the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy.
[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—7.3(155A) Reference library. References may be printed or computer-accessed. A reference library shall be maintained which includes, as a minimum, one current reference from each of the following categories, including access to current periodic updates.

1. The Iowa Pharmacy Law and Information Manual.
2. A patient information reference that includes or provides patient information in compliance with rule 657—6.14(155A).
3. A reference on drug interactions.
4. A general information reference.
5. A drug equivalency reference.
6. An injectable-drug compatibility reference.
7. A drug identification reference to enable identification of drugs brought into the facility by patients.
8. The readily accessible telephone number of a poison control center that serves the area.
9. Additional references as may be necessary for the pharmacist to adequately meet the needs of the patients served. For example, the treatment of pediatric patients and oncology patients would require additional references unique to those specialties.

657—7.4 and 7.5 Reserved.

657—7.6(124,155A) Security. The pharmacy shall be located in an area or areas that facilitate the provision of services to patients and shall be integrated with the facility's communication and transportation systems. The following conditions must be met to ensure appropriate control over drugs and chemicals in the pharmacy:

7.6(1) Pharmacist responsibility. Each pharmacist, while on duty, shall be responsible for the security of the pharmacy area, including provisions for effective control against theft of, diversion of, or unauthorized access to drugs or devices, controlled substances, records for such drugs, and patient records as provided in 657—Chapter 21. Policies and procedures shall identify the minimum amount of time that a pharmacist is available at the hospital pharmacy.

7.6(2) Access when pharmacist absent. When the pharmacist is absent from the facility, the pharmacy is closed. Policies and procedures shall be established that identify who will have access to the pharmacy when the pharmacy is closed and the procedures to be followed for obtaining drugs, devices, and chemicals to fill an emergent need during the pharmacist's absence.

a. The pharmacist in charge may designate pharmacy technicians or pharmacy support persons who may be present in the pharmacy to perform technical or nontechnical functions, respectively, designated by the pharmacist in charge. Activities identified in paragraph "*d*" of this subrule may not be performed when the pharmacy is closed.

b. If the pharmacist in charge has authorized the presence in the pharmacy of a pharmacy technician or a pharmacy support person to perform designated functions when the pharmacy is closed, only a certified pharmacy technician may assist another authorized, licensed health care professional to locate a drug or device pursuant to an emergent need. The pharmacy technician or the pharmacy support person may not dispense or deliver the drug, chemical, or device to the licensed health care professional. The licensed health care professional shall comply with established policies and procedures for obtaining drugs, devices, and chemicals when the pharmacy is closed. The licensed health care professional shall not ask or expect the pharmacy technician or the pharmacy support person to verify that the appropriate drug, chemical, or device has been obtained from the pharmacy.

c. A pharmacy technician or a pharmacy support person who is present in the pharmacy when the pharmacy is closed shall prepare and maintain in the pharmacy a log identifying each period of time that the pharmacy technician or pharmacy support person worked in the pharmacy while the pharmacy was

closed and identifying each activity performed during that time period. Each entry shall be dated and each daily record shall be signed by the pharmacy technician or pharmacy support person who prepared the record. The log shall be periodically reviewed by the pharmacist in charge.

d. Activities which shall not be performed by a pharmacy technician or a pharmacy support person when the pharmacist is absent from the facility include:

(1) Dispensing, delivering, or distributing any prescription drugs or devices to patients or others, including health care professionals, prior to pharmacist verification. Verification by a nurse or other licensed health care professional shall not supplant verification by a pharmacist.

(2) Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.

(3) Conducting prospective drug use review or evaluating a patient's medication record for purposes identified in rule 657—8.21(155A).

(4) Providing patient counseling, consultation, or drug information.

(5) Making decisions that require a pharmacist's professional judgment such as interpreting or applying information.

(6) Preparing compounded drug products for immediate administration by other hospital staff or health care professionals without verification by a pharmacist.

7.6(3) Locked areas. All pharmacy areas where drugs or devices are maintained or stored and where a pharmacist is not continually present shall be locked.

7.6(4) Verification by pharmacist. When the pharmacy is open, patient-specific drugs or devices shall not be distributed prior to the pharmacist's final verification and approval.

7.6(5) Drugs or devices in patient care areas. Drugs or devices maintained or stored in patient care areas shall be in locked storage unless the patient care unit is staffed by health care personnel and the medication area is visible to staff at all times.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9408B, IAB 3/9/11, effective 4/13/11]

657—7.7(155A) Verification by pharmacist when pharmacy is closed. A hospital pharmacy may contract with another pharmacy for remote pharmacist preview and verification of patient-specific drugs or devices ordered for a patient when the hospital pharmacy is closed. Contracted services may include pharmacist order entry pursuant to subrule 7.8(3). Pharmacies entering into a contract or agreement pursuant to this rule shall comply with the following requirements:

7.7(1) Nonsupplanting service. A contract or agreement for remote pharmacist services shall not relieve the hospital pharmacy from employing or contracting with a pharmacist to provide routine pharmacy services within the facility. The activities authorized by this rule are intended to supplement hospital pharmacy services when the pharmacy is closed and are not intended to eliminate the need for an on-site hospital pharmacy or pharmacist.

7.7(2) Hospital-staff pharmacist. Nothing in this rule shall prohibit a pharmacist employed by or contracting with a hospital pharmacy for on-site services from also providing remote preview and verification of patient-specific drugs or devices ordered for a patient when the hospital pharmacy is closed. A pharmacist previewing and verifying drug or device orders from a remote location shall have access to patient information pursuant to subrule 7.7(4) or 7.7(5), shall have access to the prescriber as provided in subrule 7.7(6), and shall be identified on the drug or device order as provided in subrule 7.7(7).

7.7(3) Licenses required. A pharmacy contracting with a hospital pharmacy to provide services pursuant to this rule shall maintain with the board a current Iowa pharmacy license. A remote pharmacist providing pharmacy services as an employee or agent of a contracting pharmacy pursuant to this rule shall be licensed to practice pharmacy in Iowa.

7.7(4) Electronic access to patient information. The remote pharmacist shall have secure electronic access to the hospital pharmacy's patient information system and to all other electronic systems that the on-site pharmacist has access to when the pharmacy is open. The remote pharmacist shall receive training in the use of the hospital's electronic systems.

7.7(5) *Nonelectronic patient information.* If a hospital's patient information is not maintained in an electronic data system or if the hospital pharmacy is not able to provide remote electronic access to the patient information system, the hospital pharmacy may petition for a waiver of subrule 7.7(4) pursuant to 657—Chapter 34 and this subrule. In addition to the information required pursuant to 657—Chapter 34, the petition for waiver shall identify the hospital pharmacy's alternative to the electronic sharing of patient information, shall explain in detail how the alternative method will ensure timely provision of patient information necessary for the remote pharmacist to effectively review the patient's drug regimen and history, and shall detail the processes involved in the alternative proposal including identification of all individuals involved in each of those processes.

7.7(6) *Access to prescriber.* The remote pharmacist shall be able to contact the prescriber to discuss any concerns identified during the pharmacist's review of the patient's information.

7.7(7) *Pharmacist identified.* The record of each patient-specific drug or device order processed pursuant to this rule shall identify, by name or other unique identifier, each pharmacist involved in the preview and verification of the order. The record of each patient-specific drug or device visually verified pursuant to this rule shall identify, by name or other unique identifier, each pharmacist involved in the visual verification of the product.

[ARC 9408B, IAB 3/9/11, effective 4/13/11]

657—7.8(124,126,155A) Drug distribution and control. Policies and procedures governing drug distribution and control shall be developed by the pharmacist in charge with input from other involved hospital staff such as physicians and nurses, from committees such as the pharmacy and therapeutics committee or its equivalent, and from any related patient care committee. It is essential that the pharmacist in charge or designee routinely be available to or on all patient care areas to establish rapport with the personnel and to become familiar with and contribute to medical and nursing procedures relating to drugs.

7.8(1) *Drug preparation.* The pharmacist shall institute the control procedures needed to ensure that patients receive the correct drugs at the proper times. Adequate quality assurance procedures shall be developed.

a. Hospitals shall utilize a unit dose dispensing system pursuant to rule 657—22.1(155A). All drugs dispensed by the pharmacist for administration to patients shall be in single unit or unit dose packages if practicable unless the dosage form or drug delivery device makes it impracticable to package the drug in a unit dose or single unit package.

(1) The pharmacist in charge shall establish policies and procedures that identify situations when drugs may be dispensed in other than unit dose or single unit packages outside the unit dose dispensing system.

(2) The need for nurses to manipulate drugs prior to their administration shall be minimized.

b. Pharmacy personnel shall, except as specified in policies and procedures, prepare all sterile products in conformance with 657—Chapter 13.

c. Pharmacy personnel shall compound or prepare drug formulations, strengths, dosage forms, and packages useful in the care of patients.

7.8(2) *Drug formulary.* The pharmacist in charge shall maintain a current formulary of drug products approved for use in the institution and shall be responsible for specifications for those drug products and for selecting their source of supply.

7.8(3) *Medication orders.* Except as provided in subrule 7.8(14), a pharmacist shall receive a copy of the original medication order for review except when the prescriber directly enters the medication order into an electronic medical record system or when the prescriber issues a verbal medication order directly to a registered nurse or pharmacist who then enters the order into an electronic medical record system. If an individual other than the prescriber enters a medication order into an electronic medical record system, the pharmacist shall review and verify the entry against the original order before the drug is dispensed except for emergency use, when the pharmacy is closed, or when the original order is a verbal order from the prescriber to the registered nurse or pharmacist, or as provided in rule 657—7.7(155A). When the pharmacy is closed, a registered nurse or pharmacist may enter a

medication order into an electronic medical record system for the purpose of creating an electronic medication administration record and a pharmacist shall verify the entry against the original medication order as soon as practicable. Hospitalwide and pharmacy stand-alone computer systems shall be secure against unauthorized entry. The use of abbreviations and chemical symbols on medication orders shall be discouraged but, if used, shall be limited to abbreviations and chemical symbols approved by the appropriate patient care committee.

7.8(4) *Stop order.* A written policy or other system concerning stop orders shall be established to ensure that medication orders are not inappropriately continued.

7.8(5) *Emergency drug supplies and floor stock.* Supplies of drugs for use in medical emergencies shall be immediately available at each nursing unit or service area as specified in policies and procedures. Authorized stocks shall be periodically reviewed in a multidisciplinary manner. All drug storage areas within the hospital shall be routinely inspected to ensure that no outdated or unusable items are present and that all stock items are properly labeled and stored.

7.8(6) *Disaster services.* The pharmacy shall be prepared to provide drugs and pharmaceutical services in the event of a disaster affecting the availability of drugs or internal access to drugs or access to the pharmacy.

7.8(7) *Drugs brought into the institution.* The pharmacist in charge shall determine those circumstances when patient-owned drugs brought into the institution may be administered to a hospital patient and shall establish policies and procedures governing the use and security of drugs brought into the institution. Procedures shall address identification of the drug and methods for ensuring the integrity of the product prior to permitting its use by the patient. The use of patient-owned drugs shall be minimized to the greatest extent possible.

7.8(8) *Samples.* The use of drug samples within the institution shall be eliminated to the extent possible. Sample use is prohibited for hospital inpatient use. If the use of drug samples is permitted for hospital outpatients, that use of samples shall be controlled and the samples shall be distributed through the pharmacy or through a process developed in cooperation with the pharmacy and the institution's appropriate patient care committee, subject to oversight by the pharmacy.

7.8(9) *Investigational drugs.* If investigational drugs are used in the institution:

- a. A pharmacist shall be a member of the institutional review board.
- b. The pharmacy shall be responsible, in cooperation with the principal investigator, for providing information about investigational drugs used in the institution and for the distribution and control of those drugs.

7.8(10) *Hazardous drugs and chemicals.* The pharmacist, in cooperation with other hospital staff, shall establish policies and procedures for handling drugs and chemicals that are known occupational hazards. The procedures shall maintain the integrity of the drug or chemical and protect hospital personnel.

7.8(11) *Leave meds.* Labeling of prescription drugs for a patient on leave from the facility for a period in excess of 24 hours shall comply with 657—subrule 6.10(1). The dispensing pharmacy shall be responsible for packaging and labeling leave meds in compliance with this subrule.

7.8(12) *Discharge meds.* Drugs authorized for a patient being discharged from the facility shall be labeled in compliance with 657—subrule 6.10(1) before the patient removes those drugs from the facility premises. The dispensing pharmacy shall be responsible for packaging and labeling discharge meds in compliance with this subrule.

7.8(13) *Own-use outpatient prescriptions.* If the hospital pharmacy dispenses own-use outpatient prescriptions, the pharmacy shall comply with all requirements of 657—Chapter 6 except rule 657—6.1(155A).

7.8(14) *Influenza and pneumococcal vaccines.* As authorized by federal law, a written or verbal patient-specific medication administration order shall not be required prior to administration to an adult patient of influenza and pneumococcal polysaccharide vaccines pursuant to physician-approved hospital policy and after the patient has been assessed for contraindications. Administration shall be recorded in the patient's medical record.

[ARC 8170B, IAB 9/23/09, effective 10/28/09]

657—7.9(124,155A) Drug information. The pharmacy is responsible for providing the institution's staff and patients with accurate, comprehensive information about drugs and their use and shall serve as its center for drug information.

7.9(1) Staff education. The pharmacist shall keep the institution's staff well informed about the drugs used in the institution and their various dosage forms and packagings.

7.9(2) Patient education. The pharmacist shall help ensure that all patients are given adequate information about the drugs that they receive. This is particularly important for ambulatory, home care, and discharged patients. These patient education activities shall be coordinated with the nursing and medical staffs and patient education department, if any.

657—7.10(124,155A) Ensuring rational drug therapy. An important aspect of pharmaceutical services is that of maximizing rational drug use. The pharmacist, in concert with the medical staff, shall develop policies and procedures for ensuring the quality of drug therapy.

7.10(1) Patient profile. Sufficient patient information shall be collected, maintained, and reviewed by the pharmacist to ensure meaningful and effective participation in patient care. This requires that a drug profile be maintained for each patient receiving care at the hospital. A pharmacist-conducted drug history from patients may be useful in this regard.

a. Appropriate clinical information about patients shall be available and accessible to the pharmacist for use in daily practice.

b. The pharmacist shall review each patient's current drug regimen and directly communicate any suggested changes to the prescriber.

7.10(2) Adverse drug events. The pharmacist, in cooperation with the appropriate patient care committee, shall develop a mechanism for the reporting and review, by the committee or other appropriate medical group, of adverse drug events. The pharmacist shall be informed of all reported adverse drug events occurring in the facility. Adverse drug events include but need not be limited to adverse drug reactions and medication errors.

657—7.11(124,126,155A) Outpatient services. No prescription drugs shall be dispensed to patients in a hospital outpatient setting. If a need is established for the dispensing of a prescription drug to an outpatient, a prescription drug order shall be provided to the patient to be filled at a pharmacy of the patient's choice.

7.11(1) Definitions. For the purposes of this rule, the following definitions shall apply:

"Emergency department patient" means an individual who is examined and evaluated in the emergency department.

"Outpatient" means an individual examined and evaluated by a prescriber who determined the individual's need for the administration of a drug or device, which individual presents to the hospital outpatient setting with a prescription or order for administration of a drug or device. "Outpatient" does not include an emergency department patient.

"Outpatient medication order" means a written order from a prescriber or an oral or electronic order from a prescriber or the prescriber's authorized agent for administration of a drug or device. An outpatient medication order may authorize continued or periodic administration of a drug or device for a period of time and frequency determined by the prescriber or by hospital policy, not to exceed legal limits for the refilling of a prescription drug order.

7.11(2) Administration in the outpatient setting. Drugs shall be administered only to outpatients who have been examined and evaluated by a prescriber who determined the patient's need for the drug therapy ordered.

a. Accountability. A system of drug control and accountability shall be developed and supervised by the pharmacist in charge and the facility's outpatient services committee, or a similar group or person responsible for policy in the outpatient setting. The system shall ensure accountability of drugs incidental to outpatient nonemergency therapy or treatment. Drugs shall be administered only in accordance with the system.

b. Controlled substances. Controlled substances maintained in the outpatient setting are kept for use by or at the direction of prescribers for the nonemergency therapy or treatment of outpatients. In order to receive a controlled substance, a patient shall be examined in the outpatient setting or in an alternate practice setting or office by a prescriber who shall determine the patient's need for the drug. If the patient is examined in a setting outside the outpatient setting, the prescriber shall provide the patient with a written prescription or order to be presented at the hospital outpatient setting.

c. Outpatient medication orders. A prescriber may authorize, by outpatient medication order, the periodic administration of a drug to an outpatient.

(1) Schedule II controlled substance. An outpatient medication order for administration of a Schedule II controlled substance shall be written and, except as provided in rule 657—10.25(124) regarding the issuance of multiple Schedule II prescriptions, shall authorize a single administration of the prescribed substance.

(2) Schedule III, IV, or V controlled substance. An outpatient medication order for administration of a Schedule III, IV, or V controlled substance shall be written and may be authorized for a period not to exceed six months from the date ordered.

(3) Noncontrolled substance. An outpatient medication order for administration of a noncontrolled prescription drug may be authorized for a period not to exceed 18 months from the date ordered.

[ARC 8909B, IAB 6/30/10, effective 8/4/10]

657—7.12(124,126,155A) Drugs in the emergency department. Drugs maintained in the emergency department are kept for use by or at the direction of prescribers in the emergency department. Drugs shall be administered or dispensed only to emergency department patients. For the purposes of this rule, "emergency department patient" means an individual who is examined and evaluated in the emergency department.

7.12(1) Accountability. A system of drug control and accountability shall be developed and supervised by the pharmacist in charge and the facility's emergency department committee, or a similar group or person responsible for policy in the emergency department. The system shall identify drugs of the nature and type to meet the immediate needs of emergency department patients. Drugs shall be administered or dispensed only in accordance with the system.

7.12(2) Controlled substances. Controlled substances maintained in the emergency department are kept for use by or at the direction of prescribers in the emergency department.

a. In order to receive a controlled substance, a patient shall be examined in the emergency department by a prescriber who shall determine the need for the drug. It is not permissible under state and federal regulations for a prescriber to see a patient outside the emergency department setting, or talk to the patient on the telephone, and then proceed to call the emergency department and order the administration of a stocked controlled substance upon the patient's arrival at the emergency department except as provided in paragraph 7.12(2) "c" or "d."

b. A prescriber may authorize, without again examining the patient, the administration of additional doses of a previously authorized drug to a patient presenting to the emergency department within 24 hours of the patient's examination and treatment in the emergency department.

c. In an emergency situation when a health care practitioner authorized to prescribe controlled substances is not available on site, and regardless of the provisions of paragraph 7.12(2) "a," the emergency department nurse may examine the patient in the emergency department and contact the on-call prescriber. The on-call prescriber may then authorize the nurse to administer a controlled substance to the patient pending the arrival of the prescriber at the emergency department. As soon as possible, the prescriber shall examine the patient in the emergency department and determine the patient's further treatment needs.

d. In an emergency situation when a health care practitioner authorized to prescribe controlled substances examines a patient in the prescriber's office and determines a need for the administration of a controlled substance, and regardless of the provisions of paragraph 7.12(2) "a," the prescriber may direct the patient to present to the emergency department, with a valid written prescription or order for

the administration of the controlled substance. As soon as possible, the prescriber shall examine the patient in the emergency department and determine the patient's further treatment needs.

7.12(3) Drug dispensing. In those facilities with 24-hour pharmacy services, only a pharmacist or prescriber may dispense any drugs to an emergency department patient. In those facilities located in an area of the state where 24-hour outpatient or 24-hour on-call pharmacy services are not available within 15 miles of the hospital, and which facilities are without 24-hour outpatient pharmacy services, the provisions of this rule shall apply.

a. Pharmacist in charge responsibility. The pharmacist in charge is responsible for maintaining accurate records of dispensing of drugs from the emergency department and for ensuring the accuracy of prepackaged drugs and the complete and accurate labeling of prepackaged drugs pursuant to this paragraph.

(1) Prepackaging. Except as provided in subrule 7.12(4), drugs dispensed to an emergency department patient in greater than a 24-hour supply may be dispensed only in prepackaged quantities not to exceed a 72-hour supply or the minimum prepackaged quantity in suitable containers, except that a seven-day supply of doxycycline provided through the department of public health pursuant to the crime victim compensation program of the Iowa department of justice may be dispensed for the treatment of a victim of sexual assault. Prepackaged drugs shall be prepared pursuant to the requirements of rule 657—22.3(126).

(2) Labeling. Drugs dispensed pursuant to this paragraph shall be appropriately labeled as required in paragraph 7.12(3) "b," including necessary auxiliary labels.

b. Prescriber responsibility. Except as provided in subrule 7.12(4), a prescriber who authorizes dispensing of a prescription drug to an emergency department patient is responsible for the accuracy of the dispensed drug and for the accurate completion of label information pursuant to this paragraph.

(1) Labeling. Except as provided in subrule 7.12(4), at the time of delivery of the drug the prescriber shall appropriately complete the label such that the dispensing container bears a label with at least the following information:

1. Name and address of the hospital;
2. Date dispensed;
3. Name of prescriber;
4. Name of patient;
5. Directions for use;
6. Name and strength of drug.

(2) Delivery of drug to patient. Except as provided in subrule 7.12(4), the prescriber, or a licensed nurse under the supervision of the prescriber, shall give the appropriately labeled, prepackaged drug to the patient or patient's caregiver. The prescriber, or a licensed nurse under the supervision of the prescriber, shall explain the correct use of the drug and shall explain to the patient that the dispensing is for an emergency or starter supply of the drug. If additional quantities of the drug are required to complete the needed course of treatment, the prescriber shall provide the patient with a prescription for the additional quantities.

7.12(4) Use of InstyMeds dispensing system. A hospital located in an area of the state where 24-hour outpatient pharmacy services are not available within 15 miles of the hospital may implement the InstyMeds dispensing system in the hospital emergency department only as provided by this subrule.

a. Persons with access to the dispensing machine for the purposes of stocking, inventory, and monitoring shall be limited to pharmacists, pharmacy technicians, and pharmacist-interns.

b. The InstyMeds dispensing system shall be used only in the hospital emergency department for the benefit of patients examined or treated in the emergency department.

c. The dispensing machine shall be located in a secure and professionally appropriate environment.

d. The stock of drugs maintained and dispensed utilizing the InstyMeds dispensing system shall be limited to acute care drugs provided in appropriate quantities for a 72-hour supply or the minimum commercially available package size, except that antimicrobials may be dispensed in a quantity to provide the full course of therapy.

e. Drugs dispensed utilizing the InstyMeds dispensing system shall be appropriately labeled as provided in 657—subrule 6.10(1), paragraphs “a” through “g.”

f. Prior to authorizing the dispensing of a drug utilizing the InstyMeds dispensing system, the prescriber shall offer the patient the option of being provided a prescription that may be filled at the pharmacy of the patient’s choice.

g. When appropriate for an acute condition, the prescriber shall provide to the patient or the patient’s caregiver a prescription for the remainder of drug therapy beyond the supply available utilizing the InstyMeds dispensing system. During consultation with the patient or the patient’s caregiver, the prescriber shall clearly explain the appropriate use of the drug supplied, the need to have a prescription for any additional supply of the drug filled at a pharmacy of the patient’s choice, and the need to complete the full course of drug therapy.

h. The pharmacy shall, in conjunction with the hospital emergency department, implement policies and procedures to ensure that a patient utilizing the InstyMeds dispensing system has been positively identified.

i. The hospital pharmacist shall review the printout of drugs provided utilizing the InstyMeds dispensing system within 24 hours unless the pharmacy is closed, in which case the printout shall be reviewed during the first day the pharmacy is open following the provision of the drugs. The purpose of the review is to identify any dispensing errors, to determine dosage appropriateness, and to complete a retrospective drug use review of any antimicrobials dispensed in a quantity greater than a 72-hour supply. Any discrepancies found shall be addressed by the pharmacy’s continuous quality improvement program.

[ARC 8909B, IAB 6/30/10, effective 8/4/10]

657—7.13(124,155A) Records. Every inventory or other record required to be kept under this chapter or other board rules or under Iowa Code chapters 124 and 155A shall be kept by the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record unless a longer retention period is specified for the particular inventory or record.

7.13(1) Medication order information. Each original medication order contained in inpatient records shall bear the following information:

- a.* Patient name and identification number;
- b.* Drug name, strength, and dosage form;
- c.* Directions for use;
- d.* Date ordered;
- e.* Practitioner’s signature or electronic signature or that of the practitioner’s authorized agent.

7.13(2) Medication order maintained. The original medication order shall be maintained with the medication administration record in the medical records of the patient following discharge.

7.13(3) Documentation of drug administration. Each dose of medication administered shall be properly recorded in the patient’s medical record.

These rules are intended to implement Iowa Code sections 124.301, 124.303, 124.306, 126.10, 126.11, 155A.6, 155A.13, 155A.27, 155A.28, 155A.31, and 155A.33 through 155A.36.

[Filed 11/25/87, Notice 10/7/87—published 12/16/87, effective 1/20/88]

[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]

[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]

[Filed 9/12/89, Notice 6/14/89—published 10/4/89, effective 11/8/89]

[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]

[Filed 7/30/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]

[Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]

[Filed 3/21/94, Notice 10/13/93—published 4/13/94, effective 5/18/94]

[Filed 12/6/95, Notice 8/16/95—published 1/3/96, effective 2/7/96]

[Filed 12/10/96, Notice 8/28/96—published 1/1/97, effective 2/5/97]

[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]

[Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 11/12/97]
[Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]
[Filed 2/22/99, Notice 10/21/98—published 3/10/99, effective 4/14/99]
[Filed 4/22/99, Notice 3/10/99—published 5/19/99, effective 6/23/99]
[Filed 9/8/99, Notice 6/2/99—published 10/6/99, effective 11/10/99]
[Filed 2/7/01, Notice 10/18/00—published 3/7/01, effective 4/11/01]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 6/2/05, Notice 3/16/05—published 6/22/05, effective 7/27/05][◇]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed 3/5/08, Notice 12/5/07—published 3/26/08, effective 4/30/08]
[Filed 3/5/08, Notice 12/19/07—published 3/26/08, effective 4/30/08]
[Filed 11/24/08, Notice 10/8/08—published 12/17/08, effective 1/21/09]
[Filed ARC 8170B (Notice ARC 7912B, IAB 7/1/09), IAB 9/23/09, effective 10/28/09]
[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 8909B (Notice ARC 8413B, IAB 12/30/09), IAB 6/30/10, effective 8/4/10]
[Filed ARC 9408B (Notice ARC 9183B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

[◇] Two or more ARCs

CHAPTER 8
UNIVERSAL PRACTICE STANDARDS
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 6]

657—8.1(155A) Purpose and scope. The requirements of these rules apply to all Iowa-licensed pharmacists and to all pharmacies providing the services addressed in this chapter to patients in Iowa and are in addition to rules of the board relating to specific types of pharmacy licenses issued by the board.

657—8.2(155A) Pharmaceutical care. Pharmaceutical care is a comprehensive, patient-centered, outcomes-oriented pharmacy practice in which the pharmacist accepts responsibility for assisting the prescriber and the patient in optimizing the patient's drug therapy plan and works to promote health, to prevent disease, and to optimize drug therapy. Pharmaceutical care does not include the prescribing of drugs without the consent of the prescribing practitioner.

8.2(1) Drug therapy problems. In providing pharmaceutical care, the pharmacist shall strive to identify, resolve, and prevent drug therapy problems.

8.2(2) Drug therapy plan. In providing pharmaceutical care, the pharmacist shall access and evaluate patient-specific information, identify drug therapy problems, and utilize that information in a documented plan of therapy that assists the patient or the patient's caregiver in achieving optimal drug therapy. In concert with the patient, the patient's prescribing practitioner, and the patient's other health care providers, the pharmacist shall assess, monitor, and suggest modifications of the plan as appropriate.

8.2(3) Eligibility. Any Iowa-licensed pharmacist may practice pharmaceutical care.

657—8.3(155A) Responsibility.

8.3(1) Pharmacy operations. The pharmacy and the pharmacist in charge share responsibility for ensuring that all operations of the pharmacy are in compliance with federal and state laws, rules, and regulations relating to pharmacy operations and the practice of pharmacy.

8.3(2) Practice functions. The pharmacist is responsible for all functions performed in the practice of pharmacy. The pharmacist maintains responsibility for any and all delegated functions including functions delegated to pharmacist-interns, pharmacy technicians, and pharmacy support persons.

8.3(3) Pharmacist-documented verification. The pharmacist shall provide and document the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—8.4(155A) Pharmacist identification and staff logs.

8.4(1) Display of pharmacist license. During any period the pharmacist is working in a pharmacy, each pharmacist shall display, in a position visible to the public, an original license to practice pharmacy. A current license renewal certificate, which may be a photocopy of an original renewal certificate, shall be displayed with the original license.

8.4(2) Identification codes. A permanent log of the initials or identification codes identifying by name each dispensing pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person shall be maintained for a minimum of two years and shall be available for inspection and copying by the board or its representative. The initials or identification code shall be unique to the individual to ensure that each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person can be identified.

8.4(3) Temporary or intermittent pharmacy staff. The pharmacy shall maintain a log of all pharmacists, pharmacist-interns, pharmacy technicians, and pharmacy support persons who have worked at that pharmacy and who are not regularly staffed at that pharmacy. Such log shall include the dates and shifts worked by each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person and shall be available for inspection and copying by the board or its representative for a minimum of two years following the date of the entry.

8.4(4) Identification badge. A pharmacist shall wear a visible identification badge while on duty that clearly identifies the person as a pharmacist and includes at least the pharmacist's first name.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9409B, IAB 3/9/11, effective 4/13/11]

657—8.5(155A) Environment and equipment requirements. There shall be adequate space, equipment, and supplies for the professional and administrative functions of the pharmacy. Space and equipment in an amount and type to provide secure, environmentally controlled storage of drugs shall be available.

8.5(1) Refrigeration. The pharmacy shall maintain one or more refrigeration units. The temperature of the refrigerator shall be maintained within a range compatible with the proper storage of drugs requiring refrigeration, and a thermometer shall be maintained in the refrigerator to verify the temperature.

8.5(2) Sink. The pharmacy shall have a sink with hot and cold running water located within the pharmacy department and available to all pharmacy personnel; the sink shall be maintained in a sanitary condition.

8.5(3) Secure barrier. The pharmacy department shall be surrounded by a physical barrier capable of being securely locked to prevent entry when the department is closed. A secure barrier may be constructed of other than a solid material with a continuous surface if the openings in the material are not large enough to permit removal of items from the pharmacy department by any means. Any material used in the construction of the barrier shall be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent. The plans and specifications of the barrier shall be submitted to the board for approval prior to the start of construction. The board may also require on-site inspection of the facility or pharmacy department prior to the pharmacy's opening or relocation. The pharmacy department shall be closed and secured in the absence of the pharmacist except as provided in rule 657—6.7(124,155A) or 657—7.6(124,155A).

8.5(4) Orderly and clean. The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be in good operating condition and maintained in a sanitary manner. Animals shall not be allowed within a licensed pharmacy unless that pharmacy is exclusively providing services for the treatment of animals or unless the animal is a service dog or assistive animal as defined in Iowa Code subsection 216C.11(1).

8.5(5) Light and ventilation. The pharmacy shall be properly lighted and ventilated.

8.5(6) Temperature and humidity. The temperature and humidity of the pharmacy shall be maintained within a range compatible with the proper storage of drugs.

8.5(7) Other equipment. The pharmacist in charge shall ensure the availability of any other equipment necessary for the particular practice of pharmacy and to meet the needs of the patients served by the pharmacy.

8.5(8) Bulk counting machines. Unless bar-code scanning is required and utilized to verify the identity of each stock container of drugs utilized to restock a counting machine cell or bin, a pharmacist shall verify the accuracy of the drugs to be restocked prior to filling the counting machine cell or bin. A record identifying the individual who verified the drugs to be restocked, the individual who restocked the counting machine cell or bin, and the date shall be maintained. The pharmacy shall have a method to calibrate and verify the accuracy of the counting device and shall, at least quarterly, verify the accuracy of the device and maintain a dated record identifying the individual who performed the quarterly verification.

[ARC 8671B, IAB 4/7/10, effective 5/12/10]

657—8.6(155A) Health of personnel. Only personnel authorized by the responsible pharmacist shall be in the immediate vicinity of the drug dispensing, preparation, compounding, or storage areas. Any person shown, either by medical examination or pharmacist determination, to have an apparent illness or open lesions that may adversely affect the quality or safety of a drug product or another individual shall be excluded from direct contact with components, bulk drug substances, drug product containers, closures, in-process materials, drug products, and patients until the condition is corrected or determined by competent medical personnel not to jeopardize the quality or safety of drug products or patients. All

personnel who normally assist the pharmacist shall be instructed to report to the pharmacist any health conditions that may have an adverse effect on drug products or may pose a health or safety risk to others.

657—8.7(155A) Procurement, storage, and recall of drugs and devices.

8.7(1) Source. Procurement of prescription drugs and devices shall be from a drug wholesaler licensed by the board to distribute to Iowa pharmacies or, on a limited basis, from another licensed pharmacy or licensed practitioner located in the United States.

8.7(2) Sufficient stock. A pharmacy shall maintain sufficient stock of drugs and devices to fulfill the foreseeable needs of the patients served by the pharmacy.

8.7(3) Manner of storage. Drugs and devices shall be stored in a manner to protect their identity and integrity.

8.7(4) Storage temperatures. All drugs and devices shall be stored at the proper temperature, as defined by the following terms:

a. “Controlled room temperature” means temperature maintained thermostatically between 15 degrees and 30 degrees Celsius (59 degrees and 86 degrees Fahrenheit);

b. “Cool” means temperature between 8 degrees and 15 degrees Celsius (46 degrees and 59 degrees Fahrenheit). Drugs and devices may be stored in a refrigerator unless otherwise specified on the labeling;

c. “Refrigerate” means temperature maintained thermostatically between 2 degrees and 8 degrees Celsius (36 degrees and 46 degrees Fahrenheit); and

d. “Freeze” means temperature maintained thermostatically between -20 degrees and -10 degrees Celsius (-4 degrees and 14 degrees Fahrenheit).

8.7(5) Product recall. There shall be a system for removing from use, including unit dose, any drugs and devices subjected to a product recall.

657—8.8(124,155A) Out-of-date drugs or devices. Any drug or device bearing an expiration date shall not be dispensed for use beyond the expiration date of the drug or device. Outdated drugs or devices shall be removed from dispensing stock and shall be quarantined until such drugs or devices are properly disposed of.

657—8.9(124,155A) Records. Every inventory or other record required to be maintained by a pharmacy pursuant to board rules or Iowa Code chapters 124 and 155A shall be maintained and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record unless a longer retention period is specified for the particular record or inventory. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department. The following records shall be maintained for at least two years.

8.9(1) Drug supplier invoices. All pharmacies shall maintain supplier invoices of prescription drugs and controlled substances upon which the actual date of receipt of the controlled substances by the pharmacist or other responsible individual is clearly recorded.

8.9(2) Drug supplier credits. All pharmacies shall maintain supplier credit memos for controlled substances and prescription drugs.

[ARC 8539B, IAB 2/24/10, effective 4/1/10]

657—8.10 Reserved.

657—8.11(147,155A) Unethical conduct or practice. The provisions of this rule apply to licensed pharmacies, licensed pharmacists and registered pharmacist-interns.

8.11(1) Misrepresentative deeds. A pharmacist shall not make any statement intended to deceive, misrepresent or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

8.11(2) *Undue influence.*

a. A pharmacist shall not accept professional employment or share or receive compensation in any form arising out of, or incidental to, the pharmacist's professional activities from a prescriber of prescription drugs or any other person or corporation in which one or more such prescribers have a proprietary or beneficial interest sufficient to permit them to directly or indirectly exercise supervision or control over the pharmacist in the pharmacist's professional responsibilities and duties or over the pharmacy wherein the pharmacist practices.

b. The prohibition in paragraph "a" shall not apply until April 23, 2006, to a pharmacist who is working at a prescriber-owned pharmacy location licensed as of April 23, 1981.

c. A prescriber may employ a pharmacist to provide nondispensing, drug information, or other cognitive services.

8.11(3) *Lease agreements.* A pharmacist shall not lease space for a pharmacy under any of the following conditions:

a. From a prescriber of prescription drugs or a group, corporation, association, or organization of such prescribers on a percentage of income basis;

b. From a group, corporation, association, or organization in which prescribers have majority control or have directly or indirectly a majority beneficial or proprietary interest on a percentage of income basis; or

c. If the rent is not reasonable according to commonly accepted standards of the community in which the pharmacy will be located.

8.11(4) *Nonconformance with law.* A pharmacist shall not knowingly serve in a pharmacy which is not operated in conformance with law, or which engages in any practice which if engaged in by a pharmacist would be unethical conduct.

8.11(5) *Freedom of choice/solicitation/kickbacks/fee-splitting and imprinted prescription blanks or forms.* A pharmacist or pharmacy shall not enter into any agreement which negates a patient's freedom of choice of pharmacy services. A pharmacist or pharmacy shall not participate in prohibited agreements with any person in exchange for recommending, promoting, accepting, or promising to accept the professional pharmaceutical services of any pharmacist or pharmacy. "Person" includes an individual, corporation, partnership, association, firm, or other entity. "Prohibited agreements" includes an agreement or arrangement that provides premiums, "kickbacks," fee-splitting, or special charges as compensation or inducement for placement of business or solicitation of patronage with any pharmacist or pharmacy. "Kickbacks" includes, but is not limited to, the provision of medication carts, facsimile machines, any other equipment, or preprinted forms or supplies for the exclusive use of a facility or practitioner at no charge or billed below reasonable market rate. A pharmacist shall not provide, cause to be provided, or offer to provide to any person authorized to prescribe prescription blanks or forms bearing the pharmacist's or pharmacy's name, address, or other means of identification, except that a hospital may make available to hospital staff prescribers, emergency department prescribers, and prescribers granted hospital privileges for the prescribers' use during practice at or in the hospital generic prescription blanks or forms bearing the name, address, or telephone number of the hospital pharmacy.

8.11(6) *Discrimination.* It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

8.11(7) *Claims of professional superiority.* A pharmacist shall not make a claim, assertion, or inference of professional superiority in the practice of pharmacy which cannot be substantiated, or claim an unusual, unsubstantiated capacity to supply a drug or professional service to the community.

8.11(8) *Unprofessional conduct or behavior.* A pharmacist shall not exhibit unprofessional behavior in connection with the practice of pharmacy or refuse to provide reasonable information or answer reasonable questions for the benefit of the patient. Unprofessional behavior shall include, but not be limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

657—8.12(126,147) Advertising. Prescription drug price and nonprice information may be provided to the public by a pharmacy so long as the information is not false or misleading and is not in violation of any federal or state laws applicable to the advertisement of such articles generally and if all of the following conditions are met:

1. All charges for services to the consumer must be stated.
2. The effective dates for the prices listed shall be stated.
3. No reference shall be made to controlled substances listed in Schedules II through V of the latest revision of the Iowa uniform controlled substances Act and the rules of the Iowa board of pharmacy.

657—8.13(135C,155A) Personnel histories. Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this rule shall apply to any pharmacy employing any person to provide patient care services in a patient's home. For the purposes of this rule, "employed by the pharmacy" shall include any individual who is paid to provide treatment or services to any patient in the patient's home, whether the individual is paid by the pharmacy or by any other entity such as a corporation, a temporary staffing agency, or an independent contractor. Specifically excluded from the requirements of this rule are individuals such as delivery persons or couriers who do not enter the patient's home for the purpose of instructing the patient or the patient's caregiver in the use or maintenance of the equipment, device, or drug being delivered, or who do not enter the patient's home for the purpose of setting up or servicing the equipment, device, or drug used to treat the patient in the patient's home.

8.13(1) Applicant acknowledgment. The pharmacy shall ask the following question of each person seeking employment in a position that will provide in-home services: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" The applicant shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

8.13(2) Criminal history check. Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall submit to the department of public safety a form specified by the department of public safety and receive the results of a criminal history check.

8.13(3) Abuse history checks. Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall submit to the department of human services a form specified by the department of human services and receive the results of a dependent adult abuse record check. The pharmacy may submit to the department of human services a form specified by the department of human services to request a child abuse history check.

a. A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services unless the department of human services has evaluated the crime or founded abuse report, has concluded that the crime or founded abuse does not merit prohibition from such employment, and has notified the pharmacy that the person may be employed to provide in-home services.

b. The pharmacy shall keep copies of all record checks and evaluations for a minimum of two years following receipt of the record or for a minimum of two years after the individual is no longer employed by the pharmacy, whichever is greater.

657—8.14(155A) Training and utilization of pharmacy technicians or pharmacy support persons. All Iowa-licensed pharmacies utilizing pharmacy technicians or pharmacy support persons shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians and pharmacy support persons appropriate to the practice of pharmacy at that licensed location. Pharmacy policies shall specify the frequency of review. Pharmacy technician and pharmacy support person training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of pharmacy technician and pharmacy support person training shall be available for inspection by the board or an agent of the board.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—8.15(155A) Delivery of prescription drugs and devices. Prescription drug orders, prescription devices, and completed prescription drug containers may be delivered, in compliance with all laws, rules, and regulations relating to the practice of pharmacy, to patients at any place of business licensed as a pharmacy.

8.15(1) *Alternative methods.* A licensed pharmacy may, by means of its employee or by use of a common carrier, pick up or deliver prescriptions to the patient or the patient's caregiver as follows:

- a. At the office or home of the prescriber.
- b. At the residence of the patient or caregiver.
- c. At the hospital or medical care facility in which a patient is confined.
- d. At an outpatient medical care facility where the patient receives treatment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient's caregiver for receipt or delivery at the outpatient medical care facility;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, or an authorized agent identified in the written authorization;

(3) A prescription authorized by a prescriber not treating the patient at the outpatient medical care facility may be transmitted to the pharmacy by the authorized agent via facsimile provided that the means of transmission does not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the prescription and provided that the original written prescription is delivered to the pharmacy prior to delivery of the filled prescription to the patient; and

(4) The outpatient medical care facility shall store the patient's filled prescriptions in a secure area pending delivery to the patient.

e. At the patient's or caregiver's place of employment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient's caregiver for receipt or delivery at the place of employment;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, the prescriber, or an authorized agent identified in the written authorization; and

(3) The pharmacy shall ensure the security of confidential information as defined in subrule 8.16(1).

8.15(2) *Policies and procedures required.* Every pharmacy shipping or otherwise delivering prescription drugs or devices to Iowa patients shall develop and implement policies and procedures to ensure accountability, safe delivery, and compliance with temperature requirements as defined by subrule 8.7(4).

[ARC 7636B, IAB 3/11/09, effective 4/15/09]

657—8.16(124,155A) Confidential information.

8.16(1) *Definition.* "Confidential information" means information accessed or maintained by the pharmacy in the patient's records which contains personally identifiable information that could be used to identify the patient. This includes but is not limited to patient name, address, telephone number, and social security number; prescriber name and address; and prescription and drug or device information such as therapeutic effect, diagnosis, allergies, disease state, pharmaceutical services rendered, medical information, and drug interactions, regardless of whether such information is communicated to or from the patient, is in the form of paper, is preserved on microfilm, or is stored on electronic media.

8.16(2) *Release of confidential information.* Confidential information in the patient record may be released only as follows:

- a. Pursuant to the express written authorization of the patient or the order or direction of a court.
- b. To the patient or the patient's authorized representative.
- c. To the prescriber or other licensed practitioner then caring for the patient.
- d. To another licensed pharmacist when the best interests of the patient require such release.
- e. To the board or its representative or to such other persons or governmental agencies duly authorized by law to receive such information.

A pharmacist shall utilize the resources available to determine, in the professional judgment of the pharmacist, that any persons requesting confidential patient information pursuant to this rule are entitled to receive that information.

8.16(3) Exceptions. Nothing in this rule shall prohibit pharmacists from releasing confidential patient information as follows:

- a.* Transferring a prescription to another pharmacy upon the request of the patient or the patient's authorized representative.
- b.* Providing a copy of a nonrefillable prescription to the person for whom the prescription was issued which is clearly marked as a copy and not to be filled.
- c.* Providing drug therapy information to physicians or other authorized prescribers for their patients.
- d.* Disclosing information necessary for the processing of claims for payment of health care operations or services.

8.16(4) System security and safeguards. To maintain the integrity and confidentiality of patient records and prescription drug orders, any system or computer utilized shall have adequate security including system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of patient records and prescription drug orders.

8.16(5) Record disposal. Disposal of any materials containing or including patient-specific or confidential information shall be conducted in a manner to preserve patient confidentiality.

657—8.17 and 8.18 Reserved.

657—8.19(124,126,155A) Manner of issuance of a prescription drug or medication order. A prescription drug order or medication order may be transmitted from a prescriber to a pharmacy in written form, orally including telephone voice communication, or by electronic transmission in accordance with applicable federal and state laws and rules. Any prescription drug order or medication order provided to a patient in written or printed form shall include the original, handwritten signature of the prescriber except as provided in rule 657—21.7(124,155A).

8.19(1) Verification. The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of any prescription drug order or medication order consistent with federal and state laws and rules. In exercising professional judgment, the prescribing practitioner and the pharmacist shall take adequate measures to guard against the diversion of prescription drugs and controlled substances through prescription forgeries.

8.19(2) Transmitting agent. The prescribing practitioner may authorize an agent to transmit to the pharmacy a prescription drug order or medication order orally or by electronic transmission provided that the name of the transmitting agent is included in the order.

a. New order. A new written or electronically prepared and transmitted prescription drug or medication order shall be manually or electronically signed by the prescriber. If transmitted by the prescriber's agent, the name and title of the transmitting agent shall be included in the order.

b. Refill order or renewal order. An authorization to refill a prescription drug or medication order, or to renew or continue an existing drug therapy, may be transmitted to a pharmacist through oral communication, in writing, or by electronic transmission initiated by or directed by the prescriber.

(1) If the transmission is completed by the prescriber's agent and the name and title of the transmitting agent is included in the order, the prescriber's signature is not required on the fax or alternate electronic transmission.

(2) If the order differs in any manner from the original order, such as a change of the drug strength, dosage form, or directions for use, the prescriber shall sign the order as provided by paragraph "a."

8.19(3) Receiving agent. Regardless of the means of transmission to a pharmacy, only a pharmacist, a pharmacist-intern, or a pharmacy technician shall be authorized to receive a prescription drug or medication order from a practitioner or the practitioner's agent.

8.19(4) Legitimate purpose. The pharmacist shall ensure that the prescription drug or medication order, regardless of the means of transmission, has been issued for a legitimate medical purpose by an

authorized practitioner acting in the usual course of the practitioner's professional practice. A pharmacist shall not dispense a prescription drug if the pharmacist knows or should have known that the prescription was issued solely on the basis of an Internet-based questionnaire, an Internet-based consultation, or a telephonic consultation and without a valid preexisting patient-practitioner relationship.

8.19(5) Refills. A prescription for a prescription drug or device that is not a controlled substance may authorize no more than 12 refills within 18 months following the date on which the prescription is issued. A refill is one or more dispensings of a prescription drug or device that results in the patient's receipt of the quantity authorized by the prescriber for a single fill as indicated on the prescription drug order.

[ARC 8171B, IAB 9/23/09, effective 10/28/09]

657—8.20(155A) Valid prescriber/patient relationship. Prescription drug orders and medication orders shall be valid as long as a prescriber/patient relationship exists. Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or oversee the patient's use of a prescription drug, the order loses its validity and the pharmacist, on becoming aware of the situation, shall cancel the order and any remaining refills. The pharmacist shall, however, exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the prescribed drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new order can be issued.

657—8.21(155A) Prospective drug use review. For purposes of promoting therapeutic appropriateness and ensuring rational drug therapy, a pharmacist shall review the patient record, information obtained from the patient, and each prescription drug or medication order to identify:

1. Overutilization or underutilization;
2. Therapeutic duplication;
3. Drug-disease contraindications;
4. Drug-drug interactions;
5. Incorrect drug dosage or duration of drug treatment;
6. Drug-allergy interactions;
7. Clinical abuse/misuse;
8. Drug-prescriber contraindications.

Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem and shall, if necessary, include consultation with the prescriber. The review and assessment of patient records shall not be delegated to staff assistants but may be delegated to registered pharmacist-interns under the direct supervision of the pharmacist.

657—8.22 to 8.25 Reserved.

657—8.26(155A) Continuous quality improvement program. Each pharmacy licensed to provide pharmaceutical services to patients in Iowa shall implement or participate in a continuous quality improvement program or CQI program. The CQI program is intended to be an ongoing, systematic program of standards and procedures to detect, identify, evaluate, and prevent medication errors, thereby improving medication therapy and the quality of patient care. A pharmacy that participates as an active member of a hospital or corporate CQI program that meets the objectives of this rule shall not be required to implement a new program pursuant to this rule.

8.26(1) Reportable program events. For purposes of this rule, a reportable program event or program event means a preventable medication error resulting in the incorrect dispensing of a prescribed drug received by or administered to the patient and includes but is not necessarily limited to:

- a. An incorrect drug;
- b. An incorrect drug strength;
- c. An incorrect dosage form;
- d. A drug received by the wrong patient;
- e. Inadequate or incorrect packaging, labeling, or directions; or

f. Any incident related to a prescription dispensed to a patient that results in or has the potential to result in serious harm to the patient.

8.26(2) Responsibility. The pharmacist in charge is responsible for ensuring that the pharmacy utilizes a CQI program consistent with the requirements of this rule. The pharmacist in charge may delegate program administration and monitoring, but the pharmacist in charge maintains ultimate responsibility for the validity and consistency of program activities.

8.26(3) Policies and procedures. Each pharmacy shall develop, implement, and adhere to written policies and procedures for the operation and management of the pharmacy's CQI program. A copy of the pharmacy's CQI program description and policies and procedures shall be maintained and readily available to all pharmacy personnel. The policies and procedures shall address, at a minimum, a planned process to:

- a.* Train all pharmacy personnel in relevant phases of the CQI program;
- b.* Identify and document reportable program events;
- c.* Minimize the impact of reportable program events on patients;
- d.* Analyze data collected to assess the causes and any contributing factors relating to reportable program events;
- e.* Use the findings to formulate an appropriate response and to develop pharmacy systems and workflow processes designed to prevent and reduce reportable program events; and
- f.* Periodically, but at least annually, meet with appropriate pharmacy personnel to review findings and inform personnel of changes that have been made to pharmacy policies, procedures, systems, or processes as a result of CQI program findings.

8.26(4) Event discovery and notification. As provided by the procedures of the CQI program, the pharmacist in charge or appropriate designee shall be informed of and review all reported and documented program events. All pharmacy personnel shall be trained to immediately inform the pharmacist on duty of any discovered or suspected program event. When the pharmacist on duty determines that a reportable program event has occurred, the pharmacist shall ensure that all reasonably necessary steps are taken to remedy any problems or potential problems for the patient and that those steps are documented. Necessary steps include, but are not limited to, the following:

- a.* Notifying the patient or the patient's caregiver and the prescriber or other members of the patient's health care team as warranted;
- b.* Identifying and communicating directions or processes for correcting the error; and
- c.* Communicating instructions for minimizing any negative impact on the patient.

8.26(5) CQI program records. All CQI program records shall be maintained on site at the pharmacy or shall be accessible at the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of the record. When a reportable program event occurs or is suspected to have occurred, the program event shall be documented in a written or electronic storage record created solely for that purpose. Records of program events shall be maintained in an orderly manner and shall be filed chronologically by date of discovery.

a. The program event shall initially be documented as soon as practicable by the staff member who discovers the event or is informed of the event.

b. Program event documentation shall include a description of the event that provides sufficient information to permit categorization and analysis of the event and shall include:

- (1) The date and time the program event was discovered and the name of the staff person who discovered the event; and
- (2) The names of the individuals recording and reviewing or analyzing the program event information.

8.26(6) Program event analysis and response. The pharmacist in charge or designee shall review each reportable program event and determine if follow-up is necessary. When appropriate, information and data collected and documented shall be analyzed, individually and collectively, to assess the cause and any factors contributing to the program event. The analysis may include, but is not limited to, the following:

a. A consideration of the effects on the quality of the pharmacy system related to workflow processes, technology utilization and support, personnel training, and both professional and technical staffing levels;

b. Any recommendations for remedial changes to pharmacy policies, procedures, systems, or processes; and

c. The development of a set of indicators that a pharmacy will utilize to measure its program standards over a designated period of time.

657—8.27 to 8.29 Reserved.

657—8.30(126,155A) Sterile products. Rescinded IAB 6/6/07, effective 7/11/07.

657—8.31 Reserved.

657—8.32(124,155A) Individuals qualified to administer. The board designates the following as qualified individuals to whom a practitioner may delegate the administration of prescription drugs. Any person specifically authorized under pertinent sections of the Iowa Code to administer prescription drugs shall construe nothing in this rule to limit that authority.

1. Persons who have successfully completed a medication administration course.
2. Licensed pharmacists.

657—8.33(147,155A) Supervision of pharmacists who administer adult immunizations. A physician may prescribe via written protocol adult immunizations for influenza and pneumococcal vaccines for administration by an authorized pharmacist if the physician meets these requirements for supervising the pharmacist.

8.33(1) Definitions.

a. *“Authorized pharmacist”* means an Iowa-licensed pharmacist who has documented that the pharmacist has successfully completed an organized course of study in a college or school of pharmacy or an Accreditation Council for Pharmacy Education (ACPE)-approved continuing pharmaceutical education program on vaccine administration that:

(1) Requires documentation by the pharmacist of current certification in the American Heart Association or the Red Cross Basic Cardiac Life Support Protocol for health care providers;

(2) Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current Centers for Disease Control and Prevention guidelines, and provides instruction and experiential training in the following content areas:

1. Standards for immunization practices;
2. Basic immunology and vaccine protection;
3. Vaccine-preventable diseases;
4. Recommended immunization schedules;
5. Vaccine storage and management;
6. Informed consent;
7. Physiology and techniques for vaccine administration;
8. Pre- and post-vaccine assessment and counseling;
9. Immunization record management; and
10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. *“Vaccine”* means a specially prepared antigen which, upon administration to a person, will result in immunity and, specifically for the purposes of this rule, shall mean influenza and pneumococcal vaccines.

c. *“Written protocol”* means a physician’s order for one or more patients that contains, at a minimum, the following:

- (1) A statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of administration of adult immunizations for influenza and pneumococcus;
- (2) A statement identifying the individual authorized pharmacist;
- (3) A statement that forbids an authorized pharmacist from delegating the administration of adult immunizations to anyone other than another authorized pharmacist, a registered pharmacist-intern under the direct personal supervision of the authorized pharmacist, or a registered nurse;
- (4) A statement identifying the vaccines that may be administered by an authorized pharmacist, the dosages, and the route of administration;
- (5) A statement identifying the activities an authorized pharmacist shall follow in the course of administering adult immunizations, including:
 1. Procedures for determining if a patient is eligible to receive the vaccine;
 2. Procedures for determining the appropriate scheduling and frequency of drug administration in accordance with applicable guidelines;
 3. Procedures for record keeping and long-term record storage including batch or identification numbers;
 4. Procedures to follow in case of life-threatening reactions; and
 5. Procedures for the pharmacist and patient to follow in case of reactions following administration.
- (6) A statement that describes how the authorized pharmacist shall report the administration of adult immunizations, within 30 days, to the physician issuing the written protocols and to the patient's primary care physician if one has been designated by the patient. In case of serious complications, the authorized pharmacist shall notify the physicians within 24 hours and submit a VAERS report to the bureau of immunizations, Iowa department of public health. (VAERS is the Vaccine Advisory Event Reporting System.) A serious complication is one that requires further medical or therapeutic intervention to effectively protect the patient from further risk, morbidity, or mortality.

8.33(2) *Supervision.* A physician who prescribes adult immunizations to an authorized pharmacist for administration shall adequately supervise that pharmacist. Physician supervision shall be considered adequate if the delegating physician:

- a. Ensures that the authorized pharmacist is prepared as described in subrule 8.33(1), paragraph "a";
- b. Provides a written protocol that is updated at least annually;
- c. Is available through direct telecommunication for consultation, assistance, and direction, or provides physician backup to provide these services when the physician supervisor is not available;
- d. Is an Iowa-licensed physician who has a working relationship with an authorized pharmacist within the physician's local provider service area.

8.33(3) *Administration of other adult immunizations by pharmacists.* A physician may prescribe, for an individual patient by prescription or medication order, other adult immunizations to be administered by an authorized pharmacist.

This rule is intended to implement Iowa Code sections 147.76, 155A.3, 155A.4, and 272C.3.

657—8.34(155A) Collaborative drug therapy management. An authorized pharmacist may only perform collaborative drug therapy management pursuant to protocol with a physician pursuant to the requirements of this rule. The physician retains the ultimate responsibility for the care of the patient. The pharmacist is responsible for all aspects of drug therapy management performed by the pharmacist.

8.34(1) *Definitions.*

"*Authorized pharmacist*" means an Iowa-licensed pharmacist whose license is in good standing and who meets the drug therapy management criteria defined in this rule.

"*Board*" means the board of pharmacy.

"*Collaborative drug therapy management*" means participation by an authorized pharmacist and a physician in the management of drug therapy pursuant to a written community practice protocol or a written hospital practice protocol.

“*Collaborative practice*” means that a physician may delegate aspects of drug therapy management for the physician’s patients to an authorized pharmacist through a community practice protocol. “Collaborative practice” also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and hospital clinic patients through a hospital practice protocol.

“*Community practice protocol*” means a written, executed agreement entered into voluntarily between an authorized pharmacist and a physician establishing drug therapy management for one or more of the pharmacist’s and physician’s patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 8.34(2).

“*Community setting*” means a location outside a hospital inpatient, acute care setting or a hospital clinic setting. A community setting may include, but is not limited to, a home, group home, assisted living facility, correctional facility, hospice, or long-term care facility.

“*Drug therapy management criteria*” means one or more of the following:

1. Graduation from a recognized school or college of pharmacy with a doctor of pharmacy (Pharm.D.) degree;
2. Certification by the Board of Pharmaceutical Specialties (BPS);
3. Certification by the Commission for Certification in Geriatric Pharmacy (CCGP);
4. Successful completion of a National Institute for Standards in Pharmacist Credentialing (NISPC) disease state management examination and credentialing by the NISPC;
5. Successful completion of a pharmacy residency program accredited by the American Society of Health-System Pharmacists (ASHP); or
6. Approval by the board of pharmacy.

“*Hospital clinic*” means an outpatient care clinic operated and affiliated with a hospital and under the direct authority of the hospital’s P&T committee.

“*Hospital pharmacist*” means an Iowa-licensed pharmacist who meets the requirements for participating in a hospital practice protocol as determined by the hospital’s P&T committee.

“*Hospital practice protocol*” means a written plan, policy, procedure, or agreement that authorizes drug therapy management between hospital pharmacists and physicians within a hospital and the hospital’s clinics as developed and determined by the hospital’s P&T committee. Such a protocol may apply to all pharmacists and physicians at a hospital or the hospital’s clinics or only to those pharmacists and physicians who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 8.34(3).

“*IBM*” means the Iowa board of medicine.

“*P&T committee*” means a committee of the hospital composed of physicians, pharmacists, and other health professionals that evaluates the clinical use of drugs within the hospital, develops policies for managing drug use and administration in the hospital, and manages the hospital drug formulary system.

“*Physician*” means a person who is currently licensed in Iowa to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy. A physician who executes a written protocol with an authorized pharmacist shall supervise the pharmacist’s activities involved in the overall management of patients receiving medications or disease management services under the protocol. The physician may delegate only drug therapies that are in areas common to the physician’s practice.

“*Therapeutic interchange*” means an authorized exchange of therapeutic alternate drug products in accordance with a previously established and approved written protocol.

8.34(2) Community practice protocol.

a. An authorized pharmacist shall engage in collaborative drug therapy management with a physician only under a written protocol that has been identified by topic and has been submitted to the board or a committee authorized by the board. A protocol executed after July 1, 2008, will no longer be required to be submitted to the board; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBM.

b. The community practice protocol shall include:

(1) The name, signature, date, and contact information for each authorized pharmacist who is a party to the protocol and is eligible to manage the drug therapy of a patient. If more than one authorized

pharmacist is a party to the agreement, the pharmacists shall work for a single licensed pharmacy and a principal authorized pharmacist shall be designated in the protocol.

(2) The name, signature, date, and contact information for each physician who may prescribe drugs and is responsible for supervising a patient's drug therapy management. The physician who initiates a protocol shall be considered the main caregiver for the patient respective to that protocol and shall be noted in the protocol as the principal physician.

(3) The name and contact information of the principal physician and the principal authorized pharmacist who are responsible for development, training, administration, and quality assurance of the protocol.

(4) A detailed written protocol pursuant to which the authorized pharmacist will base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration, and route of administration of the drug authorized by the patient's physician. The protocol shall not authorize the pharmacist to change a Schedule II drug or to initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the pharmacist to obtain or to conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred back to the patient's physician for follow-up.

4. Patient activities. The protocol may authorize the pharmacist to monitor specific patient activities.

(5) Procedures for securing the patient's written consent. If the patient's consent is not secured by the physician, the authorized pharmacist shall secure such and notify the patient's physician within 24 hours.

(6) Circumstances that shall cause the authorized pharmacist to initiate communication with the physician including but not limited to the need for new prescription orders and reports of the patient's therapeutic response or adverse reaction.

(7) A detailed statement identifying the specific drugs, laboratory tests, and physical findings upon which the authorized pharmacist shall base drug therapy management decisions.

(8) A provision for the collaborative drug therapy management protocol to be reviewed, updated, and reexecuted or discontinued at least every two years.

(9) A description of the method the pharmacist shall use to document the pharmacist's decisions or recommendations for the physician.

(10) A description of the types of reports the authorized pharmacist is to provide to the physician and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame within which a pharmacist shall report any adverse reaction to the physician.

(11) A statement of the medication categories and the type of initiation and modification of drug therapy that the physician authorizes the pharmacist to perform.

(12) A description of the procedures or plan that the pharmacist shall follow if the pharmacist modifies a drug therapy.

(13) Procedures for record keeping, record sharing, and long-term record storage.

(14) Procedures to follow in emergency situations.

(15) A statement that prohibits the authorized pharmacist from delegating drug therapy management to anyone other than another authorized pharmacist who has signed the applicable protocol.

(16) A statement that prohibits a physician from delegating collaborative drug therapy management to any unlicensed or licensed person other than another physician or an authorized pharmacist.

(17) A description of the mechanism for the pharmacist and the physician to communicate with each other and for documentation by the pharmacist of the implementation of collaborative drug therapy.

c. Collaborative drug therapy management is valid only when initiated by a written protocol executed by at least one authorized pharmacist and at least one physician.

d. The collaborative drug therapy protocol must be filed with the board, kept on file in the pharmacy, and be made available upon request of the board or the IBM. After July 1, 2008, protocols shall no longer be filed with the board but shall be maintained in the pharmacy and made available to the board and the IBM upon request.

e. A physician may terminate or amend the collaborative drug therapy management protocol with an authorized pharmacist if the physician notifies, in writing, the pharmacist and the board. Notification shall include the name of the authorized pharmacist, the desired change, and the proposed effective date of the change. After July 1, 2008, the physician shall no longer be required to notify the board of changes in a protocol but the written notification shall be maintained in the pharmacy and made available upon request of the board or the IBM.

f. The physician or pharmacist who initiates a protocol with a patient is responsible for securing a patient's written consent to participate in drug therapy management and for transmitting a copy of the consent to the other party within 24 hours. The consent shall indicate which protocol is involved. Any variation in the protocol for a specific patient shall be communicated to the other party at the time of securing the patient's consent. The patient's physician shall maintain the patient consent in the patient's medical record.

8.34(3) Hospital practice protocol.

a. A hospital's P&T committee shall determine the scope and extent of collaborative drug therapy management practices that may be conducted by the hospital's pharmacists.

b. Collaborative drug therapy management within a hospital setting or the hospital's clinic setting is valid only when approved by the hospital's P&T committee.

c. The hospital practice protocol shall include:

(1) The names or groups of pharmacists and physicians who are authorized by the P&T committee to participate in collaborative drug therapy management.

(2) A plan for development, training, administration, and quality assurance of the protocol.

(3) A detailed written protocol pursuant to which the hospital pharmacist shall base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Medication orders and prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration, and route of administration of the drug authorized by the physician. The protocol shall not authorize the hospital pharmacist to change a Schedule II drug or to initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or to conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the hospital pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred back to the physician for follow-up.

(4) Circumstances that shall cause the hospital pharmacist to initiate communication with the patient's physician including but not limited to the need for new medication orders and prescription drug orders and reports of a patient's therapeutic response or adverse reaction.

(5) A statement of the medication categories and the type of initiation and modification of drug therapy that the P&T committee authorizes the hospital pharmacist to perform.

(6) A description of the procedures or plan that the hospital pharmacist shall follow if the hospital pharmacist modifies a drug therapy.

(7) A description of the mechanism for the hospital pharmacist and the patient's physician to communicate and for the hospital pharmacist to document implementation of the collaborative drug therapy.

657—8.35(155A) Pharmacy license. A pharmacy license issued by the board is required for all sites where prescription drugs are offered for sale or dispensed under the supervision of a pharmacist. A pharmacy license issued by the board is also required for all sites where drug information or other cognitive pharmacy services, including but not limited to drug use review and patient counseling, are provided by a pharmacist. The board may issue any of the following types of pharmacy licenses: a general pharmacy license, a hospital pharmacy license, a special or limited use pharmacy license, or a nonresident pharmacy license. Nonresident pharmacy license applicants shall comply with board rules regarding nonresident pharmacy practice except when specific exemptions have been granted. Applicants for general or hospital pharmacy practice shall comply with board rules regarding general or hospital pharmacy practice except when specific exemptions have been granted. Any pharmacy located within Iowa that dispenses controlled substances must also register pursuant to 657—Chapter 10.

8.35(1) Exemptions. Applicants who are granted exemptions shall be issued a “general pharmacy license with exemption,” a “hospital pharmacy license with exemption,” a “nonresident pharmacy license with exemption,” or a “limited use pharmacy license with exemption” and shall comply with the provisions set forth by that exemption. A written petition for exemption from certain licensure requirements shall be submitted pursuant to the procedures and requirements of 657—Chapter 34 and will be determined on a case-by-case basis.

8.35(2) Limited use pharmacy license. Limited use pharmacy license may be issued for nuclear pharmacy practice, correctional facility pharmacy practice, and veterinary pharmacy practice. Applications for limited use pharmacy license for these and other limited use practice settings shall be determined on a case-by-case basis.

8.35(3) Application form. Application for licensure and license renewal shall be on forms provided by the board. The application for a pharmacy license shall require an indication of the pharmacy ownership classification. If the owner is a sole proprietorship (100 percent ownership), the name and address of the owner shall be indicated. If the owner is a partnership or limited partnership, the names and addresses of all partners shall be listed or attached. If the owner is a corporation, the names and addresses of the officers and directors of the corporation shall be listed or attached. Any other pharmacy ownership classification shall be further identified and explained on the application. The application form shall require the name, signature, and license number of the pharmacist in charge. The names and license numbers of all pharmacists engaged in practice in the pharmacy, the names and registration numbers of all pharmacy technicians and pharmacy support persons working in the pharmacy, and the average number of hours worked by each pharmacist, pharmacy technician, and pharmacy support person shall be listed or attached. Additional information may be required of specific types of pharmacy license applicants. The application shall be signed by the pharmacy owner or the owner’s, partnership’s, or corporation’s authorized representative.

8.35(4) License expiration and renewal. General pharmacy licenses, hospital pharmacy licenses, special or limited use pharmacy licenses, and nonresident pharmacy licenses shall be renewed before January 1 of each year. The fee for a new or renewal license shall be \$150.

a. Late payment penalty. Failure to renew the pharmacy license before January 1 following expiration shall require payment of the renewal fee and a penalty fee of \$150. Failure to renew the license before February 1 following expiration shall require payment of the renewal fee and a penalty fee of \$250. Failure to renew the license before March 1 following expiration shall require payment of the renewal fee and a penalty fee of \$350. Failure to renew the license before April 1 following expiration shall require payment of the renewal fee and a penalty fee of \$450 and may require an appearance before the board. In no event shall the combined renewal fee and penalty fee for late renewal of a pharmacy license exceed \$600.

b. Delinquent license. If a license is not renewed before its expiration date, the license is delinquent and the licensee may not operate or provide pharmacy services to patients in the state of Iowa until the licensee renews the delinquent license. A pharmacy that continues to operate in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.1(4).

8.35(5) *Inspection of new pharmacy location.* If the new pharmacy location within Iowa was not a licensed pharmacy immediately prior to the proposed opening of the new pharmacy, the pharmacy location shall require an on-site inspection by a pharmacy board inspector prior to the issuance of the pharmacy license. The purpose of the inspection is to determine compliance with requirements pertaining to space, library, equipment, security, temperature control, and drug storage safeguards. Inspection may be scheduled anytime following submission of necessary license and registration applications and prior to opening for business as a pharmacy. Prescription drugs, including controlled substances, may not be delivered to a new pharmacy location prior to satisfactory completion of the opening inspection.

8.35(6) *Pharmacy license changes.* When a pharmacy changes its name, location, ownership, or pharmacist in charge, a new pharmacy license application with a license fee as provided in subrule 8.35(4) shall be submitted to the board office. Upon receipt of the fee and properly completed application, the board will issue a new pharmacy license certificate. The old license certificate shall be returned to the board office within ten days of the change of name, location, ownership, or pharmacist in charge.

a. A change of pharmacy location in Iowa shall require an on-site inspection of the new location as provided in subrule 8.35(5) if the new location was not a licensed pharmacy immediately prior to the relocation.

b. A change of ownership of a currently licensed Iowa pharmacy, or a change of pharmacy location to another existing Iowa pharmacy location, shall not require on-site inspection pursuant to subrule 8.35(5). A new pharmacy license is required as provided above. In those cases in which the pharmacy is owned by a corporation, the sale or transfer of all stock of the corporation does not constitute a change of ownership provided the corporation that owns the pharmacy continues to exist following the stock sale or transfer.

c. A change of pharmacist in charge shall require completion and submission of the application and fee for new pharmacy license. If a permanent pharmacist in charge has not been identified by the time of the vacancy, a temporary pharmacist in charge shall be identified. Written notification identifying the temporary pharmacist in charge, signed by the pharmacy owner or corporate officer and the temporary pharmacist in charge, shall be submitted to the board within 10 days following the vacancy. Within 90 days following the vacancy, a permanent pharmacist in charge shall be identified, and an application for pharmacy license, including the license fee as provided in subrule 8.35(4), shall be submitted to the board office.

8.35(7) *Pharmacy closing.* At least two weeks prior to the closing of a pharmacy, a written notice shall be sent to the board and to the Drug Enforcement Administration (DEA) notifying those agencies of the intent to discontinue business or sell the pharmacy including the anticipated date of sale or closing.

a. Prior notification shall include the name, address, DEA registration number, Iowa pharmacy license number, and Iowa controlled substances Act (CSA) registration number of the closing pharmacy and of the pharmacy to which prescription drugs will be transferred. Notification shall also include the name, address, DEA registration number, Iowa pharmacy license number, and CSA registration number of the location at which prescription files, patient profiles, and controlled substance receipt and disbursement records will be maintained.

b. Pharmacy patients with active prescriptions on file with a pharmacy that intends to close permanently shall be notified by that pharmacy, via direct mail or public notice at least two weeks prior to the closure of the pharmacy, that each patient has the right to transfer the patient's active prescriptions to a pharmacy of the patient's choosing. This paragraph shall not apply in the case of an emergency or unforeseeable closure including, but not limited to, emergency board action, foreclosure, fire, or natural disaster.

c. A complete inventory of all prescription drugs being transferred shall be taken as of the close of business. The inventory shall serve as the ending inventory for the closing pharmacy as well as a record of additional or starting inventory for the pharmacy to which the drugs are transferred. A copy of the inventory shall be included in the records of each licensee.

(1) DEA Form 222 is required for transfer of Schedule II controlled substances.

(2) The inventory of controlled substances shall be completed pursuant to the requirements in 657—10.35(124,155A).

- (3) The inventory of all noncontrolled prescription drugs may be estimated.
- (4) The inventory shall include the name, strength, dosage form, and quantity of all prescription drugs transferred.
- (5) Controlled substances requiring destruction or other disposal shall be transferred in the same manner as all other drugs. The new owner is responsible for the disposal of these substances as provided in rule 657—10.18(124).

d. The license certificate and CSA certificate of the closing or selling pharmacy shall be returned to the board office within ten days of closing or sale. The DEA registration certificate and all unused DEA Forms 222 shall be returned to the DEA.

e. A location that no longer houses a licensed pharmacy shall not display any sign, placard, or other notification, visible to the public, which identifies the location as a pharmacy. A sign or other public notification that cannot feasibly be removed shall be covered so as to conceal the identification as a pharmacy.

8.35(8) *Failure to complete licensure.* An application for a pharmacy license, including an application for registration pursuant to 657—Chapter 10, if applicable, will become null and void if the applicant fails to complete the licensure process within six months of receipt by the board of the required applications. The licensure process shall be complete upon the pharmacy's opening for business at the licensed location following an inspection rated as satisfactory by an agent of the board if such an inspection is required pursuant to this rule. When an applicant fails to timely complete the licensure process, fees submitted with applications will not be transferred or refunded.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

These rules are intended to implement Iowa Code sections 124.101, 124.301, 124.306, 124.308, 126.10, 126.11, 126.16, 135C.33, 147.7, 147.55, 147.72, 147.74, 147.76, 155A.2 through 155A.4, 155A.6, 155A.10, 155A.12 through 155A.15, 155A.19, 155A.20, 155A.27 through 155A.29, 155A.32, and 155A.33.

[Filed 4/11/68; amended 11/14/73]

[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]

[Filed 11/9/77, Notice 10/5/77—published 11/30/77, effective 1/4/78]

[Filed emergency 12/9/77—published 12/28/77, effective 12/9/77]

[Filed 10/20/78, Notice 8/9/78—published 11/15/78, effective 1/9/79]

[Filed 12/2/78, Notice 11/15/78—published 1/10/79, effective 2/14/79]

[Filed 12/21/78, Notice 11/15/78—published 1/10/79, effective 2/14/79]

[Filed 1/8/79, Notice 11/29/78—published 1/24/79, effective 2/28/79]

[Filed 8/28/79, Notice 5/30/79—published 9/19/79, effective 10/24/79]

[Filed 12/7/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]

[Filed 2/22/80, Notice 10/3/79—published 3/19/80, effective 4/23/80]

[Filed emergency 4/22/80—published 5/14/80, effective 4/22/80]

[Filed 12/1/80, Notice 10/15/80—published 12/24/80, effective 1/28/81]

[Filed 2/12/81, Notice 12/24/80—published 3/4/81, effective 4/8/81]

[Filed 5/27/81, Notice 4/1/81—published 6/24/81, effective 7/29/81]

[Filed emergency 7/28/81—published 8/19/81, effective 8/1/81]

[Filed emergency 9/14/81—published 9/30/81, effective 9/30/81]

[Filed 7/28/82, Notice 3/17/82—published 8/18/82, effective 9/22/82]

[Filed emergency 8/26/82—published 9/15/82, effective 9/22/82]

[Filed 9/10/82, Notice 6/9/82—published 9/29/82, effective 11/8/82]

[Filed emergency 10/6/82—published 10/27/82, effective 10/27/82]^o

[Filed emergency 12/2/82—published 12/22/82, effective 12/22/82]

[Filed 11/18/83, Notice 8/3/83—published 12/7/83, effective 1/11/84]

[Filed 1/13/84, Notice 11/9/83—published 2/1/84, effective 3/7/84]

[Filed 6/22/84, Notice 4/11/84—published 7/18/84, effective 8/22/84]

[Filed emergency 7/13/84—published 8/1/84, effective 7/13/84]

[Filed 9/21/84, Notice 7/18/84—published 10/10/84, effective 11/14/84]

- [Filed 2/22/85, Notice 11/21/84—published 3/13/85, effective 4/18/85]
[Filed emergency 6/18/85—published 7/3/85, effective 7/1/85]
[Filed 8/30/85, Notice 7/3/85—published 9/25/85, effective 10/30/85]◊
[Filed 11/27/85, Notice 8/28/85—published 12/18/85, effective 1/22/86]
[Filed 9/19/86, Notice 6/4/86—published 10/8/86, effective 11/12/86]
[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]
[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]
[Filed 1/21/88, Notice 11/4/87—published 2/10/88, effective 3/16/88]
[Filed 3/29/88, Notice 1/27/88—published 4/20/88, effective 5/25/88]
[Filed 3/29/88, Notice 2/10/88—published 4/20/88, effective 5/25/88]
[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]◊
[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
[Filed 12/26/89, Notice 10/4/89—published 1/24/90, effective 2/28/90]
[Filed 3/19/90, Notice 1/10/90—published 4/18/90, effective 5/23/90]
[Filed 8/31/90, Notice 6/13/90—published 9/19/90, effective 10/24/90]
[Filed 1/29/91, Notice 6/13/90—published 2/20/91, effective 3/27/91]
[Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]
[Filed 4/26/91, Notice 2/20/91—published 5/15/91, effective 6/19/91]
[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
[Filed 7/30/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 1/21/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed 3/12/92, Notice 1/8/92—published 4/1/92, effective 5/6/92]
[Filed 5/21/92, Notice 4/1/92—published 6/10/92, effective 7/15/92]
[Filed 10/22/92, Notice 9/2/92—published 11/11/92, effective 1/1/93]
[Filed 2/5/93, Notice 11/11/92—published 3/3/93, effective 4/8/93]
[Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]
[Filed 3/21/94, Notices 10/13/93, 12/8/93—published 4/13/94, effective 5/18/94]
[Filed 6/24/94, Notice 4/13/94—published 7/20/94, effective 8/24/94]
[Filed 11/30/94, Notices 5/11/94, 7/20/94—published 12/21/94, effective 1/25/95]
[Filed 3/22/95, Notice 11/9/94—published 4/12/95, effective 5/31/95]
[Filed 10/6/95, Notices 6/7/95, 8/16/95—published 10/25/95, effective 1/1/96]
[Filed emergency 12/14/95—published 1/3/96, effective 1/1/96]
[Filed 12/10/96, Notice 8/28/96—published 1/1/97, effective 2/5/97]
[Filed 2/27/97, Notice 8/28/96—published 3/26/97, effective 4/30/97]
[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]
[Filed 6/23/97, Notice 3/26/97—published 7/16/97, effective 8/20/97]
[Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]
[Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]
[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 10/15/98]
[Filed 4/22/99, Notice 3/10/99—published 5/19/99, effective 6/23/99]
[Filed 11/23/99, Notice 6/2/99—published 12/15/99, effective 1/19/00]
[Filed 2/18/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]
[Filed 11/9/00, Notice 4/19/00—published 11/29/00, effective 1/3/01]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 3/11/04, Notice 8/6/03—published 3/31/04, effective 5/5/04]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
[Filed 10/22/04, Notice 5/12/04—published 11/10/04, effective 12/15/04]
[Filed 6/2/05, Notice 3/16/05—published 6/22/05, effective 7/27/05]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]

[Filed 5/17/06, Notice 2/15/06—published 6/7/06, effective 10/1/06]
[Filed 11/30/06, Notice 9/27/06—published 12/20/06, effective 1/24/07]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed 5/14/07, Notice 2/28/07—published 6/6/07, effective 7/11/07][◇]
[Filed 8/3/07, Notice 5/9/07—published 8/29/07, effective 10/3/07]
[Filed 8/3/07, Notice 6/20/07—published 8/29/07, effective 10/3/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed 11/13/07, Notice 8/29/07—published 12/5/07, effective 1/9/08]
[Filed 5/19/08, Notice 3/26/08—published 6/18/08, effective 7/23/08]
[Filed 9/5/08, Notice 7/2/08—published 9/24/08, effective 10/29/08]
[Filed ARC 7636B (Notice ARC 7448B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]
[Filed ARC 8171B (Notice ARC 7910B, IAB 7/1/09), IAB 9/23/09, effective 10/28/09]
[Filed ARC 8539B (Notice ARC 8269B, IAB 11/4/09), IAB 2/24/10, effective 4/1/10]
[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 8671B (Notice ARC 8414B, IAB 12/30/09), IAB 4/7/10, effective 5/12/10]
[Filed ARC 9409B (Notice ARC 9194B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

[◇] Two or more ARCs

CHAPTER 10
CONTROLLED SUBSTANCES
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 8]

657—10.1(124) Who shall register. Any person or business located in Iowa that manufactures, distributes, dispenses, prescribes, imports or exports, conducts research or instructional activities, or conducts chemical analysis with controlled substances in the state of Iowa, or that proposes to engage in such activities with controlled substances in the state, shall obtain and maintain a registration issued by the board unless exempt from registration pursuant to rule 657—10.6(124). A person or business required to be registered shall not engage in any activity for which registration is required until the application for registration is granted and the board has issued a certificate of registration to such person or business.

Manufacturers, distributors, reverse distributors, importers and exporters, individual practitioners (M.D., D.O., D.D.S., D.V.M., D.P.M., O.D., P.A., resident physician, advanced registered nurse practitioner), pharmacies, hospitals and animal shelters, care facilities, researchers and dog trainers, analytical laboratories, and teaching institutions shall register on forms provided by the board office. To be eligible to register, individual practitioners must hold a current, active license in good standing, issued by the appropriate Iowa professional licensing board, to practice their profession in Iowa.

657—10.2(124) Application forms. Application forms may be obtained from the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Forms are also available on the board's Web site, www.state.ia.us/ibpe. Registration renewal forms will be mailed to each registrant approximately 60 days before the expiration date of the registration. A registrant who has not received a renewal form 45 days before the expiration date of the registration is responsible for contacting the board to request an application.

10.2(1) Signature requirements. Each application, attachment, or other document filed as part of an application shall be signed by the applicant as follows:

a. If the applicant is an individual practitioner, the practitioner shall sign the application and supporting documents.

b. If the applicant is a business, the application and supporting documents shall be signed by the person ultimately responsible for the security and maintenance of controlled substances at the registered location.

10.2(2) Submission of multiple applications. Any person or business required to obtain more than one registration may submit all applications in one package. Each application shall be complete and shall not refer to any accompanying application or any attachment to an accompanying application for required information.

657—10.3(124) Registration and renewal. For each registration or timely renewal of a registration to manufacture, distribute, dispense, prescribe, import or export, conduct research or instructional activities, or conduct chemical analysis with controlled substances listed in Schedules I through V of Iowa Code chapter 124, registrants shall pay a biennial fee of \$100.

10.3(1) Time and method of payment. Registration and renewal fees shall be paid at the time the application for registration or renewal is submitted. Payment should be made in the form of a personal, certified, or cashier's check or a money order made payable to the Iowa Board of Pharmacy. Payments made in the form of foreign currency or third-party endorsed checks will not be accepted.

10.3(2) Late renewal. Any registered person or business may apply, on forms provided by the board office, for registration renewal not more than 60 days prior to the expiration of the registration. Failure to renew a registration prior to the first day of the month following expiration shall require payment of the renewal fee and a penalty fee of \$100. Payment shall be made as specified in subrule 10.3(1).

657—10.4(124) Exemptions—registration fee. The registration fee is waived for federal, state, and local law enforcement agencies and for the following federal and state institutions: hospitals, health care

or teaching institutions, and analytical laboratories authorized to possess, manufacture, distribute, and dispense controlled substances in the course of official duties.

10.4(1) *Law enforcement officials.* In order to enable law enforcement agency laboratories to obtain and transfer controlled substances for use as standards in chemical analysis, such laboratories shall maintain a registration to conduct chemical analysis. Such laboratories shall be exempt from payment of a fee for registration.

10.4(2) *Registration and duties not exempt.* Exemption from payment of a registration or registration renewal fee as provided in this rule does not relieve the agency or institution of registration or of any other requirements or duties prescribed by law.

657—10.5(124) Separate registration for independent activities; coincident activities. The following activities are deemed to be independent of each other and shall require separate registration. Any person or business engaged in more than one of these activities shall be required to separately register for each independent activity, provided, however, that registration in an independent activity shall authorize the registrant to engage in activities identified coincident with that independent activity.

10.5(1) *Manufacturing controlled substances.* A person or business registered to manufacture controlled substances in Schedules I through V may distribute any substances for which registration to manufacture was issued. A person or business registered to manufacture controlled substances in Schedules II through V may conduct chemical analysis and preclinical research, including quality control analysis, with any substances listed in those schedules for which the person or business is registered to manufacture.

10.5(2) *Distributing controlled substances.* This independent activity includes the delivery, other than by administering or dispensing, of controlled substances listed in Schedules I through V. No coincident activities are authorized.

10.5(3) *Dispensing or instructing with controlled substances.* This independent activity includes, but is not limited to, prescribing by individual practitioners, dispensing by pharmacies and hospitals, and conducting instructional activities with controlled substances listed in Schedules II through V. A person or business registered for this independent activity may conduct research and instructional activities with those substances for which the person or business is registered to the extent authorized under state law.

10.5(4) *Conducting research with controlled substances listed in Schedule I.* A researcher may manufacture or import the substances for which registration was issued provided that such manufacture or import is permitted under the federal Drug Enforcement Administration (DEA) registration. A researcher may distribute the substances for which registration was issued to persons or businesses registered or authorized to conduct research with that class of substances or registered or authorized to conduct chemical analysis with controlled substances.

10.5(5) *Conducting research with controlled substances listed in Schedules II through V.* A researcher may conduct chemical analysis with controlled substances in those schedules for which registration was issued, may manufacture such substances if and to the extent such manufacture is permitted under the federal DEA registration, and may import such substances for research purposes. A researcher may distribute controlled substances in those schedules for which registration was issued to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances, and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3), and may conduct instructional activities with controlled substances.

10.5(6) *Conducting chemical analysis with controlled substances.* A person or business registered to conduct chemical analysis with controlled substances listed in Schedules I through V may manufacture and import controlled substances for analytical or instructional activities; may distribute such substances to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3); may export such substances to persons in other countries performing chemical analysis or enforcing laws relating to controlled substances or drugs in those countries; and may conduct instructional activities with controlled substances.

10.5(7) *Importing or exporting controlled substances.* A person or business registered to import controlled substances listed in Schedules I through V may distribute any substances for which such registration was issued.

657—10.6(124) *Separate registrations for separate locations; exemption from registration.* A separate registration is required for each principal place of business or professional practice location where controlled substances are manufactured, distributed, imported, exported, or dispensed unless the person or business is exempt from registration pursuant to Iowa Code subsection 124.302(3) or this rule.

10.6(1) *Warehouse.* A warehouse where controlled substances are stored by or on behalf of a registered person or business shall be exempt from registration except as follows:

a. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to registered locations other than the registered location from which the substances were delivered to the warehouse.

b. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to persons exempt from registration pursuant to Iowa Code subsection 124.302(3).

10.6(2) *Sales office.* An office used by agents of a registrant where sales of controlled substances are solicited, made, or supervised shall be exempt from registration. Such office shall not contain controlled substances, except substances used for display purposes or for lawful distribution as samples, and shall not serve as a distribution point for filling sales orders.

10.6(3) *Prescriber's office.* An office used by a prescriber who is registered at another location and where controlled substances are prescribed but where no supplies of controlled substances are maintained shall be exempt from registration. However, a prescriber who practices at more than one office location where controlled substances are administered or otherwise dispensed as a regular part of the prescriber's practice shall register at each location wherein the prescriber maintains supplies of controlled substances.

10.6(4) *Prescriber in hospital.* A prescriber who is registered at another location and who treats patients and may order the administration of controlled substances in a hospital other than the prescriber's registered practice location shall not be required to obtain a separate registration for the hospital.

10.6(5) *Affiliated interns, residents, or foreign physicians.* An individual practitioner who is an intern, resident, or foreign physician may dispense and prescribe controlled substances under the registration of the hospital or other institution which is registered and by whom the registrant is employed provided that:

a. The hospital or other institution by which the individual practitioner is employed has determined that the practitioner is permitted to dispense or prescribe drugs by the appropriate licensing board;

b. Such individual practitioner is acting only in the scope of employment in the hospital or institution;

c. The hospital or other institution authorizes the intern, resident, or foreign physician to dispense or prescribe under the hospital registration and designates a specific internal code number, letters, or combination thereof which shall be appended to the institution's DEA registration number, preceded by a hyphen (e.g., AP1234567-10 or AP1234567-12); and

d. The hospital or institution maintains a current list of internal code numbers identifying the corresponding individual practitioner, available for the purpose of verifying the authority of the prescribing individual practitioner.

657—10.7 to 10.9 Reserved.

657—10.10(124,147,155A) *Inspection.* The board may inspect, or cause to be inspected, the establishment of an applicant or registrant. The board shall review the application for registration and other information regarding an applicant or registrant in order to determine whether the applicant or registrant has met the applicable standards of Iowa Code chapter 124 and these rules.

657—10.11(124) Modification or termination of registration. A registered individual or business may apply to modify a current registration as provided by this rule.

10.11(1) Change of substances authorized. Any registrant may apply to modify the substances authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, registration number, and the substances or schedules to be added to or removed from the registration and shall be signed by the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

10.11(2) Change of address of registered location.

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the address of the registered location by submitting a written request to the board. The request shall include the registrant's name, current address, new address, telephone number, effective date of the address change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the address of the registered location by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

10.11(3) Change of registrant's name.

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the registrant's name by submitting a written request to the board. The request shall include the registrant's current name, the new name, address, telephone number, effective date of the name change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification. Change of name, as used in this paragraph, refers to a change of the legal name of the registrant and does not authorize the transfer of a registration issued to an individual practitioner or researcher to another individual practitioner or researcher.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the registrant name by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

10.11(4) Change of ownership of registered business entity. A change of immediate ownership of a pharmacy, hospital, care facility, manufacturer, distributor, analytical laboratory, teaching institution, importer, or exporter shall require the completion of an application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

10.11(5) Change of responsible individual. Any registrant, except an individual practitioner, a researcher, a hospital, or a pharmacy, may apply to change the responsible individual authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, the name and title of the current responsible individual and of the new responsible individual, the effective date of the change, and the registration number, and shall be signed by the new responsible individual. No fee shall be required for the modification.

a. Individual practitioners and researchers. Responsibility under a registration issued to an individual practitioner or researcher shall remain with the named individual practitioner or researcher. The responsible individual under such registration may not be changed.

b. Pharmacies and hospitals. The responsible pharmacist may execute a power of attorney for DEA order forms to change responsibility under the registration issued to the pharmacy or hospital. The power of attorney shall include the name, address, DEA registration number, and Iowa uniform controlled substances Act (CSA) registration number of the registrant. The power of attorney shall

identify the current and new responsible individuals and shall authorize the new responsible individual to execute applications and official DEA order forms to requisition Schedule II controlled substances. The power of attorney shall be signed by both individuals, shall be witnessed by two adults, and shall be maintained by the registrant and available for inspection or copying by representatives of the board or other state or federal authorities.

10.11(6) Termination of registration. A registration issued to an individual shall terminate upon the death of the individual. A registration issued to an individual or business shall terminate when the registered individual or business ceases legal existence, discontinues business, or discontinues professional practice.

657—10.12(124) Denial, modification, suspension, or revocation of registration.

10.12(1) Grounds for suspension or revocation. The board may suspend or revoke any registration upon a finding that the registrant:

a. Has furnished false or fraudulent material information in any application filed under this chapter;

b. Has had the registrant's federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked;

c. Has been convicted of a public offense under any state or federal law relating to any controlled substance. For the purpose of this rule only, a conviction shall include a plea of guilty, a forfeiture of bail or collateral deposited to secure a defendant's appearance in court which forfeiture has not been vacated, or a finding of guilt in a criminal action even though entry of the judgment or sentence has been withheld and the individual has been placed on probation;

d. Has committed such acts as would render the registrant's registration under Iowa Code section 124.303 inconsistent with the public interest as determined by that section; or

e. Has been subject to discipline by the registrant's respective professional licensing board and the discipline revokes, suspends, or modifies the registrant's authority regarding controlled substances (including, but not limited to, limiting or prohibiting the registrant from prescribing or handling controlled substances). A certified copy of the record of licensee discipline or a copy of the licensee's surrender of the professional license shall be conclusive evidence.

10.12(2) Limited suspension or revocation. If the board finds grounds to suspend or revoke a registration, the board may limit revocation or suspension of the registration to the particular controlled substance with respect to which the grounds for revocation or suspension exist. If the revocation or suspension is limited to a particular controlled substance or substances, the registrant shall be given a new certificate of registration for all substances not affected by revocation or suspension; no fee shall be required for the new certificate of registration. The registrant shall deliver the old certificate of registration to the board.

10.12(3) Denial of registration or registration renewal. If upon examination of an application for registration or registration renewal, including any other information the board has or receives regarding the applicant, the board determines that the issuance of the registration would be inconsistent with the public interest, the board shall serve upon the applicant an order to show cause why the registration should not be denied.

10.12(4) Considerations in denial of registration. In determining the public interest, the board shall consider all of the following factors:

a. Maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels.

b. Compliance with applicable state and local law.

c. Any convictions of the applicant under any federal and state laws relating to any controlled substance.

d. Past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion.

e. Furnishing by the applicant of false or fraudulent material in any application filed under this chapter.

f. Suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law.

g. Any other factors relevant to and consistent with the public health and safety.

10.12(5) *Order to show cause.* Before denying, modifying, suspending, or revoking a registration, the board shall serve upon the applicant or registrant an order to show cause why the registration should not be denied, modified, revoked, or suspended. The order to show cause shall contain a statement of the basis therefor and shall call upon the applicant or registrant to appear before an administrative law judge or the board at a time and place not less than 30 days after the date of service of the order. The order to show cause shall also contain a statement of the legal basis for such hearing and for the denial, revocation, or suspension of registration and a summary of the matters of fact and law asserted. If the order to show cause involves the possible denial of registration renewal, the order shall be served not later than 30 days before the expiration of the registration. Proceedings to refuse renewal of registration shall not abate the existing registration, which shall remain in effect pending the outcome of the administrative hearing unless the board issues an order of immediate suspension pursuant to subrule 10.12(9).

10.12(6) *Hearing requested.* If an applicant or registrant who has received an order to show cause desires a hearing on the matter, the applicant or registrant shall file a request for a hearing within 30 days after the date of service of the order to show cause. If a hearing is requested, the board shall hold a hearing pursuant to 657—Chapter 35 at the time and place stated in the order and without regard to any criminal prosecution or other proceeding. Unless otherwise ordered by the board, an administrative law judge employed by the department of inspections and appeals shall be assigned to preside over the case and to render a proposed decision for the board's consideration.

10.12(7) *Waiver of hearing.* If an applicant or registrant entitled to a hearing on an order to show cause fails to file a request for hearing, or if the applicant or registrant requests a hearing but fails to appear at the hearing, the applicant or registrant shall be deemed to have waived the opportunity for a hearing unless the applicant or registrant shows good cause for such failure.

10.12(8) *Final board order when hearing waived.* If an applicant or registrant entitled to a hearing waives or is deemed to have waived the opportunity for a hearing, the executive director of the board may cancel the hearing and issue, on behalf of the board, the board's final order on the order to show cause.

10.12(9) *Order of immediate suspension.* The board may suspend any registration simultaneously with the service upon the registrant of an order to show cause why such registration should not be revoked or suspended if it finds there is an imminent danger to the public health or safety that warrants such action. If the board suspends a registration simultaneously with the service of the order to show cause upon the registrant, it shall serve an order of immediate suspension containing a statement of its findings regarding the danger to public health or safety upon the registrant with the order to show cause. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review thereof, under the provisions of the Iowa administrative procedure Act, unless sooner withdrawn by the board or dissolved by the order of the district court or an appellate court.

10.12(10) *Disposition of controlled substances.* If the board suspends or revokes a registration, the registrant shall promptly return the certificate of registration to the board. Also, upon service of the order of the board suspending or revoking the registration, the registrant shall deliver all affected controlled substances in the registrant's possession to the board or authorized agent of the board. Upon receiving the affected controlled substances from the registrant, the board or its authorized agent shall place all such substances under seal and retain the sealed controlled substances pending final resolution of any appeals or until a court of competent jurisdiction directs otherwise. No disposition may be made of the substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of proceeds of the sale with the court. Upon a revocation order's becoming final, all such controlled substances may be forfeited to the state.

10.12(11) *Notifications.* The board shall promptly notify the DEA and the Iowa department of public safety of all orders suspending or revoking registration and all forfeitures of controlled substances.

657—10.13 and **10.14** Reserved.

657—10.15(124,155A) Security requirements. All applicants and registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances. In order to determine whether a person has provided effective controls against diversion, the board shall use the security requirements set forth in these rules as standards for the physical security controls and operating procedures necessary to prevent diversion.

10.15(1) Physical security. Physical security controls shall be commensurate with the schedules and quantity of controlled substances in the possession of the registrant in normal business operation. A registrant shall periodically review and adjust security measures based on rescheduling of substances or changes in the quantity of substances in the possession of the registrant.

a. Controlled substances listed in Schedule I shall be stored in a securely locked, substantially constructed cabinet.

b. Controlled substances listed in Schedules II through V may be stored in a securely locked, substantially constructed cabinet. However, pharmacies and hospitals may disperse these substances throughout the stock of noncontrolled substances in a manner so as to obstruct the theft or diversion of the controlled substances.

10.15(2) Factors in evaluating physical security systems. In evaluating the overall security system of a registrant or applicant necessary to maintain effective controls against theft or diversion of controlled substances, the board may consider any of the following factors it deems relevant to the need for strict compliance with the requirements of this rule:

- a.* The type of activity conducted;
- b.* The type, form, and quantity of controlled substances handled;
- c.* The location of the premises and the relationship such location bears to security needs;
- d.* The type of building construction comprising the facility and the general characteristics of the building or buildings;
- e.* The type of vault, safe, and secure enclosures available;
- f.* The type of closures on vaults, safes, and secure enclosures;
- g.* The adequacy of key control systems or combination lock control systems;
- h.* The adequacy of electric detection and alarm systems, if any;
- i.* The adequacy of supervision over employees having access to controlled substances, to storage areas, or to manufacturing areas;
- j.* The extent of unsupervised public access to the facility, including the presence and characteristics of perimeter fencing, if any;
- k.* The procedures for handling business guests, visitors, maintenance personnel, and nonemployee service personnel;
- l.* The availability of local police protection or of the registrant's or applicant's security personnel; and
- m.* The adequacy of the registrant's or applicant's system for monitoring the receipt, manufacture, distribution, and disposition of controlled substances.

10.15(3) Manufacturing and compounding storage areas. Raw materials, bulk materials awaiting further processing, and finished products which are controlled substances listed in any schedule shall be stored pursuant to federal laws and regulations.

657—10.16(124) Report of theft or loss. A registrant shall report in writing, on forms provided by the board, any theft or significant loss of any controlled substance when the loss is attributable to other than inadvertent error. The report shall be submitted to the board office within two weeks of the discovery of the theft or loss. Thefts shall be reported whether or not the controlled substances are subsequently recovered or the responsible parties are identified and action is taken against them. A copy of the report shall be maintained in the files of the registrant, and the board will provide a copy of the report to the DEA. In addition to this required report, DEA requires the registrant to deliver notice, immediately

upon discovery of a theft or significant loss of controlled substances, to the nearest DEA field office via telephone, facsimile, or a brief written message explaining the circumstances.

657—10.17(124) Accountability of stock supply. An individual who administers a controlled substance from a non-patient-specific, stock supply in an institutional setting shall personally document on a separate readily retrievable record system each dose administered, wasted, or returned to the pharmacy. Such documentation shall not be delegated to another individual. Wastage documentation shall include the signature of a witnessing licensed health care practitioner.

Distribution records for non-patient-specific, floor-stocked controlled substances shall bear the following information:

1. Patient's name;
2. Prescriber who ordered drug;
3. Name of drug, dosage form, and strength;
4. Time and date of administration to patient and quantity administered;
5. Signature or unique electronic signature of individual administering controlled substance;
6. Returns to the pharmacy;
7. Waste, which is required to be witnessed and cosigned by another licensed health care practitioner.

657—10.18(124) Disposal. Any persons legally authorized to possess controlled substances in the course of their professional practice or the conduct of their business shall dispose of such drugs pursuant to the procedures and requirements of this rule. Disposal records shall be maintained in the files of the registrant.

10.18(1) Registrant stock supply. Pharmacy personnel, registrants, and registrant staff shall remove from current inventory and dispose of controlled substances by one of the following procedures.

a. The responsible individual shall utilize the services of a DEA-registered and Iowa-licensed disposal firm.

b. The board may authorize and instruct the registrant to dispose of the controlled substances in one of the following manners:

- (1) By delivery to an agent of the board or to the board office;
- (2) By destruction of the drugs in the presence of a board officer, agent, inspector, or other authorized individual; or
- (3) By such other means as the board may determine to ensure that drugs do not become available to unauthorized persons.

10.18(2) Waste. Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient from a registrant's stock or emergency supply or resulting from drug compounding operations may be destroyed or otherwise disposed of by the registrant or a pharmacist in witness of one other licensed health care provider or a registered pharmacy technician 18 years of age or older pursuant to this subrule. A written record of the wastage shall be made and maintained by the registrant for a minimum of two years following the destruction or other disposal. The record shall include the signatures of the individual destroying or otherwise disposing of the waste controlled substance and of the witnessing licensed health care provider or registered pharmacy technician and shall identify the following:

- a.* The controlled substance wasted;
- b.* The date of destruction or other disposition;
- c.* The quantity or estimated quantity of the wasted controlled substance;
- d.* The source of the controlled substance, including identification of the patient to whom the substance was administered or the drug compounding process utilizing the controlled substance; and
- e.* The reason for the waste.

10.18(3) Previously dispensed controlled substances. Controlled substances dispensed to or for a patient and subsequently requiring destruction due to discontinuance of the drug, death of the patient, or other reasons necessitating destruction may be destroyed or otherwise disposed of by a pharmacist in

witness of one other responsible adult pursuant to this subrule. All licenses and registrations issued to the pharmacy, the pharmacist, and any individual witnessing the destruction or other disposition shall not be subject to sanctions relating to controlled substances at the time of the destruction or disposition. The individuals involved in the destruction or other disposition shall not have been subject to any criminal, civil, or administrative action relating to violations of controlled substances laws, rules, or regulations within the past five years. The pharmacist in charge shall be responsible for designating pharmacists authorized to participate in the destruction or other disposition pursuant to this subrule. The authorized pharmacist shall prepare and maintain in the pharmacy a readily retrievable record of the destruction or other disposition, which shall be clearly marked to indicate the destruction or other disposition of noninventory or patient drugs. The record shall include, at a minimum, the following:

- a. Source of the controlled substance (patient identifier or administering practitioner, if applicable, and date of return);
- b. The name, strength, and dosage form of the substance;
- c. The quantity returned and destroyed or otherwise disposed;
- d. The date the substance is destroyed or otherwise disposed;
- e. The signatures or other unique identification of the pharmacist and the witness.

657—10.19 and **10.20** Reserved.

657—10.21(124,126,155A) Prescription requirements. All prescriptions for controlled substances shall be dated as of, and manually signed on, the day issued. Controlled substances prescriptions shall be valid for six months following date of issue.

10.21(1) Form of prescription. All prescriptions shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and DEA registration number of the prescriber. All prescriptions issued by individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber's signature. When an oral order is not permitted, prescriptions shall be written with ink, indelible pencil, or typed print and shall be manually signed by the prescriber. A secretary or agent may prepare a prescription for the signature of the prescriber but the prescribing practitioner is responsible for the accuracy, completeness, and validity of the prescription. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by this rule.

10.21(2) Verification by pharmacist. The pharmacist shall verify the authenticity of the prescription with the individual prescriber in each case when a prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient's agent is known to the pharmacist. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist's name or unique identifier.

10.21(3) Intern, resident, foreign physician. An intern, resident, or foreign physician exempt from registration pursuant to subrule 10.6(5) shall include on all prescriptions issued the hospital's registration number and the special internal code number assigned by the hospital in lieu of the prescriber's registration number required by this rule. Each prescription shall include the stamped or printed name of the intern, resident, or foreign physician as well as the prescriber's signature.

10.21(4) Valid prescriber/patient relationship. Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or to oversee the patient's use of the controlled substance, a prescription shall lose its validity. A prescriber/patient relationship shall be deemed broken when the prescriber dies, retires, or moves out of the local service area or when the prescriber's authority to prescribe is suspended, revoked, or otherwise modified to exclude authority for the schedule in which the prescribed substance is listed. The pharmacist, upon becoming aware of the situation, shall cancel the prescription and any remaining refills. However, the pharmacist shall exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new prescription can be issued.

10.21(5) Schedule II prescriptions. With appropriate verification, a pharmacist may add information provided by the patient or patient's agent, such as the patient's address, to a Schedule II controlled substance prescription. A pharmacist shall never change the patient's name, the controlled substance prescribed except for generic substitution, or the name or signature of the prescriber. After consultation with the prescribing practitioner and documentation of such consultation, a pharmacist may change or add the following information on a Schedule II controlled substance prescription:

- a. The drug strength;
- b. The dosage form;
- c. The drug quantity;
- d. The directions for use; and
- e. The date the prescription was issued.

657—10.22(124) Schedule II emergency prescriptions.

10.22(1) Emergency situation defined. For the purposes of authorizing an oral or electronically transmitted prescription for a Schedule II controlled substance listed in Iowa Code section 124.206, the term "emergency situation" means those situations in which the prescribing practitioner determines that all of the following apply:

- a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.
- b. No appropriate alternative treatment is available, including administration of a drug that is not a Schedule II controlled substance.
- c. It is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance prior to the dispensing.

10.22(2) Requirements of emergency prescription. In the case of an emergency situation as defined herein, a pharmacist may dispense a controlled substance listed in Schedule II pursuant to an electronic transmission or upon receiving oral authorization of a prescribing individual practitioner provided that:

- a. The quantity prescribed and dispensed is limited to the smallest available quantity to meet the needs of the patient during the emergency period. Dispensing beyond the emergency period requires a written prescription manually signed by the prescribing individual practitioner.
- b. If the pharmacist does not know the prescribing individual practitioner, the pharmacist shall make a reasonable effort to determine that the authorization came from an authorized prescriber. The pharmacist shall record the manner by which the authorization was verified and include the pharmacist's name or unique identification.
- c. The pharmacist shall prepare a temporary written record of the emergency prescription. The temporary written record shall consist of a hard copy of the electronic transmission or a written record of the oral transmission authorizing the emergency dispensing. A written record is not required to consist of a handwritten record and may be a printed facsimile or a print of a computer-generated record of the prescription if the printed record includes all of the required elements for the prescription. If the emergency prescription is transmitted by the practitioner's agent, the record shall include the name and title of the individual who transmitted the prescription.

d. If the emergency prescription is transmitted via electronic transmission, the means of transmission shall not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the written prescription, and the hard-copy record of the electronic transmission shall not be obscured or rendered illegible due to such security features.

e. Within seven days after authorizing an emergency prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of 657—10.21(124,126,155A), the prescription shall have written on its face "Authorization for Emergency Dispensing" and the date of the emergency order. The written prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the seven-day period. The written prescription shall be attached to and maintained with the temporary written record prepared pursuant to paragraph "c."

f. The pharmacist shall notify the board if the prescribing individual fails to deliver a written prescription. Failure of the pharmacist to so notify the board, or failure of the prescribing individual to deliver the required written prescription as herein required, shall void the authority conferred by this subrule.

[ARC 7636B, IAB 3/11/09, effective 4/15/09; ARC 9410B, IAB 3/9/11, effective 4/13/11]

657—10.23(124) Schedule II prescriptions—partial filling. The partial filling of a prescription for a controlled substance listed in Schedule II is permitted as provided in this rule.

10.23(1) *Insufficient supply on hand.* If the pharmacist is unable to supply the full quantity called for in a prescription and makes a notation of the quantity supplied on the prescription record, a partial fill of the prescription is permitted. The remaining portion of the prescription must be filled within 72 hours of the first partial filling. If the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall so notify the prescriber. No further quantity may be supplied beyond 72 hours without a new prescription.

10.23(2) *Long-term care or terminally ill patient.* A prescription for a Schedule II controlled substance written for a patient in a long-term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units as provided by this subrule.

a. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner prior to partially filling the prescription. Both the pharmacist and the practitioner have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient.

b. The pharmacist shall record on the prescription whether the patient is “terminally ill” or an “LTCF patient.” For each partial filling, the dispensing pharmacist shall record on the back of the prescription, or on another appropriate uniformly maintained and readily retrievable record, the date of the partial filling, the quantity dispensed, the remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

c. The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed. Schedule II prescriptions for patients in a LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

d. Information pertaining to current Schedule II prescriptions for patients in a LTCF or for patients with a medical diagnosis documenting a terminal illness may be maintained in a computerized system pursuant to rule 657—21.4(124,155A).

657—10.24(124) Schedule II medication order. Schedule II controlled substances may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.18(124,155A), as applicable.

657—10.25(124) Schedule II—issuing multiple prescriptions. An individual prescriber may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance pursuant to the provisions and limitations of this rule.

10.25(1) *Refills prohibited.* The issuance of refills for a Schedule II controlled substance is prohibited. The use of multiple prescriptions for the dispensing of Schedule II controlled substances, pursuant to this rule, ensures that the prescriptions are treated as separate dispensing authorizations and not as refills of an original prescription.

10.25(2) *Legitimate medical purpose.* Each separate prescription issued pursuant to this rule shall be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of the prescriber’s professional practice.

10.25(3) *Dates and instructions.* Each prescription issued pursuant to this rule shall be dated as of and manually signed by the prescriber on the day the prescription is issued. Each separate prescription,

other than the first prescription if that prescription is intended to be filled immediately, shall contain written instructions indicating the earliest date on which a pharmacist may fill each prescription.

10.25(4) *Authorized fill date unalterable.* Regardless of the provisions of subrule 10.21(5), when a prescription contains instructions from the prescriber indicating that the prescription shall not be filled before a certain date, a pharmacist shall not fill the prescription before that date. The pharmacist shall not contact the prescriber for verbal authorization to fill the prescription before the fill date originally indicated by the prescriber pursuant to this rule.

10.25(5) *Number of prescriptions and authorized quantity.* An individual prescriber may issue for a patient as many separate prescriptions, to be filled sequentially pursuant to this rule, as the prescriber deems necessary to provide the patient with adequate medical care. The cumulative effect of the filling of each of these separate prescriptions shall result in the receipt by the patient of a quantity of the Schedule II controlled substance not exceeding a 90-day supply.

10.25(6) *Prescriber's discretion.* Nothing in this rule shall be construed as requiring or encouraging an individual prescriber to issue multiple prescriptions pursuant to this rule or to see the prescriber's patients only once every 90 days when prescribing Schedule II controlled substances. An individual prescriber shall determine, based on sound medical judgment and in accordance with established medical standards, how often to see patients and whether it is appropriate to issue multiple prescriptions pursuant to this rule.

[ARC 8172B, IAB 9/23/09, effective 10/28/09]

657—10.26 Reserved.

657—10.27(124,155A) Facsimile transmission of a controlled substance prescription.

10.27(1) *Schedule II prescription.* A prescription for a Schedule II controlled substance may be transmitted via facsimile to the pharmacy only as provided in rules 657—21.12(124,155A) to 657—21.16(124,155A).

10.27(2) *Schedule III, IV, or V prescription.* A prescription for a Schedule III, IV, or V controlled substance may be transmitted via facsimile to the pharmacy only as provided in rule 657—21.9(124,155A).

657—10.28(124,155A) Schedule III, IV, or V refills. No prescription for a controlled substance listed in Schedule III, IV, or V shall be filled or refilled more than six months after the date on which it was issued nor be refilled more than five times.

10.28(1) *Record.* Each filling and refilling of a prescription shall be entered on the prescription or on another uniformly maintained and readily retrievable record.

a. The following information shall be retrievable by the prescription number: the name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, the unique identification of the dispensing pharmacist for each refill, and the total number of refills authorized for that prescription.

b. If the pharmacist merely initials or affixes the pharmacist's unique identifier and dates the back of the prescription, it shall be deemed that the full face amount of the prescription has been dispensed.

10.28(2) *Oral refill authorization.* The prescribing practitioner may authorize additional refills of Schedule III, IV, or V controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

a. The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issuance of the original prescription.

b. The pharmacist who obtains the oral authorization records from the prescriber who issued the original prescription records on or with the original prescription the date, the quantity of each refill, the number of additional refills authorized, and the pharmacist's unique identification.

c. The quantity of each additional refill is equal to or less than the quantity authorized for the initial filling of the original prescription.

d. The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

10.28(3) Automated data processing record system. An automated data processing record system may be used for the storage and retrieval of Schedule III, IV, and V controlled substance prescription fill and refill information subject to the conditions and requirements of rules 657—21.4(124,155A) and 657—21.5(124,155A).

657—10.29(124,155A) Schedule III, IV, or V partial fills. The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible provided that each partial fill is recorded in the same manner as a refill. The total quantity dispensed in all partial fills shall not exceed the total quantity prescribed. No dispensing shall occur later than six months after the date on which the prescription was issued.

657—10.30(124,155A) Schedule III, IV, and V medication order. A Schedule III, IV, or V controlled substance may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124,155A), as applicable.

657—10.31(124,155A) Dispensing Schedule V controlled substances without a prescription. A controlled substance listed in Schedule V, which substance is not a prescription drug as determined under the federal Food, Drug and Cosmetic Act, and excepting products containing ephedrine, pseudoephedrine, or phenylpropanolamine, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.31(1) Who may dispense. Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.31(2) Frequency and quantity. Dispensing at retail to the same purchaser in any 48-hour period shall be limited to no more than one of the following quantities of a Schedule V controlled substance:

- a. 240 cc (8 ounces) of any controlled substance containing opium.
- b. 120 cc (4 ounces) of any other controlled substance.
- c. 48 dosage units of any controlled substance containing opium.
- d. 24 dosage units of any other controlled substance.

10.31(3) Age of purchaser. The purchaser shall be at least 18 years of age.

10.31(4) Identification. The pharmacist shall require every purchaser under this rule not known by the pharmacist to present a government-issued photo identification, including proof of age when appropriate.

10.31(5) Record. A bound record book (i.e., with pages sewn or glued to the spine) for dispensing of Schedule V controlled substances pursuant to this rule shall be maintained by the pharmacist. The book shall contain the name and address of each purchaser, the name and quantity of controlled substance purchased, the date of each purchase, and the name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the substance to the purchaser.

10.31(6) Prescription not required under other laws. No other federal or state law or regulation requires a prescription prior to distributing or dispensing a Schedule V controlled substance.

657—10.32(124,155A) Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine without a prescription. A product containing ephedrine, pseudoephedrine, or phenylpropanolamine, which substance is a Schedule V controlled substance and is not listed in another controlled substance schedule, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.32(1) Who may dispense. Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit,

after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.32(2) *Packaging of nonliquid forms.* A nonliquid form of a product containing ephedrine, pseudoephedrine, or phenylpropanolamine includes gel caps. Nonliquid forms of these products to be sold pursuant to this rule shall be packaged either in blister packaging with each blister containing no more than two dosage units or, if blister packs are technically infeasible, in unit dose packets or pouches.

10.32(3) *Frequency and quantity.* Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

10.32(4) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.32(5) *Identification.* The pharmacist shall require every purchaser under this rule to present a current government-issued photo identification, including proof of age when appropriate. The pharmacist shall be responsible for verifying that the name on the identification matches the name provided by the purchaser and that the photo image depicts the purchaser.

10.32(6) *Record.* Purchase records shall be recorded in the real-time electronic pseudoephedrine tracking system (PTS) established and administered by the governor's office of drug control policy pursuant to 657—Chapter 100. If the real-time electronic repository is unavailable for use, the purchase record shall be recorded in an alternate format and submitted to the PTS as provided in 657—subrule 100.3(4).

a. Alternate record contents. The alternate record shall contain the following:

- (1) The name, address, and signature of the purchaser.
- (2) The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.
- (3) The date and time of the purchase.
- (4) The name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the product.

b. Alternate record format. The record shall be maintained using one of the following options:

- (1) A hard-copy record.
- (2) A record in the pharmacy's electronic prescription dispensing record-keeping system that is capable of producing a hard-copy printout of a record.
- (3) A record in an electronic data collection system that captures each of the data elements required by this subrule and that is capable of producing a hard-copy printout of a record.

c. PTS records retrieval. Pursuant to 657—subrule 100.4(6), the pharmacy shall be able to produce a hard-copy printout of transactions recorded in the PTS by the pharmacy for one or more specific products for a specified period of time upon request by the board or its representative or to such other persons or governmental agencies authorized by law to receive such information.

10.32(7) *Notice required.* The pharmacy shall ensure that the following notice is provided to purchasers of ephedrine, pseudoephedrine, or phenylpropanolamine products and that the notice is displayed with or on the electronic signature device or is displayed in the dispensing area and visible to the public:

“WARNING: Section 1001 of Title 18, United States Code, states that whoever, with respect to the logbook, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, shall be fined not more than \$250,000 if an individual or \$500,000 if an organization, imprisoned not more than five years, or both.”

[ARC 8892B, IAB 6/30/10, effective 9/1/10]

657—10.33(124,155A) Schedule II perpetual inventory in pharmacy. Each pharmacy located in Iowa that dispenses Schedule II controlled substances shall maintain a perpetual inventory system for all

Schedule II controlled substances pursuant to the requirements of this rule. All records relating to the perpetual inventory shall be maintained by the pharmacy and shall be available for inspection and copying by the board or its representative for a period of two years from the date of the record.

10.33(1) Record format. The perpetual inventory record may be maintained in a manual or an electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed.

10.33(2) Information included. The perpetual inventory record shall identify all receipts for and disbursements of Schedule II controlled substances by drug or by national drug code (NDC) number. The record shall be updated to identify each prescription filled and each shipment received. The record shall also include incident reports and reconciliation records pursuant to subrules 10.33(3) and 10.33(4).

10.33(3) Changes to a record. If a perpetual inventory record is able to be changed, the individual making a change to the record shall complete an incident report documenting the change. The incident report shall identify the specific information that was changed including the information before and after the change, shall identify the individual making the change, and shall include the date and the reason the record was changed. If the electronic record system documents within the perpetual inventory record all of the information that must be included in an incident report, a separate report is not required.

10.33(4) Reconciliation. The pharmacist in charge shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance on a periodic basis but no less frequently than annually. In case of any discrepancies between the physical inventory and the perpetual inventory, the pharmacist in charge shall determine the need for further investigation, and significant discrepancies shall be reported to the board pursuant to rule 10.16(124) and to the DEA pursuant to federal DEA regulations. Periodic reconciliation records shall be maintained and available for review and copying by the board or agents of the board for a period of two years from the date of the record. The reconciliation process may be completed using either of the following procedures or a combination thereof:

a. The dispensing pharmacist verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. If controlled substances are maintained on the patient care unit, the nurse or other responsible licensed health care provider verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. All discrepancies shall be reported to the pharmacist in charge. If any Schedule II controlled substances in the pharmacy's current inventory have been dispensed and verified in this manner within the year, and there are no discrepancies noted, no additional reconciliation action is required. A drug that has had no activity within the year shall be reconciled pursuant to paragraph "b" of this subrule.

b. A physical count of each Schedule II controlled substance stocked by the pharmacy shall be completed at least once each year, and that count shall be reconciled with the perpetual inventory record balance. The physical count and reconciliation may be completed over a period of time not to exceed one year in a manner that ensures that the perpetual inventory and the physical inventory of Schedule II controlled substances are annually reconciled. The individual performing the reconciliation shall record the date, the time, the individual's initials or unique identification, and any discrepancies between the physical inventory and the perpetual inventory. Any discrepancies between the physical inventory and the perpetual inventory shall be reported to the pharmacist in charge.

657—10.34(124,155A) Records. Every inventory or other record required to be kept under this chapter or under Iowa Code chapter 124 shall be kept by the registrant and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record except as otherwise required in these rules. Controlled substances records shall be maintained in a readily retrievable manner that establishes the receipt and distribution of all controlled substances. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited

under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department.

10.34(1) *Schedule I and II records.* Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the registrant.

10.34(2) *Schedule III, IV, and V records.* Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the required information is readily retrievable from the ordinary business records of the registrant.

10.34(3) *Date of record.* The date on which a controlled substance is actually received, imported, distributed, exported, or otherwise transferred shall be used as the date of receipt or distribution.

10.34(4) *Receipt and disbursement records.* Each record of receipt or disbursement of controlled substances, unless otherwise provided in these rules or pursuant to federal law, shall include the following:

- a. The name of the substance;
- b. The strength and dosage form of the substance;
- c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from whom the substances were acquired;
- d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to whom the substances were distributed; and
- e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to whom the substances were distributed for disposal, if appropriate.

10.34(5) *Dispensing records.* Each record of dispensing of controlled substances to a patient or research subject shall include the following information:

- a. The name and address of the person to whom dispensed;
- b. The date of dispensing;
- c. The name of the substance;
- d. The quantity of the substance dispensed; and
- e. The name or unique identification of the individual who dispensed or administered the substance.

10.34(6) *Ordering or distributing Schedule I or II controlled substances - DEA Form 222.* Except as otherwise provided by subrule 10.34(7) and under federal law, a DEA Form 222 is required for each distribution of a Schedule I or II controlled substance. An order form may be executed only on behalf of the registrant named on the order form and only if the registrant's DEA and Iowa registrations for the substances being purchased have not expired or been revoked or suspended by the issuing agency.

a. Order forms shall be obtained, executed, and filled pursuant to DEA requirements. Each form shall be complete, legible, and properly prepared, executed, and endorsed and shall contain no alteration, erasure, or change of any kind.

b. The purchaser shall submit Copy 1 and Copy 2 of the order form to the supplier.

c. The purchaser shall maintain Copy 3 of the order form in the files of the registrant. Upon receipt of the substances from the supplier, the purchaser shall record on Copy 3 of the order form the quantity of each substance received, and the date of receipt, and shall initial each line identifying a substance received.

d. The supplier shall record on Copy 1 and Copy 2 of the order form the quantity of each substance distributed to the purchaser and the date on which the shipment is made. The supplier shall maintain Copy 1 of the order form in the files of the supplier and shall forward Copy 2 of the order form to the DEA district office.

e. Order forms shall be maintained separately from all other records of the registrant.

f. Each unaccepted, defective, or otherwise "void" order form and any attached statement or other documents relating to any order form shall be maintained in the files of the registrant.

g. If the registration of any purchaser of Schedule I or II controlled substances is terminated for any reason, or if the name or address of the registrant as shown on the registration is changed, the registrant shall return all unused order forms to the DEA district office.

10.34(7) Ordering or distributing Schedule I or II controlled substances - electronic ordering system. A registrant authorized to order or distribute Schedule I or II controlled substances via the DEA Controlled Substances Ordering System (CSOS) shall comply with the requirements of the DEA relating to that system, including the maintenance and security of digital certificates, signatures, and passwords and all record-keeping and reporting requirements.

a. For an electronic order to be valid, the purchaser shall sign the electronic order with a digital signature issued to the purchaser or the purchaser's agent by the DEA.

b. An electronic order may include controlled substances that are not in Schedules I and II and may also include noncontrolled substances.

c. A purchaser shall submit an order to a specific wholesale distributor appropriately licensed to distribute in Iowa.

d. Prior to filling an order, a supplier shall verify the integrity of the signature and the order, verify that the digital certificate has not expired, check the validity of the certificate, and verify the registrant's authority to order the controlled substances.

e. The supplier shall retain an electronic record of every order, including a record of the number of commercial or bulk containers furnished for each item and the date on which the supplier shipped the containers to the purchaser. The shipping record shall be linked to the electronic record of the order. Unless otherwise provided under federal law, a supplier shall ship the controlled substances to the registered location associated with the digital certificate used to sign the order.

f. If an order cannot be filled for any reason, the supplier shall notify the purchaser and provide a statement as to the reason the order cannot be filled. When a purchaser receives such a statement from a supplier, the purchaser shall electronically link the statement of nonacceptance to the original electronic order. Neither a purchaser nor a supplier may correct a defective order; the purchaser must issue a new order for the order to be filled.

g. When a purchaser receives a shipment, the purchaser shall create a record of the quantity of each item received and the date received. The record shall be electronically linked to the original order and shall identify the individual reconciling the order. A purchaser shall, for each order filled, retain the original signed order and all linked records for that order for two years. The purchaser shall also retain all copies of each unfilled or defective order and each linked statement.

h. A supplier shall retain each original order filled and all linked records for two years. A supplier shall, for each electronic order filled, forward to the DEA within two business days either a copy of the electronic order or an electronic report of the order in a format specified by the DEA.

i. Records of CSOS electronic orders and all linked records shall be maintained by a supplier and a purchaser for two years following the date of shipment or receipt, respectively. Records may be maintained electronically or in hard-copy format. Records that are maintained electronically shall be readily retrievable from all other records, shall be easily readable or easily rendered into a readable format, shall be readily retrievable at the registered location, and shall be made available to the board, to the board's agents, or to the DEA upon request. Records maintained in hard-copy format shall be maintained in the same manner as DEA Form 222.

[ARC 8539B, IAB 2/24/10, effective 4/1/10]

657—10.35(124,155A) Physical count and record of inventory. Responsibility for ensuring that a required inventory is timely completed shall rest with the registrant or, in the case of a registered business, shall rest with the owner of the business. A registrant or owner of a registered business may delegate the actual taking of any inventory. The person or persons responsible for taking the inventory shall sign the completed inventory record.

10.35(1) Record and procedure. Each inventory record, except the periodic count and reconciliation required pursuant to subrule 10.33(4), shall comply with the requirements of this subrule and shall be maintained for a minimum of two years from the date of the inventory.

a. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date and at the time the inventory is taken.

b. Each inventory shall be maintained in a handwritten, typewritten, or electronically printed form at the registered location. An inventory of Schedule II controlled substances shall be maintained separately from an inventory of all other controlled substances.

c. Controlled substances shall be deemed to be on hand if they are in the possession of or under the control of the registrant. These shall include prescriptions prepared for dispensing to a patient but not yet delivered to the patient, substances maintained in emergency medical services programs or care facility emergency supplies, outdated or adulterated substances pending destruction, and substances stored in a warehouse on behalf of the registrant.

d. A separate inventory shall be made for each registered location and for each independent activity registered except as otherwise provided under federal law.

e. The inventory shall be taken either prior to opening or following the close of business on the inventory date, and the inventory record shall identify either opening or close of business.

f. The inventory record, unless otherwise provided under federal law, shall include the following information:

- (1) The name of the substance;
- (2) The strength and dosage form of the substance; and
- (3) The quantity of the substance.

g. For all substances listed in Schedule I or II, and for all solid oral and injectable hydrocodone-containing products, the quantity shall be an exact count or measure of the substance.

h. For all substances listed in Schedule III, IV, or V, except for hydrocodone-containing products identified in paragraph "g" herein, the quantity may be an estimated count or measure of the substance unless the container has been opened and originally held more than 100 dosage units. If the opened commercial container originally held more than 100 dosage units, an exact count of the contents shall be made. Liquid oral hydrocodone-containing products packaged in incremented containers shall be measured to the nearest increment; products packaged in nonincremented containers may be estimated to the nearest one-fourth container.

10.35(2) *Initial inventory.* A new registrant shall take an inventory of all stocks of controlled substances on hand on the date the new registrant first engages in the manufacture, distribution, or dispensing of controlled substances. If the registrant commences business or the registered activity with no controlled substances on hand, the initial inventory shall record that fact.

10.35(3) *Annual inventory.* After the initial inventory is taken, a registrant shall take a new inventory of all stocks of controlled substances on hand at least annually. The annual inventory may be taken on any date that is within one year of the previous inventory date.

10.35(4) *Change of ownership.* Both the current owner and the prospective owner shall be responsible for ensuring that an inventory of all controlled substances is timely completed whenever there is a change of ownership of any pharmacy or drug wholesaler licensed pursuant to Iowa Code section 155A.13 or 155A.17, respectively.

10.35(5) *Change of pharmacist in charge (PIC).* An inventory of all controlled substances shall be completed whenever there is a change of PIC. The inventory shall be taken following the close of business the last day of the terminating PIC's employment and prior to opening for business the first day of the new PIC's employment. A single inventory shall be sufficient if there is no lapse between employment of the terminating PIC and the new PIC.

10.35(6) *Change of registered location.* A registrant shall take an inventory of all controlled substances whenever there is a change of registered location. The inventory shall be taken following the close of business the last day at the location being vacated. This inventory shall serve as the ending inventory for the location being vacated as well as a record of beginning inventory for the new location.

10.35(7) *Discontinuing registered activity.* A registrant shall take an inventory of controlled substances at the close of business the last day the registrant is engaged in registered activities. If the registrant is selling or transferring the remaining controlled substances to another registrant, this

inventory shall serve as the ending inventory for the registrant discontinuing business as well as a record of additional or starting inventory for the registrant to whom the substances are transferred.

10.35(8) *Newly controlled substances.* On the effective date of the addition of a previously noncontrolled substance to any schedule of controlled substances, any registrant who possesses the newly controlled substance shall take an inventory of all stocks of the substance on hand. That initial inventory record shall be maintained with the most recent controlled substances inventory record. Thereafter, the newly controlled substance shall be included in each inventory made by the registrant.

657—10.36(124) Samples and other complimentary packages—records. Complimentary packages and samples of controlled substances may be distributed to practitioners pursuant to federal and state law only if the person distributing the items leaves with the practitioner a specific written list of the items delivered.

10.36(1) *Distribution record.* The record form for the distribution of complimentary packages of controlled substances shall contain the following information:

- a. The name, address, and DEA registration number of the supplier;
- b. The name, address, and DEA registration number of the practitioner;
- c. The name, strength, and quantity of the specific controlled substances delivered; and
- d. The date of delivery.

10.36(2) *Reports to the board.* Any person who distributes controlled substances pursuant to this rule shall report all such distributions to the board. Reports shall:

- a. Include the information identified in subrule 10.36(1). Reports may consist of copies of those distribution records or may be computer-generated listings identifying those distributions.
- b. Be submitted as soon as practicable after distribution to the practitioner but no less often than once each calendar quarter.

10.36(3) *Practitioner records.* A practitioner who regularly administers or dispenses controlled substances shall keep records of the receipt and disbursement of such drugs, including complimentary packages and samples. Records shall be filed in a readily retrievable manner in accordance with federal requirements and shall be made available for inspection and copying by agents of the board or other authorized individuals for at least two years from the date of the record.

657—10.37(124,126) Revision of controlled substances schedules.

10.37(1) *Application for exception.* Any person seeking to have any compound, mixture, or preparation containing any depressant or stimulant substance listed in any of the schedules in Iowa Code chapter 124 excepted from the application of all or any part of that chapter may apply to the board for such exception.

- a. An application for an exception under this rule shall provide evidence that an exception has been granted under the federal Controlled Substances Act.
- b. The board shall permit any interested person to file written comments on or objections to the proposal for exception and shall designate the time during which such filings may be made. After consideration of the application and any comments on or objections to the proposal for exception, the board shall issue its findings on the application.

10.37(2) *Designation of new controlled substance.* The board may designate any new substance as a controlled substance to be included in any of the schedules in Iowa Code chapter 124 no sooner than 30 days following publication in the Federal Register of a final order so designating the substance under federal law. Designation of a new controlled substance under this subrule shall be temporary as provided in Iowa Code section 124.201, subsection 4.

10.37(3) *Objection to designation of a new controlled substance.* The board may object to the designation of any new substance as a controlled substance within 30 days following publication in the Federal Register of a final order so designating the substance under federal law. The board shall file objection to the designation of a substance as controlled, shall afford all interested parties an opportunity to be heard, and shall issue the board's decision on the new designation as provided in Iowa Code section 124.201, subsection 4.

657—10.38(124) Temporary designation of controlled substances.**10.38(1)** Rescinded IAB 9/22/10, effective 8/30/10.**10.38(2)** Reserved.

[ARC 7906B, IAB 7/1/09, effective 6/22/09; ARC 8411B, IAB 12/30/09, effective 12/1/09; ARC 8989B, IAB 8/11/10, effective 7/21/10; ARC 9091B, IAB 9/22/10, effective 8/30/10]

657—10.39(124,126) Excluded substances. The Iowa board of pharmacy hereby excludes from all schedules the current list of “Excluded Nonnarcotic Products” identified in Title 21, CFR Part 1308, Section 22. Copies of the list of excluded products may be obtained by written request to the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

657—10.40(124,126) Anabolic steroid defined. Anabolic steroid, as defined in Iowa Code section 126.2, paragraph 2, includes any substance identified as such in Iowa Code section 124.208, paragraph 6, or in Iowa Code section 126.2, paragraph 2.

657—10.41(124A) Designation of imitation controlled substances.

10.41(1) Synthetic cannabinoids. The following synthetic cannabinoids, including products by whatever trade name that are treated, sprayed, or saturated with these synthetic cannabinoids, are designated imitation controlled substances subject to the provisions of Iowa Code chapter 124A:

a. Dexanabinol, (6aS, 10aS)-9-(hydroxymethyl)-6, 6-dimethyl-3-(2-methyloctan-2-yl)-6a, 7, 10, 10a-tetrahydrobenzo[c]chromen-1-ol, also known as HU-211.

b. 1-butyl-3-(1-naphthoyl) indole, also known as JWH-073.

c. 1-pentyl-3-(1-naphthoyl) indole, also known as JWH-018.

d. Phenol, CP 47, 497 and homologues, or 2-[(1R,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol, where side chain n=5, and homologues where side chain n=4, 6, or 7.

10.41(2) Product examples. Some currently marketed products containing the imitation controlled substances identified in subrule 10.41(1) include K2, Red Dragon Smoke, Spice, K2 Spice, Mojo, Smoke, Skunk, K2 Summit, and Pandora Potpourri.

[ARC 9000B, IAB 8/11/10, effective 7/22/10]

These rules are intended to implement Iowa Code sections 124.201, 124.301 to 124.308, 124.402, 124.403, 124.501, 126.2, 126.11, 147.88, 147.95, 147.99, 155A.13, 155A.17, 155A.26, 155A.37, and 205.3.

[Filed 9/29/71; amended 8/9/72, 12/15/72, 11/14/73, 8/14/74, 4/8/75]

[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]

[Filed 11/9/77, Notice 8/24/77—published 11/30/77, effective 1/4/78]

[Filed 10/20/78, Notices 8/9/78, 9/6/78—published 11/15/78, effective 1/9/79]

[Filed 8/28/79, Notice 5/30/79—published 9/19/79, effective 10/24/79]

[Filed 2/12/81, Notice 12/24/80—published 3/4/81, effective 7/1/81]

[Filed 7/24/81, Notice 5/13/81—published 8/19/81, effective 9/23/81]

[Filed emergency 12/14/81—published 1/6/82, effective 1/6/82]

[Filed emergency 10/6/82—published 10/27/82, effective 10/27/82]

[Filed 6/16/83, Notice 5/11/83—published 7/6/83, effective 8/10/83]

[Filed 2/23/84, Notice 11/23/83—published 3/14/84, effective 4/18/84]

[Filed emergency 8/10/84—published 8/29/84, effective 8/10/84]

[Filed emergency 6/14/85—published 7/3/85, effective 6/14/85]

[Filed emergency 8/30/85—published 9/25/85, effective 9/6/85]

[Filed emergency 12/4/85—published 1/1/86, effective 12/5/85]

[Filed emergency 5/14/86—published 6/4/86, effective 5/16/86]

[Filed 5/14/86, Notice 4/9/86—published 6/4/86, effective 7/9/86]◊

[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]

[Filed emergency 7/24/87—published 8/12/87, effective 7/24/87]

[Filed 8/5/87, Notice 6/3/87—published 8/26/87, effective 9/30/87]

[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]

- [Filed 3/29/88, Notice 2/10/88—published 4/20/88, effective 5/25/88]
 - [Filed emergency 8/5/88—published 8/24/88, effective 8/5/88]
- [Filed emergency 10/13/88—published 11/2/88, effective 10/13/88]
 - [Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
 - [Filed emergency 9/12/89—published 10/4/89, effective 9/13/89]
- [Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]
- [Filed 8/31/90, Notice 6/13/90—published 9/19/90, effective 10/24/90]
 - [Filed emergency 1/29/91—published 2/20/91, effective 2/27/91]
- [Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]
 - [Filed emergency 2/27/91—published 3/20/91, effective 2/27/91]
- [Filed 4/26/91, Notice 2/20/91—published 5/15/91, effective 6/19/91]
 - [Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
- [Filed 7/30/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
 - [Filed emergency 9/23/91—published 10/16/91, effective 9/23/91]
- [Filed emergency 10/18/91—published 11/13/91, effective 10/21/91]
 - [Filed 3/12/92, Notice 1/8/92—published 4/1/92, effective 5/6/92]
 - [Filed 5/21/92, Notice 4/1/92—published 6/10/92, effective 7/15/92]
 - [Filed emergency 8/10/92—published 9/2/92, effective 8/10/92]
 - [Filed 10/22/92, Notice 9/2/92—published 11/11/92, effective 1/1/93]
- [Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]
 - [Filed emergency 3/21/94—published 4/13/94, effective 3/23/94]
- [Filed 3/21/94, Notice 10/13/93—published 4/13/94, effective 5/18/94]
- [Filed 4/22/94, Notice 11/10/93—published 5/11/94, effective 6/15/94]
- [Filed 6/24/94, Notice 4/13/94—published 7/20/94, effective 8/24/94]
- [Filed 3/22/95, Notice 11/9/94—published 4/12/95, effective 5/31/95]
 - [Filed 12/6/95, Notice 8/16/95—published 1/3/96, effective 2/7/96]
- [Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]
 - [Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]
 - [Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 9/30/98]
 - [Filed emergency 8/18/99—published 9/8/99, effective 8/18/99]
 - [Filed emergency 10/6/99—published 11/3/99, effective 10/11/99]
 - [Filed emergency 7/18/00—published 8/9/00, effective 7/18/00]
 - [Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
 - [Filed emergency 12/13/02—published 1/8/03, effective 12/13/02]
- [Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
- [Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
 - [Filed emergency 5/3/05—published 5/25/05, effective 5/21/05]
- [Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
 - [Filed 8/9/05, Notice 5/25/05—published 8/31/05, effective 10/5/05]
- [Filed 3/22/06, Notice 12/21/05—published 4/12/06, effective 5/17/06]
 - [Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
 - [Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
 - [Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
 - [Filed 5/14/07, Notice 2/28/07—published 6/6/07, effective 7/11/07]
 - [Filed emergency 8/2/07—published 8/29/07, effective 8/2/07]
- [Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
- [Filed ARC 7636B (Notice ARC 7448B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]
 - [Filed Emergency ARC 7906B, IAB 7/1/09, effective 6/22/09]
- [Filed ARC 8172B (Notice ARC 7908B, IAB 7/1/09), IAB 9/23/09, effective 10/28/09]
 - [Filed Emergency ARC 8411B, IAB 12/30/09, effective 12/1/09]
- [Filed ARC 8539B (Notice ARC 8269B, IAB 11/4/09), IAB 2/24/10, effective 4/1/10]
- [Filed ARC 8892B (Notice ARC 8667B, IAB 4/7/10), IAB 6/30/10, effective 9/1/10]

[Filed Emergency ARC 8989B, IAB 8/11/10, effective 7/21/10]

[Filed Emergency ARC 9000B, IAB 8/11/10, effective 7/22/10]

[Filed Emergency ARC 9091B, IAB 9/22/10, effective 8/30/10]

[Filed ARC 9410B (Notice ARC 9196B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

⁰ Two or more ARCs

¹ Effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held September 11, 1991.

CHAPTER 13
STERILE COMPOUNDING PRACTICES

657—13.1(124,126,155A) Purpose and scope. These rules establish standards and procedures for the preparation, labeling, and distribution of sterile preparations by licensed pharmacies pursuant to a practitioner's order or prescription; for sterile product quality and characteristics; for personnel training, environmental quality, and equipment standards; and for pharmaceutical care. Sterile compounding differs from nonsterile compounding primarily by requiring the maintenance of sterility when preparations are compounded exclusively with sterile ingredients and components and by requiring the achievement of sterility when preparations are compounded with nonsterile ingredients and components. The standards and procedures outlined in this chapter apply to pharmacy practice when a preparation:

1. Is prepared according to the manufacturer's labeled instructions and requires other manipulations that expose the original contents to potential contamination;
2. Contains nonsterile ingredients or employs nonsterile components or devices that must be sterilized before administration; or
3. Is a biologic, diagnostic, drug, or nutrient that possesses characteristics of either "1" or "2" above and includes, but is not limited to, the following preparations that are required to be sterile when they are administered to patients: baths and soaks for live organs and tissues, injections (e.g., colloidal dispersions, emulsions, solutions, and suspensions), aqueous bronchial and nasal inhalations, irrigations for wounds and body cavities, ophthalmic drops and ointments, and tissue implants.

Standards and safe practices for the compounding of radioactive preparations are identified in 657—Chapter 16.

657—13.2(124,126,155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Anteroom" or *"ante area"* means an ISO Class 8 or superior area where personnel perform hand hygiene and garbing procedures, staging of components, order entry, preparation labeling, and other high-particulate generating activities.

"Aseptic processing" means a method of preparing pharmaceutical and medical products that involves the separate sterilization of the product and of the package, the transfer of the product into the container, and closure of the container under at least ISO Class 5 conditions and using procedures designed to preclude contamination of drugs, packaging, equipment, or supplies by microorganisms during processing.

"Beyond-use date" means the date or time following compounding after which the preparation shall not be stored or transported and after which administration of the preparation shall not begin. The beyond-use date is determined from the date or time compounding of the preparation is completed.

"Biological safety cabinet" or *"BSC"* means a ventilated cabinet having an open front with inward airflow for personnel protection, downward HEPA-filtered laminar airflow for product protection, and HEPA-filtered exhausted air for environmental protection.

"Buffer area" or *"cleanroom"* means a room or area where the primary engineering control device is physically located and in which the concentration of airborne particles is controlled to meet a specified airborne particulate cleanliness class. Microorganisms in the environment are monitored so that a microbial level for air, surface, and personnel gear is not exceeded for a specified cleanliness class. Activities that occur in the buffer area include the preparation and staging of components and supplies used when sterile preparations are compounded.

"Compounding" means the constitution, reconstitution, combination, dilution, or other process causing a change in the form, composition, or strength of any ingredient or of any other attribute of a product.

"Compounding aseptic isolator" or *"CAI"* means a form of barrier isolator specifically designed for compounding pharmaceutical ingredients or preparations. A CAI is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer

processes. Air exchange into the isolator from the surrounding environment should not occur unless the air has first passed through a microbially retentive filter, HEPA minimum.

“*Critical site*” means a location that includes any component or fluid pathway surfaces or openings, such as vial septa, injection ports, beakers, opened ampoules, and needle hubs, exposed and at risk of direct contact with air, moisture, or touch contamination.

“*Hazardous drug*” means a pharmaceutical that is antineoplastic, carcinogenic, mutagenic, or teratogenic.

“*HEPA*” means high efficiency particulate air.

“*High-risk preparation*” means a sterile preparation that is compounded from nonsterile ingredients; that is compounded with nonsterile components, containers, or equipment and requires terminal sterilization; or that meets the conditions of rule 13.13(155A).

“*ISO Class 5*” or “*Class 100 condition*” means an atmospheric environment that contains less than 100 particles, 0.5 microns or larger in diameter per cubic foot of air, according to ISO standards.

“*ISO Class 7*” or “*Class 10,000 condition*” means an atmospheric environment that contains less than 10,000 particles, 0.5 microns or larger in diameter per cubic foot of air, according to ISO standards.

“*ISO Class 8*” or “*Class 100,000 condition*” means an atmospheric environment that contains less than 100,000 particles, 0.5 microns or larger in diameter per cubic foot of air, according to ISO standards.

“*Laminar airflow workbench*” or “*LAFW*” means an apparatus designed to provide an ISO Class 5 environment for the preparation of sterile products that uses air circulation in a defined direction that passes through a HEPA filter to remove the initial particles and the particles generated within the controlled environment.

“*Low-risk preparation*” means a sterile preparation that is compounded with sterile equipment, sterile ingredients, and sterile contact surfaces or that meets the conditions of rule 13.11(155A).

“*Media-fill test*” or “*MFT*” means a test used to validate aseptic technique of compounding personnel or of processes and to ensure that the processes used are able to produce sterile product without microbial contamination.

“*Medium-risk preparation*” means a sterile preparation that is compounded with sterile equipment, sterile ingredients, and sterile contact surfaces and involves complex or numerous manipulations of a sterile product or that meets the conditions of rule 13.12(155A).

“*Multiple-dose container*” means a multiple-unit container for articles or preparations intended for parenteral administration only and usually containing antimicrobial preservatives.

“*Negative pressure room*” means a room that is at a lower pressure compared to adjacent spaces, creating a net airflow into the room.

“*Positive pressure room*” means a room that is at a higher pressure compared to adjacent spaces, creating a net airflow out of the room.

“*Preparation*” or “*compounded sterile preparation*” means a sterile drug or nutrient that is compounded in a licensed pharmacy or other health care-related facility pursuant to the order of a licensed prescriber, which preparation may or may not contain sterile products.

“*Primary engineering control device*” means a device or room that provides an ISO Class 5 environment during the compounding process. Such devices include, but may not be limited to, laminar airflow workbenches (LAFWs), biological safety cabinets (BSCs), and compounding aseptic isolators (CAIs).

“*Product*” means a commercially manufactured sterile drug or nutrient that has been evaluated for safety and efficacy by the FDA.

“*Segregated compounding area*” means a designated space, either a demarcated area or room, which is restricted to preparing low-risk preparations with 12-hour or less beyond-use date. A segregated compounding area shall contain a device that provides unidirectional airflow of ISO Class 5 air quality for the compounding of sterile preparations and shall be void of activities and materials that are extraneous to sterile compounding.

“*Single-dose container*” means a single-unit container for articles or preparations intended for parenteral administration only, intended for a single use and labeled as such. Examples include prefilled

syringes, cartridges, fusion-sealed containers, and closure-sealed containers when labeled for a single use or single dose.

“*Sterile compounding*” means the aseptic processing in a clean air environment of any pharmaceutical preparations that are required to be sterile when they are administered into patient body cavities, central nervous and vascular systems, eyes, and joints, and when used as baths for live organs and tissues, including but not limited to injections (e.g., colloidal dispersions, emulsions, solutions, and suspensions), aqueous bronchial and nasal inhalations, irrigations for wounds and body cavities, ophthalmic drops and ointments, and tissue implants.

[ARC 9180B, IAB 11/3/10, effective 12/8/10]

657—13.3(155A) Responsibilities.

13.3(1) Pharmacist. Each pharmacy shall have a pharmacist responsible for ensuring that:

- a. Preparations are accurately identified, measured, diluted, and mixed; and are correctly purified, sterilized, packaged, sealed, labeled, stored, dispensed, and distributed.
- b. Appropriate cleanliness conditions are maintained, including preservation of the sterile environment during the compounding process.
- c. Beyond-use dates are established based on direct testing or extrapolation from reliable literature sources. The pharmacy shall maintain written justification of the chosen beyond-use date or, if a written standard is not available, a maximum 24-hour expiration shall be used.
- d. Equipment, apparatus, and devices used to compound a preparation are consistently capable of operating properly and within acceptable tolerance limits.

13.3(2) In-process checking procedure. Each pharmacy shall establish a written quality assurance procedure that includes the following in-process checks:

- a. Appropriate procedures are followed for measuring, mixing, diluting, purifying, sterilizing, packaging, and labeling of the specific preparation.
- b. Packaging selection is appropriate to preserve the sterility and strength of the preparation.
- c. All functions performed by nonpharmacists are verified by the pharmacist before the preparation is dispensed to the patient.

13.3(3) Training documentation. All personnel involved with compounding, repackaging, or manipulating sterile preparations shall be adequately educated and trained. Training shall include written documentation certifying that compounding personnel are able to adequately complete the following activities:

- a. Perform antiseptic hand cleansing and disinfection of nonsterile compounding surfaces.
- b. Select and appropriately don protective garb.
- c. Maintain or achieve sterility of preparations in ISO Class 5 primary engineering control devices.
- d. Identify, weigh, and measure ingredients.
- e. Manipulate sterile products aseptically, sterilize high-risk preparations, and label preparations.
- f. Protect personnel and compounding environments from contamination by hazardous drugs.

657—13.4 Reserved.

657—13.5(155A) References required. The pharmacy shall have sufficient current reference materials related to sterile products and preparations. References may be printed or computer-accessed. In addition to meeting the requirements set forth in rule 657—6.3(155A), 657—7.3(155A), 657—15.4(155A), or 657—16.5(155A), as applicable, all pharmacies involved in sterile compounding shall maintain a minimum of one current reference, including access to current periodic updates, from each of the following categories:

1. A general information reference.
2. An injectable drug compatibility reference.
3. If the pharmacy is compounding hazardous drugs, a reference related to hazardous drugs.

657—13.6(126,155A) Policies and procedures. A written policy and procedure manual shall be prepared, implemented, maintained, and adhered to for the compounding, dispensing, delivery,

administration, storage, and use of sterile preparations. The manual shall establish policies and procedures relating to subjects identified in this and other rules within this chapter.

13.6(1) *Quality assurance program.* The policy and procedure manual shall include a quality assurance program pursuant to rule 13.31(155A).

13.6(2) *Sampling.* The policy and procedure manual shall include procedures that require sampling of a preparation as provided in rule 13.29(126,155A) or if microbial contamination is suspected.

13.6(3) *Preparation recall.* The policy and procedure manual shall include procedures for the recall of dispensed preparations that fail to meet product quality standards.

13.6(4) *Hazardous products and infectious waste.* The policy and procedure manual shall include procedures for proper handling of hazardous drug products and infectious waste, if applicable.

13.6(5) *Periodic review.* The policy and procedure manual shall be periodically reviewed. Policies shall specify the frequency of review. The manual shall be available for inspection and copying by the board or agents of the board.

657—13.7(126,155A) Labeling requirements.

13.7(1) *Patient-specific dispensing container.* At the time of delivery, a patient-specific dispensing container used for a preparation shall bear a label with at least the following information:

- a. Name and quantity of all contents.
- b. Patient's name.
- c. For home care patient prescriptions, unique serial number or prescription number.
- d. Preparer's and reviewing pharmacist's initials or unique identifiers.
- e. Stability (beyond-use date) as set forth in the pharmacy's policy and procedure manual.
- f. The prescribed flow rate in ml/hr, if applicable.
- g. Auxiliary labels as needed.

13.7(2) *Batch preparation.* Each container of a batch preparation that is compounded in anticipation of later dispensing shall bear a label with at least the following information:

- a. Name and quantity of all contents.
- b. Internal code to identify the date and time of preparation and the preparer's and reviewing pharmacist's initials or unique identifiers.
- c. Stability (beyond-use date) as set forth in the pharmacy's policy and procedure manual.
- d. Auxiliary labels as needed.

657—13.8 and 13.9 Reserved.

657—13.10(126,155A) Microbial contamination risk levels. Preparations shall be assigned an appropriate risk level—low, medium or high—according to the corresponding probability of contaminating a preparation with microbial contamination such as microbial organisms, spores, and endotoxins, and chemical and physical contamination such as foreign chemicals and physical matter. The characteristics described in rules 13.11(155A), 13.12(155A), and 13.13(155A) are intended as guides to the diligence required in compounding at each risk level.

657—13.11(155A) Low-risk preparations and low-risk preparations with 12-hour or less beyond-use date.

13.11(1) *Conditions defined—low-risk preparations.* Preparations compounded under all of the following conditions are at a low risk of contamination.

- a. The preparations are compounded with aseptic manipulations entirely within ISO Class 5 or superior air quality using only sterile ingredients, products, components, and devices.
- b. The compounding involves only transferring, measuring, and mixing not more than three commercially manufactured packages of sterile products and not more than two entries into any one container (e.g., bag, vial) of sterile product or administration container or device to make the preparation.

c. Manipulations are limited to aseptically opening ampoules, penetrating sterile stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, containers of other sterile products, and containers for storage and dispensing.

d. In the absence of the preparation's passing a sterility test and provided that the preparation is properly stored before administration, storage periods shall not exceed the following:

- (1) At controlled room temperature for 48 hours;
- (2) At a cold temperature for 14 days; or
- (3) In a solid-frozen state between minus 25 and minus 10 degrees Celsius for 45 days.

13.11(2) Examples—low-risk preparations. Examples of low-risk compounding include:

a. The single-volume transfer of sterile dosage forms from ampoules, bottles, bags, and vials using sterile syringes with sterile needles, other administration devices, and other sterile containers. When ampoules are employed, solution content shall be passed through a sterile filter to remove any particles.

b. The manual measuring and mixing of no more than three manufactured products including an infusion or diluent solution to compound drug admixtures and nutritional solutions.

13.11(3) Low-risk preparations with 12-hour or less beyond-use date. If the primary engineering control device is a CAI and does not meet the requirements described in subrule 13.27(3) or is a BSC or LAFW that cannot be located within an ISO Class 7 buffer area, then only low-risk nonhazardous and radiopharmaceutical preparations compounded pursuant to a prescriber's order for a specific patient may be prepared, and administration of such preparations shall commence within 12 hours of the start of compounding or as recommended in the manufacturers' package insert, whichever is less. Preparations shall meet all four of the following criteria:

a. The primary engineering control device shall be certified and shall maintain ISO Class 5 for exposure of critical sites and shall be in a segregated compounding area restricted to sterile compounding activities that minimize the risk of preparation contamination.

b. The segregated compounding area shall not be in a location that has unsealed windows or doors that connect to the outdoors or high traffic flow, or that is adjacent to construction sites, warehouses, food preparation areas, or other areas presenting a risk of contamination.

c. Personnel shall be appropriately garbed and shall perform appropriate cleansing activities prior to compounding. Sinks should be separated from the immediate area of the ISO Class 5 primary engineering control device.

d. Appropriate procedures for cleaning and disinfecting the sterile compounding areas, for personnel training and competency evaluation, for aseptic practices and cleaning or disinfecting processes, and for environmental air sampling and testing shall be followed.

657—13.12(155A) Medium-risk preparations.

13.12(1) Conditions defined. Preparations compounded aseptically under low-risk conditions with one or more of the following additional conditions are at a medium risk of contamination.

a. Multiple individual or small doses of sterile products are combined or pooled to prepare a sterile preparation for administration either to multiple patients or to one patient on multiple occasions.

b. The compounding process includes complex aseptic manipulations other than the single-volume transfer.

c. The compounding process requires an unusually long duration, such as that required to complete dissolution or homogeneous mixing.

d. In the absence of the preparation's passing a sterility test and provided that the preparation is properly stored before administration, storage periods shall not exceed the following:

- (1) At controlled room temperature for 30 hours;
- (2) At a cold temperature for 9 days; or
- (3) In a solid-frozen state between minus 25 and minus 10 degrees Celsius for 45 days.

13.12(2) Examples. Examples of medium-risk compounding include:

a. Compounding total parenteral nutrition fluids, using manual or automated devices and involving multiple injections, detachments, or attachments of nutrient source products to the device or machine to deliver all nutritional components to a final sterile container.

- b. Filling reservoirs of injection or infusion devices with more than three sterile drug products and evacuating air from those reservoirs before dispensing the filled device.
- c. Transferring volumes from multiple ampoules or vials into one or more final sterile containers.

657—13.13(155A) High-risk preparations.

13.13(1) Conditions defined. Preparations that are either contaminated or likely to become contaminated with infectious microorganisms when compounded under any of the following conditions are at a high risk of contamination.

- a. Nonsterile ingredients, including manufactured products not intended for sterile use, are incorporated or a nonsterile device is used in the compounding process before terminal sterilization.
- b. Sterile contents of commercially manufactured products, preparations that lack effective antimicrobial preservatives, and sterile surfaces of devices and containers intended for the preparation, transfer, sterilization, and packaging of preparations are exposed to air quality inferior to ISO Class 5 for more than one hour.
- c. Nonsterile procedures such as weighing and mixing in air quality inferior to ISO Class 7 are performed before sterilization, compounding personnel are not properly garbed and gloved, or nonsterile water-containing preparations are stored for more than six hours.
- d. The chemical purity and content strength of bulk ingredients, whether the ingredients are in opened or unopened packages, are not verified by examination of labeling and documentation of suppliers or by direct determination.

e. For a sterilized high-risk preparation, in the absence of the preparation's passing a sterility test, the storage period beyond-use date shall not exceed the following:

- (1) At controlled room temperature, 24 hours;
- (2) At a cold temperature, 3 days; or
- (3) In a solid-frozen state between minus 25 and minus 10 degrees Celsius, 45 days.

13.13(2) Examples. Examples of high-risk compounding include:

- a. Dissolving nonsterile bulk drugs or nutrient powders to make solutions that will be terminally sterilized.
- b. Measuring and mixing sterile ingredients in nonsterile devices before sterilization is performed.
- c. Assuming, without appropriate evidence or direct determination, that packages of bulk ingredients contain at least 95 percent by weight of their active chemical moiety and have not been contaminated or adulterated between uses.
- d. Exposing the sterile ingredients and components used to prepare and package the preparation to air quality inferior to ISO Class 5 for more than one hour.

[ARC 9180B, IAB 11/3/10, effective 12/8/10]

657—13.14(155A) Immediate-use preparations. The immediate-use provisions of this rule are intended only for those situations where there is a need for emergency or immediate administration of a sterile preparation. Such situations may include cardiopulmonary resuscitation, emergency room treatment, preparation of diagnostic agents, or critical therapy where the compounding of the preparation under low-risk level conditions would subject the patient to additional risk due to delays in therapy. Immediate-use preparations are not intended for storage for anticipated needs or for batch compounding. Medium-risk and high-risk preparations shall not be compounded as immediate-use preparations. Immediate-use preparations are exempt from the provisions of rule 13.11(155A) for low-risk preparations only when all of the following criteria are met:

1. The compounding process involves simple transfer of not more than three commercially manufactured packages of sterile nonhazardous products or diagnostic radiopharmaceutical products from the manufacturers' original containers and not more than two entries into any one container or package of sterile infusion solution or administration container or device. Hazardous drugs shall not be compounded as immediate-use preparations.

2. Unless required for the preparation, the compounding procedure is a continuous process not to exceed one hour.

3. During compounding, aseptic technique is followed and, if the preparation is not immediately administered, the preparation is under continuous supervision to minimize the potential for contact with nonsterile surfaces, introduction of particulate matter or biological fluids, mix-ups with other sterile preparations, and direct contact with outside surfaces.

4. Administration begins not later than one hour after compounding of the preparation is completed.

5. If administration has not begun within one hour after compounding of the preparation is completed, the preparation is promptly and safely discarded.

6. Unless immediately and completely administered by the person who compounded the preparation or unless immediate and complete administration is witnessed by the person who compounded the preparation, the preparation shall bear a label listing patient identification information, the names and amounts of all ingredients, the name or initials of the person who compounded the preparation, and the exact one-hour beyond-use date and time.

657—13.15(155A) Utilization of single-dose and multiple-dose containers. Pharmacies utilizing single-dose and multiple-dose containers in sterile compounding shall comply with the following:

1. Single-dose containers that are opened or needle-punctured shall be used within one hour if opened in air quality conditions inferior to ISO Class 5. Any remaining contents shall be discarded.

2. Single-dose vials that are continuously exposed to ISO Class 5 or cleaner air shall be used within six hours after initial needle puncture.

3. Opened single-dose ampoules shall not be stored for any period of time under any air quality conditions.

4. Multiple-dose containers with antimicrobial preservatives that are entered or opened shall be used within 28 days of initial entry or opening unless otherwise specified by the manufacturer.

5. Multiple-dose and single-dose sterile products shall not be combined for use as multiple-dose applications.

657—13.16(155A) Utilization of proprietary bag and vial systems. Sterility storage and beyond-use times for attached and activated container pairs of drug products for intravascular administration shall follow manufacturers' instructions for handling and storage.

657—13.17 to 13.19 Reserved.

657—13.20(124,155A) Sterile preparation of hazardous drugs. Hazardous drugs shall only be prepared for administration under conditions that protect pharmacy personnel in the preparation area.

13.20(1) Storage and handling. Policies and procedures shall identify appropriate storage and handling of hazardous drugs to prevent contamination and personnel exposure.

13.20(2) Caution labeling and distribution. Preparations containing hazardous drugs shall be labeled on the primary container and placed in an overwrap bag that is also properly labeled. Prepared doses of dispensed hazardous drugs shall be labeled and distributed in a manner to minimize the risk of accidental rupture of the primary container. Proper labeling shall include any necessary precautions.

13.20(3) Preparation area. All hazardous drugs shall be compounded in a vertical flow Class II or Class III biological safety cabinet or in a compounding aseptic isolator containment and control device with biohazard control capabilities.

a. It is preferable for the ISO Class 5 BSC or CAI to be placed in a contained environment, physically separated from other preparation areas, where air pressure is negative and where the ISO Class 5 BSC or CAI is appropriately vented to the outside of the building.

b. If the pharmacy compounds fewer than five preparations per week in a BSC or CAI and uses a closed system vial transfer device to compound the preparations, the BSC or CAI may be located in a positive pressure room.

13.20(4) Protective apparel. Personnel compounding hazardous drugs shall wear appropriate protective apparel in accordance with documented procedures. Protective apparel may include

disposable, nonshedding coveralls or gowns with tight cuffs, face masks, eye protection, hair covers, double gloves, and shoe covers.

13.20(5) Techniques. Appropriate safety and containment techniques for compounding hazardous drugs shall be used in conjunction with the aseptic techniques required for processing sterile preparations.

13.20(6) Training required. All personnel who compound hazardous drugs shall be fully trained in the storage, handling, and disposal of these drugs. This training shall occur before personnel prepare or handle hazardous preparations and shall be verified and documented for each person at least annually.

13.20(7) Waste. Disposal of hazardous waste shall comply with all applicable local, state, and federal requirements.

13.20(8) Spills of hazardous drugs. Written procedures for handling both major and minor spills of hazardous drugs shall be developed, maintained, implemented, and adhered to. The procedures shall be maintained with the policies and procedures required in rule 13.6(155A).

657—13.21 and 13.22 Reserved.

657—13.23(124,155A) Verification of compounding accuracy and sterility. Compounding procedures and sterilization methods used for preparations require planned testing, monitoring, and documentation to demonstrate adherence to environmental quality requirements, personnel practices, and procedures critical to achieving and maintaining sterility. Pharmacist verification of a preparation shall include visual inspection of labeling, physical integrity, and expected appearance, including final fill amount.

657—13.24(124,155A) Sterilization methods. The selected sterilization method employed shall be based on experience and appropriate information sources.

13.24(1) Presterilization requirements for high-risk preparations.

a. During all compounding activities that precede terminal sterilization, such as weighing and mixing, compounding personnel shall be garbed and gloved in the same manner as when performing compounding in an ISO Class 5 environment. All presterilization procedures shall be completed in an ISO Class 8 or superior environment.

b. Immediately before use, all nonsterile measuring, mixing, and purifying devices used in the compounding process shall be thoroughly rinsed with sterile, pyrogen-free water, and then thoroughly drained or dried.

13.24(2) Sterilization methods for high-risk preparations.

a. Sterilization by filtration. This method of sterilization involves the passage of a fluid or solution through a sterilizing grade membrane to produce a sterile effluent.

(1) Sterile filters used to sterile filter preparations shall be pyrogen-free and have a nominal porosity of 0.22 microns. The filter dimensions and liquid material to be sterile filtered shall permit the sterilization process to be completed rapidly without the replacement of the filter during the filtering process.

(2) Compounding personnel shall ascertain that selected filters will achieve sterilization of the specific preparation.

(3) Sterilization by filtration shall be performed entirely within an ISO Class 5 or superior air quality environment.

b. Terminal sterilization. Use of saturated steam under pressure, or autoclaving, is the preferred method to terminally sterilize aqueous preparations.

(1) All materials shall be exposed to steam at 121 degrees Celsius under the recommended pressure and duration, verified by testing the sterility of the finished preparation.

(2) The description of steam sterilization conditions and duration for specific preparations shall be included in written documentation maintained in the compounding facility.

(3) Before or during entry into final containers, all high-risk preparations in solution form that are subjected to terminal steam sterilization shall pass through a filter with nominal porosity not larger than 1.2 microns for removal of particulate matter.

c. Dry heat sterilization. Dry heat sterilization shall be completed in an oven designed for sterilization and shall be used only for those materials that cannot be sterilized by steam. The effectiveness of dry heat sterilization shall be verified using appropriate biological indicators and temperature-sensing devices.

13.24(3) Records. Record requirements for high-risk preparations shall include documentation of the following:

- a.* Lot numbers of nonsterile components used in compounding high-risk preparations.
- b.* Sterilization records including methods used for each preparation.

13.24(4) Testing and quarantine requirements. All high-risk preparations, except those for inhalation and ophthalmic administration, that are prepared in groups of 25 or more identical single-dose containers or in multiple-dose vials for administration to multiple patients, or that are exposed longer than 12 hours at 2 to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized, shall be quarantined and tested to ensure that the preparations are sterile and that they do not contain excessive bacterial endotoxins before they are dispensed or administered.

13.24(5) Release of preparations prior to receipt of testing results. If a preparation may be needed before the results of sterility testing have been received, the pharmacy shall have a written procedure requiring daily observation of incubating test specimens and immediate recall of the dispensed preparations when there is any evidence of microbial growth in the test specimens.

[ARC 7633B, IAB 3/11/09, effective 4/15/09]

657—13.25(155A) Media-fill testing by personnel. The pharmacy shall develop, maintain, and implement written procedures that include appropriate media-fill testing by personnel authorized to compound preparations. The issues to consider in the development of a media-fill test are media-fill procedures, media selection, fill volume, incubation, time and temperature, inspection of filled units, documentation, interpretation of results, and possible corrective actions required. Tests shall be performed without interruption in an ISO Class 5 environment under conditions that closely simulate the stressful conditions encountered during compounding of the specific risk level preparations for which the test is intended. The pharmacy shall maintain records of media-fill testing performed, and results of testing procedures shall be available to the board or agents of the board. Compounding personnel whose media-fill test vials result in gross microbial colonization shall be immediately instructed and reevaluated by expert compounding personnel to ensure correction of all aseptic practice deficiencies.

13.25(1) Low-risk MFT procedure. Each person authorized to compound low-risk preparations shall annually perform an appropriate successful MFT procedure. The following is an example of a low-risk MFT procedure:

1. Using the same sterile 10-ml syringe and vented needle combination, aseptically transferring three sets of four 5-ml aliquots of sterile soybean-casein digest medium into separate sealed, empty, sterile 30-ml clear vials (i.e., four 5-ml aliquots into each of three 30-ml vials);
2. Affixing sterile adhesive seal closures onto the three filled vials;
3. Incubating the vials at temperatures between 25 and 35 degrees Celsius for 14 days. Failure is indicated by visible turbidity in the medium on or before the passage of 14 days.

13.25(2) Medium-risk MFT procedure. Each person authorized to compound medium-risk preparations shall annually perform an appropriate successful MFT procedure. The following is an example of a medium-risk MFT procedure:

1. Aseptically transferring six 100-ml aliquots of sterile soybean-casein digest medium by gravity through separate tubing sets into separate evacuated sterile containers;
2. Arranging the six containers as three pairs and using a sterile 10-ml syringe and 18-gauge needle combination to exchange two 5-ml aliquots of medium from one container to the other container in the pair (for example, adding 5-ml aliquot from the first container to the second container in the pair, agitating the second container for 10 seconds, and transferring 5-ml aliquot from the second container back to the first container in the pair; then agitating the first container for 10 seconds and transferring the next 5-ml aliquot from the first container back to the second container in the pair; and repeating the procedure for each pair of containers);

3. Aseptically injecting a 5-ml aliquot of medium from each container into a sealed, empty, sterile 10-ml clear vial using a sterile 10-ml syringe and vented needle. Affixing sterile adhesive seals to the rubber closures on the three filled vials and incubating the vials at temperatures within a range of 20 to 35 degrees Celsius for 14 days. Failure is indicated by visible turbidity in the medium on or before the passage of 14 days.

13.25(3) High-risk MFT procedure. Each person authorized to compound high-risk preparations shall semiannually perform an appropriate successful MFT procedure. The following is an example of a high-risk MFT procedure:

1. Dissolving 3 gm of nonsterile commercially available soybean-casein digest medium in 100 ml of nonbacteriostatic water to make a 3 percent solution;

2. Drawing 25 ml of the medium into each of three 30-ml sterile syringes. Transferring 5 ml from each syringe into separate sterile 10-ml vials (these vials are the positive controls to generate exponential microbial growth, which is indicated by visible turbidity upon incubation);

3. Under aseptic conditions and using aseptic techniques, affixing a sterile 0.2 micron porosity filter unit and a 20-gauge needle to each syringe. Injecting the next 10 ml from each syringe into three separate 10-ml sterile vials. Repeating the process into three more vials. Labeling all vials, affixing sterile adhesive seals to the closure of the nine vials, and incubating them at temperatures between 25 and 35 degrees Celsius. Inspecting for microbial growth over 14 days. Failure is indicated by visible turbidity in the medium on or before the passage of 14 days.

657—13.26 Reserved.

657—13.27(124,126,155A) Physical environment requirements. The pharmacy shall have a designated area for compounding sterile preparations, with entry restricted to designated personnel. The area shall be used only for sterile compounding. The area shall be structurally isolated from other areas and shall be designed to avoid unnecessary traffic and airflow disturbances. The area shall be of sufficient size to accommodate at least one primary engineering control device and to provide for the storage of drugs and supplies under appropriate temperature, light, moisture, sanitation, ventilation, and security conditions.

13.27(1) Requirement for primary engineering control device. The primary engineering control device shall be capable of maintaining at least ISO Class 5 air quality in the area where critical objects are exposed and critical activities are performed. The device shall be capable of maintaining ISO Class 5 air quality during normal activity. A primary engineering control device includes, but is not limited to, a horizontal or vertical laminar airflow workbench or CAI.

13.27(2) Placement of primary engineering control device. The primary engineering control device shall be placed in a buffer area where HEPA filters are employed and the air quality is maintained at ISO Class 7. This area shall have cleanable, nonshedding, smooth surfaces; all junctures shall be coved; and all cracks and crevices shall be caulked. The ceiling shall be impervious and hydrophobic. The buffer area shall not contain any drains or sinks. Only the furniture, equipment, supplies and other material required for compounding activities to be performed shall be brought into the room. Such items brought into the room shall be cleaned and disinfected. Placement in buffer areas of objects and devices not essential to the compounding process is dictated by the measured effect of those objects and devices on the required environmental quality of air atmospheres and surfaces.

13.27(3) Exception for placement of CAI. The CAI shall be placed in an ISO Class 7 cleanroom unless the CAI meets each of the following conditions:

a. The CAI provides isolation from the room and maintains ISO Class 5 conditions when ingredients, components, and devices are transferred into and out of the CAI during the preparation process.

b. The manufacturer provides documentation verifying that the CAI meets the standard in paragraph "a" when the CAI is located in an environment inferior to ISO Class 7.

13.27(4) Anteroom requirements. Except for a CAI that meets the conditions specified in subrule 13.27(3) exempting the CAI from placement in an ISO Class 7 cleanroom, an anteroom or ante area

shall be located adjacent to the buffer area and maintained at ISO Class 8 air quality. This area is to be used for unpacking and disinfecting supplies for storage and for hand sanitizing and gowning. If the sterile preparation area is to be used only for the compounding of low- and medium-risk preparations, the ante area shall be clearly demarcated for the compounding of low- and medium-risk preparations. If the sterile preparation area is to be used for the compounding of high-risk preparations, the ante area shall be physically separated from the buffer area.

13.27(5) *Delayed implementation.* A pharmacy whose sterile compounding area is in substantial compliance with the physical and structural requirements of this rule shall be authorized to engage in the compounding of sterile preparations pursuant to the practice standards established by this chapter and subject to the following:

a. Any pharmacy that commences, on or after July 11, 2007, new construction or remodeling of a pharmacy sterile compounding area shall comply with the physical and structural requirements of this rule.

b. Any pharmacy engaged in the compounding of sterile preparations shall, no later than December 31, 2010, complete any necessary changes or improvements to the sterile compounding area to ensure compliance with the physical and structural requirements of this rule.

[ARC 9411B, IAB 3/9/11, effective 4/13/11]

657—13.28(155A) *Cleaning, maintenance, and supplies.* The pharmacy shall have appropriate equipment and supplies and documented procedures for maintaining an environment suitable for the aseptic processing of sterile preparations.

13.28(1) *Supplies and equipment.* Required supplies and equipment shall include, but may not be limited to, the following:

a. Appropriate attire including nonshedding coveralls or gowns, head and facial covers, face masks, appropriate gloves, and shoe covers.

b. A sink with hot and cold running water, with bactericidal soap available for the purpose of hand and forearm scrubs, which shall be located convenient to the area used for compounding sterile preparations but outside the buffer area.

13.28(2) *Documented procedures.* Documented procedures shall include, but not be limited to, the following:

- a.* Specific cleaning procedures and frequencies for each compounding area involved.
- b.* Identification of the individual responsible for completing each procedure.
- c.* A list of approved cleaning agents for each procedure.
- d.* A written plan and schedule for the evaluation of airborne microorganisms in each controlled air environment (e.g., LAFW, barrier isolators, buffer area, and anteroom).
- e.* Equipment calibration, annual maintenance, and monitoring of proper function of equipment, apparatus, and devices used to compound sterile preparations.
- f.* An appropriate cleansing and garbing procedure. Coveralls and gowns may be hung outside the entry in the buffer area and reused for one shift, provided the coveralls and gowns are not visibly soiled and have not been worn during the compounding of hazardous drugs.

657—13.29(126,155A) *Environmental monitoring requirements.*

13.29(1) *Certification required.* All cleanrooms, laminar airflow workbenches, and barrier isolators shall be certified by an independent contractor according to ISO Standards 14644-1:1999(E) and ISO Standards 14664-3:2005(E), or National Sanitation Foundation Standard 49, for operational efficiency at least every six months and whenever the device or room is relocated or altered or whenever major service to the facility is performed. Inspection and certification records shall be maintained for two years from the date of certification.

13.29(2) *Procedures required.* The pharmacy shall establish written procedures appropriate for the risk level preparations compounded by the pharmacy. The procedures shall include environmental testing, end testing, and evaluation of validation results.

a. Air sampling. Microbial sampling of air within the primary engineering control devices, buffer areas, and anterooms is required at least semiannually as part of the recertification of facilities and equipment. If compounding occurs in multiple locations within an institution, environmental sampling is required for each individual compounding area.

b. Pressure differential monitoring. A pressure gauge or velocity meter shall be installed to monitor the pressure differential or airflow between the buffer area and the anteroom and between the anteroom and the general pharmacy area. The gauge/meter shall alert the pharmacy when air conditions do not meet recommended conditions, and all compounding shall be discontinued until the alarm condition is corrected. If the gauge/meter is incapable of alerting the pharmacy to inappropriate conditions, the pharmacy shall monitor and review the gauge/meter daily and document the results in a log.

657—13.30 Reserved.

657—13.31(155A) Quality assurance (QA). The pharmacy shall establish, implement, and document an ongoing quality assurance program in order to maintain and improve facilities, equipment, personnel performance, and the provision of patient care.

13.31(1) Physical performance QA. The portion of the quality assurance program that monitors facilities, equipment, and personnel performance shall include, but need not be limited to, the following:

a. Methods for verification of automated compounding devices for parenteral nutrition compounding.

b. Methods for sampling finished preparations to ensure that the pharmacy is capable of consistently preparing sterile preparations that meet appropriate risk level specifications and to ensure product integrity.

c. Procedures for inspection of all prescription orders, written compounding procedures, preparation records, and materials used to compound at all contamination risk levels, to ensure accuracy of ingredients, aseptic mixing, sterilizing, packaging, labeling, and expected physical appearance of the finished preparation.

d. Procedures for visual inspection of preparations to ensure the absence of particulate matter in solutions, the absence of leakage from vials and bags, and the accuracy and thoroughness of labeling.

e. Procedures for review of all orders and packages of ingredients to ensure that the correct ingredients and quantity of ingredients were compounded.

f. Methods for routine disinfection and air quality testing of the direct compounding environment to minimize microbial surface contamination and maintain ISO Class 5 air quality.

g. Methods for ensuring personnel qualifications, training, and performance, including periodic performance of applicable MFT procedures.

h. Procedures for visual confirmation that compounding personnel are properly donning and wearing appropriate items and types of protective garments.

i. Methods for establishing beyond-use dates of preparations.

13.31(2) Care outcomes QA. The portion of the quality assurance program that monitors patient care shall include, but need not be limited to, the following:

a. Utilizing specific procedures for recording, filing, and evaluating reports of adverse events and the quality of preparation identified in the adverse event.

b. Utilizing written policies and procedures that include specific procedures or instructions for receiving, acknowledging, and dating the receipt of products.

c. Reviewing documented patient or caregiver education and training required pursuant to rule 13.32(155A).

d. Ensuring that a qualified pharmacist is available and accessible at all times to respond to the questions and needs of other health professionals, the patient, or the patient's caregiver.

e. Identifying activities and processes that are deemed high-risk, high-volume, or problem-prone and providing effective corrective actions to remedy these activities and processes.

657—13.32(155A) Patient or caregiver education and training. If sterile preparations are provided to the patient in the home environment, the pharmacist, in conjunction with nursing or medical personnel, shall verify and document the patient's or caregiver's training and competence in managing the type of prescribed therapy.

13.32(1) Pharmacist involvement. A pharmacist shall be actively involved in patient training processes relating to drug compounding, labeling, administration, storage, stability, compatibility, or disposal. The pharmacist shall continually reassess the patient's or caregiver's competency in these areas.

13.32(2) Demonstration and practice. Training programs shall include hands-on demonstrations and practice with actual items that the patient or caregiver is expected to use in managing the specific type of therapy.

13.32(3) Additional training tools. Printed materials and posttraining verbal counseling shall be used periodically, as appropriate, to reinforce initial training programs and to ensure the patient's or caregiver's continuing correct and complete fulfillment of responsibilities.

657—13.33(124,155A) Storage and delivery of sterile preparations. The pharmacy is responsible for proper packaging, handling, transport, and storage of preparations compounded and dispensed by the pharmacy and for appropriate education, training, and supervision of pharmacy and nonpharmacy personnel responsible for such functions. The pharmacy shall establish, maintain, and implement written policies and procedures to ensure product quality and packaging integrity until the preparation is administered.

13.33(1) Storage areas. Controlled temperature storage areas within the pharmacy shall be monitored at least once daily and the results documented on a temperature log. Temperature-sensing mechanisms shall be suitably placed within the storage space to accurately reflect the area's temperature.

13.33(2) Packaging, handling and transport. Appropriate policies and procedures shall be established, maintained, and implemented by the pharmacy with the involvement of other departments or services whose personnel are responsible for preparation or handling functions outside the pharmacy.

a. Policies and procedures shall include instruction in proper hand washing, aseptic techniques, site care, and change of administration sets to ensure the quality and sterility of the preparation.

b. A pharmacy that compounds or prepares products or devices or uses techniques where in-line filtration, automated infusion control devices, or replenishment of drug products into reservoirs of portable infusion pumps is required shall implement policies and procedures to address the special needs related to those products and techniques.

c. Policies and procedures shall provide for the return to the pharmacy of unused preparations for appropriate disposition. Appropriate disposition may include redispensing only if the continuing quality and sterility of the preparation can be fully ensured. The pharmacy shall be the sole authority for determining whether a preparation that was not administered as originally intended can be used for an alternate patient or under alternate conditions.

d. Policies and procedures regarding the handling of hazardous preparations shall identify safeguards intended to maintain the integrity of the preparations and to minimize the exposure potential of these products to the environment and to personnel who have contact with the products.

These rules are intended to implement Iowa Code sections 124.301, 126.10, 155A.2, 155A.4, 155A.13, 155A.13A, and 155A.28.

[Filed 5/14/07, Notice 2/28/07—published 6/6/07, effective 7/11/07]

[Filed 9/5/08, Notice 7/2/08—published 9/24/08, effective 10/29/08]

[Filed ARC 7633B (Notice ARC 7446B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]

[Filed ARC 9180B (Notice ARC 8913B, IAB 6/30/10), IAB 11/3/10, effective 12/8/10]

[Filed ARC 9411B (Notice ARC 9187B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

CHAPTER 35
CONTESTED CASES
[Prior to 5/19/99, see 657—Ch 9]

657—35.1(17A,124,124B,126,147,155A,205,272C) Scope and applicability. This chapter applies to contested case proceedings, including licensee, registrant, or permittee discipline, conducted by the board of pharmacy.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.2(17A,272C) Definitions. Except where otherwise specifically defined by law:

“*Board*” means the Iowa board of pharmacy.

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under 1998 Iowa Acts, chapter 1202, section 14.

“*Issuance*” means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

“*Party*” means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

“*Presiding officer*” means members of the board of pharmacy or the administrative law judge assigned to preside over the case pursuant to rule 657—35.6(17A,272C).

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the board did not preside. If the contested case involves licensee or registrant discipline, “proposed decision” means the decision of the panel of the board when the hearing is held before a panel of the board rather than the full board.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.3(17A) Time requirements.

35.3(1) Computation. Time shall be computed as provided in Iowa Code subsection 4.1(34).

35.3(2) Changing time to take action. For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute or by rule. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

657—35.4 Reserved.

657—35.5(17A,124B,126,147,155A,205,272C) Notice of hearing.

35.5(1) Delivery. Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. To the degree practicable, the board shall select the procedure for providing written notice that best ensures prompt, reliable delivery. Delivery may be executed by:

- a. Personal delivery;
- b. Certified mail, return receipt requested, to the last address on file with the board;
- c. Certified mail to the last address on file with the board;
- d. First-class mail to the last address on file with the board;
- e. Facsimile. Facsimile transmission may be used as the sole method of delivery if the party to be served has filed a written request that board communications be sent by facsimile and has provided a facsimile telephone number for that purpose;
- f. Other electronic transmission. Other electronic transmission, such as E-mail, may be used as the sole method of delivery if the party to be served has filed a written request that board communications be sent by such other electronic transmission and has provided an address for that purpose; or
- g. Publication, as provided in the Iowa Rules of Civil Procedure.

35.5(2) Contents. The notice of hearing shall contain the following information:

- a. A statement of the time, place, and nature of the hearing;
- b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;

- d.* A short and plain statement of the matters asserted. If the board or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished;
- e.* Identification of all parties including the name, address and telephone number of the person who will act as advocate for the board or the state and of parties' counsel where known;
- f.* Reference to the procedural rules governing conduct of the contested case proceeding;
- g.* Reference to the procedural rules governing informal settlement;
- h.* Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer (e.g., members of the board, administrative law judge from the department of inspections and appeals); and
- i.* Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11 and rule 35.6(17A,272C), that the presiding officer be an administrative law judge.
[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.6(17A,272C) Presiding officer for nondisciplinary hearings.

35.6(1) Request for administrative law judge. Any party may request that an administrative law judge employed by the department of inspections and appeals be assigned to render a proposed decision in a nondisciplinary hearing. The written request shall be filed with the executive director within 20 days after service of a notice of hearing identifying or describing the presiding officer as the members of the board.

35.6(2) Grounds for denial. The executive director may deny the request only upon a finding that one or more of the following apply:

- a.* Neither the board nor any member of the board, under whose authority the contested case is to take place, is a named party to the proceeding or a real party in interest to that proceeding.
- b.* There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.
- c.* The contested case involves the discipline of a licensee or registrant and therefore must be decided by the board as required by Iowa Code section 272C.6.
- d.* The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.
- e.* The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.
- f.* Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.
- g.* The request was not timely filed.
- h.* The request is not consistent with a specified statute.

35.6(3) Written ruling. The executive director shall issue a written ruling specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed.

35.6(4) Appeals to board. Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the board. A party shall seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

35.6(5) Review of proposed decision. Unless otherwise provided by law, members of the board, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.7(17A,124B,147,155A,272C) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the board in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

657—35.8(17A,272C) Telephone or network proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference or by a conference on the Iowa Communications Network (ICN) in which all parties have an opportunity to participate. Other telephone or network proceedings, including the hearing for the contested case proceeding, may be held when

appropriate under the circumstances. The presiding officer will determine the location of the parties and witnesses for telephone or network hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

657—35.9(17A) Disqualification.

35.9(1) *Reasons for withdrawal from participation.* A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a. Has a personal bias or prejudice concerning a party or a representative of a party;
- b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;
- c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;
- d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;
- e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;
- f. Has a spouse or relative within the third degree of relationship that:
 - (1) Is a party to the case, or an officer, director or trustee of a party;
 - (2) Is a lawyer in the case;
 - (3) Is known to have an interest that could be substantially affected by the outcome of the case; or
 - (4) Is likely to be a material witness in the case; or
- g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

35.9(2) *“Personally investigated” defined.* The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other board functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17(3) and subrules 35.9(3) and 35.22(9).

35.9(3) *Determination that withdrawal is not necessary.* In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit by affidavit for the record the relevant information and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

35.9(4) *Motion for disqualification.* If a party asserts disqualification on any appropriate ground, including those listed in subrule 35.9(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17. The motion shall be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 35.24(17A) and seek a stay under rule 35.28(17A,272C).

657—35.10(17A,272C) Consolidation—severance.

35.10(1) Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where:

- a. The matters at issue involve common parties or common questions of fact or law;
- b. Consolidation would expedite and simplify consideration of the issues involved; and
- c. Consolidation would not adversely affect the rights of any of the parties to those proceedings.

35.10(2) Severance. The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

657—35.11(17A,272C) Service and filing of pleadings and other papers.

35.11(1) Service—when required. Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the board, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

35.11(2) Service—how made. Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

35.11(3) Filing—when required. After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. All pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the board.

35.11(4) Filing—when made. Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the board, delivered to an established courier service for immediate delivery to the board office, or mailed by first-class mail or state interoffice mail to the board office, so long as there is proof of mailing.

35.11(5) Proof of mailing. Proof of mailing includes one of the following:

- a. A legible United States Postal Service postmark on the envelope;
- b. A certificate of service;
- c. A notarized affidavit; or
- d. A certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).

Date

Signature

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.12(17A,272C) Discovery.

35.12(1) Procedures. Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

35.12(2) Motions. Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. The presiding officer shall rule on motions in regard to discovery. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule

35.12(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

35.12(3) Admissibility of evidence. Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

657—35.13(17A,272C) Subpoenas.

35.13(1) Issuance of investigatory subpoenas.

a. The board's executive director or designee may, upon the written request of a board investigator or on the executive director's own initiative, subpoena books, papers, records, and other real evidence which the executive director determines are necessary for the board to decide whether to institute a contested case proceeding. In the case of a subpoena for mental health records, each of the following conditions shall be satisfied prior to the issuance of the subpoena:

- (1) The nature of the complaint reasonably justifies the issuance of a subpoena;
- (2) Adequate safeguards have been established to prevent unauthorized disclosure;
- (3) An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and
- (4) The patient was notified and an attempt was made to secure an authorization from the patient for release of the records at issue.

b. A written request for a subpoena or the executive director's written memorandum in support of the issuance of a subpoena shall contain the following:

- (1) The name and address of the person to whom the subpoena will be directed;
- (2) A specific description of the books, papers, records or other real evidence requested;
- (3) An explanation of why the documents sought to be subpoenaed are necessary for the board to determine whether it should institute a contested case proceeding; and
- (4) In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 35.13(1), paragraph "a," have been satisfied.

c. Each subpoena shall contain:

- (1) The name and address of the person to whom the subpoena is directed;
- (2) A description of the books, papers, records or other real evidence requested;
- (3) The date, time, and location for production or inspection and copying;
- (4) The time within which a motion to quash or modify the subpoena must be filed;
- (5) The signature, address and telephone number of the executive director or designee;
- (6) The date of issuance;
- (7) A return of service.

d. Any person who is aggrieved or adversely affected by compliance with the subpoena who desires to challenge the subpoena shall, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

e. Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to hold an argument and issue a decision, or the board may hold the argument and issue a decision. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

f. A person aggrieved by a ruling of an administrative law judge who desires to challenge the ruling shall appeal the ruling to the board in accordance with the procedure applicable to intra-agency appeals of proposed decisions set forth in rule 35.26(17A,124B,126,147,155A,205, 272C), provided that all of the time frames are reduced by one-half.

g. If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until either the person is notified the investigation has been concluded with no formal action or there is a final decision in the contested case.

35.13(2) Issuance of subpoenas in a contested case.

a. Subpoenas issued in a contested case may compel the attendance of witnesses at depositions or hearing and may compel the production of books, papers, records, and other real evidence. A command to produce evidence or to permit inspection may be joined with a command to appear at deposition or hearing or may be issued separately. Upon written request, the executive director or designee shall issue subpoenas. A request for a subpoena of patient records must confirm the conditions described in subrule 35.13(1), paragraph “*a*,” prior to the issuance of the subpoena.

b. A request for a subpoena shall include the following information, as applicable, unless the subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes:

- (1) The name, address, and telephone number of the person requesting the subpoena;
- (2) The name and address of the person to whom the subpoena shall be directed;
- (3) The date, time, and location at which the person shall be commanded to attend and give testimony;
- (4) Whether the testimony is requested in connection with a deposition or hearing;
- (5) A description of the books, papers, records, or other real evidence requested;
- (6) The date, time, and location for production or inspection and copying; and
- (7) In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 35.13(1), paragraph “*a*,” have been satisfied.

c. Each subpoena shall contain, as applicable:

- (1) The caption of the case;
- (2) The name, address, and telephone number of the person who requested the subpoena;
- (3) The name and address of the person to whom the subpoena is directed;
- (4) The date, time, and location at which the person is commanded to appear;
- (5) Whether the testimony is commanded in connection with a deposition or hearing;
- (6) A description of the books, papers, records or other real evidence the person is commanded to produce;
- (7) The date, time, and location for production or inspection and copying;
- (8) The time within which a motion to quash or modify the subpoena must be filed;
- (9) The signature, address, and telephone number of the executive director or designee;
- (10) The date of issuance;
- (11) A return of service.

d. Unless a subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes, the executive director or designee shall mail copies of all subpoenas to the parties to the contested case. The person who requested the subpoena is responsible for serving the subpoena upon the subject of the subpoena.

e. Any person who is aggrieved or adversely affected by compliance with the subpoena, or any party to the contested case who desires to challenge the subpoena, shall, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified, and may be accompanied by legal briefs or factual affidavits.

f. Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to hold an argument and issue a decision, or the board may hold the argument and issue a decision. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

g. A person aggrieved by a ruling of an administrative law judge who desires to challenge the ruling shall appeal the ruling to the board in accordance with the procedure applicable to intra-agency appeals of proposed decisions set forth in rule 35.26(17A,124B,126,147,155A,205,272C), provided that all of the time frames are reduced by one-half.

h. If the person contesting the subpoena is not the person under investigation, the board’s decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board’s decision is not final for purposes of judicial review until there is a final decision in the contested case.

35.13(3) Refusal to obey subpoena. In the event of a refusal to obey a subpoena, the board may petition the district court for its enforcement. Upon proper showing, the district court shall order the person to obey the subpoena and, if the person fails to obey the order of the court, the person may be found guilty of contempt of court.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.14(17A,272C) Motions.

35.14(1) Form. No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

35.14(2) Timely response. Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the board or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

35.14(3) Oral argument. The presiding officer may schedule oral argument on any motion.

35.14(4) Timely filing. Motions pertaining to the hearing, except motions for summary judgment, shall be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the board or an order of the presiding officer.

657—35.15(17A,272C) Prehearing conference.

35.15(1) Request or order for conference. Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the executive director to all parties. For good cause the presiding officer may permit variances from this rule.

35.15(2) Witness and exhibit lists. Each party shall bring to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names; and

b. A final list of exhibits that the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

35.15(3) Effect of conference. In addition to the requirements of subrule 35.15(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters that the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters that will expedite the hearing.

35.15(4) Conducted by telephone. Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a prehearing conference.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.16(17A,272C) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer or, in the case of a licensee or registrant disciplinary hearing, to the executive director.

35.16(1) Requirements of application. A written application for a continuance shall:

a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

- b. State the specific reasons for the request; and
- c. Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer, or in a disciplinary hearing the executive director, waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer or, in a disciplinary hearing, by the executive director. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The board may waive notice of such requests for a particular case or an entire class of cases.

35.16(2) Consideration of application. In determining whether to grant a continuance, the presiding officer, or in a disciplinary hearing the executive director, may consider:

- a. Prior continuances;
- b. The interests of all parties;
- c. The likelihood of informal settlement;
- d. The existence of an emergency;
- e. Any objection;
- f. Any applicable time requirements;
- g. The existence of a conflict in the schedules of counsel, parties, or witnesses;
- h. The timeliness of the request; and
- i. Other relevant factors.

The presiding officer, or in a disciplinary hearing the executive director, may require documentation of any grounds for continuance.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.17(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing only in accordance with board rules. Unless otherwise provided, a withdrawal shall be with prejudice.

657—35.18 Reserved.

657—35.19(17A,124B,126,147,155A,205,272C) Hearing procedures in contested cases.

35.19(1) Presiding officer. The presiding officer presides at the hearing and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

35.19(2) Objections. All objections shall be timely made and stated on the record.

35.19(3) Right of participation or representation. Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director, or duly authorized agent. An attorney or another person authorized by law may represent any party.

35.19(4) Rights of all parties. Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

35.19(5) Disorderly conduct. The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

35.19(6) Sequestering witnesses. Witnesses may be sequestered during the hearing.

35.19(7) Conduct of hearing. The presiding officer shall conduct the hearing in the following manner:

- a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;
- b. The parties shall be given an opportunity to present opening statements;
- c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

35.19(8) *Administrative law judge.* A license disciplinary hearing shall be conducted by a qualified administrative law judge and either a quorum of the board or a panel of not less than three pharmacist members of the board. The administrative law judge's duties shall include:

- a.* Opening the record and receiving appearances.
- b.* Administering oaths.
- c.* Entering notice of the hearing into the record.
- d.* Receiving testimony and exhibits presented by the parties.
- e.* At the administrative law judge's discretion, interrogating witnesses.
- f.* Making initial rulings on objections and motions.
- g.* Closing the hearing.
- h.* Participating in board or panel deliberations and preparing an order containing findings of fact and conclusions of law in accordance with the board's or panel's decisions.

35.19(9) *Written decision.* In a license disciplinary hearing, the administrative law judge shall prepare in writing the proposed decision of the panel or the final decision of the board, as applicable. Such decisions shall:

- a.* Be in writing and signed by the board chairperson or the chairperson's designee.
- b.* Set forth the issues, a brief history of the case, findings of fact, the reasons for the decision, and the actual decision.
- c.* Be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs.
- d.* Be delivered to the licensee, permittee, or registrant by one of the methods provided for in subrule 35.5(1).

35.19(10) *Hearings open to the public.* License, permit, or registration disciplinary hearings shall be open to the public except as provided in Iowa Code section 272C.6 and Iowa Code chapter 21.

35.19(11) *Decisions available for public inspection.* Copies of all decisions of the board shall be kept on file for public inspection at the office of the board pursuant to 657—Chapter 14.

35.19(12) *Proceedings recorded.* Oral proceedings in connection with a hearing in a contested case shall be recorded either by mechanized means or by certified shorthand reporters. These records shall be kept in the board office for a period of five years following the date of the hearing.

35.19(13) *Board chairperson.* The chairperson of the board shall have the right to vote in all administrative hearings.

35.19(14) *Final decision.* When a quorum of the board presides over the reception of the evidence at the hearing, its decision is a final decision.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.20(17A,272C) Evidence.

35.20(1) *Ruling on admissibility.* The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

35.20(2) *Stipulation.* Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

35.20(3) *Issues limited.* Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

35.20(4) Admissible evidence. Irrelevant, immaterial, and unduly repetitious evidence should be excluded. A finding will be based upon the kind of evidence upon which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial.

35.20(5) Exhibits. The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties. All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

35.20(6) Objection. Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. A brief statement of the grounds upon which it is based shall accompany the objection. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

35.20(7) Offer of proof. Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

35.20(8) and 35.20(9) Rescinded IAB 11/13/02, effective 12/18/02.

657—35.21(17A,272C) Default.

35.21(1) Failure to appear. If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

35.21(2) Motion for default. Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

35.21(3) Motion to vacate. A default decision or a decision rendered on the merits after a party has failed to appear or participate in a contested case proceeding shall become final board action unless within 15 days after the date of notification or mailing of the decision a motion to vacate is filed and served on all parties or unless an appeal of a decision on the merits is timely initiated within the time provided by rule 35.26(17A,124B,126,147,155A,205,272C). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

35.21(4) Appeal. The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

35.21(5) Proof of good cause. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion if a request to do so is included in that party's response.

35.21(6) "Good cause" defined. "Good cause," for purposes of this rule, shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

35.21(7) Appeal of decision on motion to vacate. A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 35.24(17A,272C).

35.21(8) Notice of hearing. If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

35.21(9) *Default decision.* A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues but, unless the defaulting party has appeared, it cannot exceed the relief demanded.

35.21(10) *Default decision effective.* A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 35.28(17A,272C).

657—35.22(17A,272C) Ex parte communication.

35.22(1) *Prohibited communications.* Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the board or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 35.9(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

35.22(2) *Duration of prohibition.* Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

35.22(3) *“Ex parte” defined.* Written, oral, or other forms of communication are “ex parte” if made without notice and opportunity for all parties to participate.

35.22(4) *Authorized communications.* To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 35.11(17A,272C) and may be supplemented by telephone, facsimile, electronic mail, or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

35.22(5) *Communications between presiding officers.* Persons who jointly act as presiding officers in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

35.22(6) *Others authorized to communicate with presiding officer.* The executive director or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 35.22(1).

35.22(7) *Communications not prohibited.* Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 35.16(17A,272C).

35.22(8) *Disclosure of prohibited communications received during pendency of case.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified.

a. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order.

b. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties.

c. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

35.22(9) Disclosure of prohibited communications received prior to assignment as presiding officer. Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

35.22(10) Sanctions for violation. The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the board. Violation of ex parte communication prohibitions by board personnel shall be reported to the executive director for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.23(17A,272C) Recording costs. Upon request, the board shall provide a copy of the whole or any portion of the record at cost. The requesting party shall pay the cost of preparing a copy of the record or of transcribing the hearing record. Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

657—35.24(17A,272C) Interlocutory appeals. If the board is not serving as the presiding officer, upon written request of a party or on its own motion, the board may review an interlocutory order of the presiding officer. In determining whether to do so, the board shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the board at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

657—35.25(17A) Final decision.

35.25(1) Presiding officer—board. When a quorum of the board presides over the reception of evidence at the hearing, the board's decision is a final decision.

35.25(2) Presiding officer—not the board. When the board does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in rule 35.26(17A,124B,126,147,155A,205,272C).

657—35.26(17A,124B,126,147,155A,205,272C) Appeals and review.

35.26(1) Appeal by party. Any adversely affected party may appeal a proposed decision to the board within 30 days after issuance of the proposed decision.

35.26(2) Review. The board may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

35.26(3) Notice of appeal. An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The appealing party or a representative of that party shall sign the notice of appeal and shall include a certificate of service. The notice shall specify:

- a. The parties initiating the appeal;
- b. The proposed decision or order appealed from;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

- d. The relief sought;
- e. The grounds for relief.

35.26(4) Requests to present additional evidence. A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a non-appealing party, within 14 days of service of the notice of appeal. The board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

35.26(5) Scheduling. The board shall issue a schedule for consideration of the appeal.

35.26(6) Briefs and arguments. Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs. The board may resolve the appeal on the briefs or provide an opportunity for oral argument. The board may shorten or extend the briefing period as appropriate.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.27(17A,124B,126,147,155A,205,272C) Applications for rehearing.

35.27(1) By whom filed. Any party to a contested case proceeding may file an application for rehearing from a final order.

35.27(2) Content of application. The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the board decision on the existing record and whether, on the basis of the grounds enumerated in subrule 35.26(4), the applicant requests an opportunity to submit additional evidence.

35.27(3) Time of filing. The application shall be filed with the board within 20 days after issuance of the final decision.

35.27(4) Notice to other parties. A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

35.27(5) Disposition. Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.28(17A,272C) Stays of board actions.

35.28(1) When available.

a. Any party to a contested case proceeding may petition the board for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the board. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The board may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the board for a stay or other temporary remedies, pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

35.28(2) When granted. In determining whether to grant a stay, the presiding officer or board shall consider the following factors:

- a. The extent to which the applicant is likely to prevail when the court finally disposes of the matter;
- b. The extent to which the applicant will suffer irreparable injury if relief is not granted;
- c. The extent to which the grant of relief to the applicant will substantially harm other parties to the proceedings;
- d. The extent to which the public interest relied on by the board is sufficient to justify the board's action in the circumstances.

35.28(3) Vacation. The issuing authority may vacate a stay upon application of the board or any other party.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—35.29(17A,272C) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable.

657—35.30(17A,124B,126,147,155A,205,272C) Emergency adjudicative proceedings.

35.30(1) Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the board may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license, registration, or permit in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the board by emergency adjudicative order. Before issuing an emergency adjudicative order, the board shall consider factors including, but not limited to, the following:

- a. Whether there has been a sufficient factual investigation to ensure that the board is proceeding on the basis of reliable information;
- b. Whether the specific circumstances that pose immediate danger to the public health, safety, or welfare have been identified and determined to be continuing;
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety, or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and
- e. Whether the specific action contemplated by the board is necessary to avoid the immediate danger.

35.30(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the agency's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

- (1) Personal delivery;
- (2) Certified mail, return receipt requested, to the last address on file with the board;
- (3) Certified mail to the last address on file with the board;
- (4) First-class mail to the last address on file with the board;
- (5) Facsimile. Facsimile transmission may be used as the sole method of delivery if the person required to comply with the order has filed a written request that board orders be sent by facsimile and has provided a facsimile telephone number for that purpose; or
- (6) Other electronic transmission. Other electronic transmission, such as E-mail, may be used as the sole method of delivery if the party to be served has filed a written request that board communications be sent by such other electronic transmission and has provided an address for that purpose.

c. To the degree practicable, the board shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

35.30(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

35.30(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the board shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which board proceedings are scheduled for hearing. After issuance of an emergency adjudicative order, continuance of further board proceedings to a later date will be granted only in compelling circumstances upon application in writing.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

These rules are intended to implement Iowa Code sections 17A.10 to 17A.23, 124.304, 124B.12, 126.17, 147.96, 155A.6, 155A.12, 155A.13A, 155A.15 to 155A.18, 155A.26, 205.11, 272C.3 to 272C.6, 272C.9, and 272C.10.

[Filed 5/11/79, Notice 4/4/79—published 5/30/79, effective 7/4/79]

[Filed 2/12/81, Notice 12/24/80—published 3/4/81, effective 4/8/81]

[Filed emergency 7/28/81—published 8/19/81, effective 8/1/81]

[Filed emergency 9/14/81—published 9/30/81, effective 9/30/81]

[Filed 12/21/81, Notice 11/11/81—published 1/6/82, effective 2/10/82]

[Filed 7/28/82, Notice 3/17/82—published 8/18/82, effective 9/22/82]

[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]

[Filed 1/21/88, Notice 11/18/87—published 2/10/88, effective 3/16/88]

[Filed 8/5/88, Notice 5/18/88—published 8/24/88, effective 9/28/88]

[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]

[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]

[Filed 1/21/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]

[Filed 10/22/92, Notice 9/2/92—published 11/11/92, effective 1/1/93]

[Filed 2/5/93, Notice 11/11/92—published 3/3/93, effective 4/8/93]

[Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]

[Filed 6/24/94, Notice 4/13/94—published 7/20/94, effective 8/24/94]

[Filed 5/1/96, Notice 1/3/96—published 5/22/96, effective 6/26/96]

[Filed 8/2/96, Notice 5/22/96—published 8/28/96, effective 10/2/96]

[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]

[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 10/15/98]

[Filed 4/22/99, Notice 3/10/99—published 5/19/99, effective 6/23/99]

[Filed emergency 10/6/99—published 11/3/99, effective 10/11/99]

[Filed 10/24/02, Notice 7/24/02—published 11/13/02, effective 12/18/02]

[Filed ARC 9412B (Notice ARC 9191B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

CHAPTER 36
DISCIPLINE**657—36.1(147,155A,272C) Authority and grounds for discipline.**

36.1(1) *Jurisdiction of the board.* The board has the authority to impose discipline for any violations of Iowa Code chapters 124, 124A, 124B, 126, 147, 155A, 205, and 272C or the rules promulgated thereunder.

36.1(2) *Disciplinary sanctions.* The board has the authority to impose the following disciplinary sanctions:

- a. Revocation of a registration, a permit, or a license issued by the board.
- b. Suspension of a registration, a permit, or a license issued by the board until further order of the board or for a specified period.
- c. Nonrenewal of a registration, a permit, or a license issued by the board.
- d. Prohibit permanently, until further order of the board, or for a specified period, the engaging in specified procedures, methods or acts.
- e. Probation.
- f. Require a pharmacist or a pharmacist-intern to complete additional education or training.
- g. Require a pharmacist to successfully complete any reexamination for licensure.
- h. Order a pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person to undergo a physical or mental examination.
- i. Impose civil penalties not to exceed \$25,000.
- j. Issue citation and warning.
- k. Such other sanctions allowed by law as may be appropriate.

36.1(3) *Considerations in determining sanctions.* The board may consider the following factors in determining the nature and severity of the disciplinary sanction to be imposed:

- a. The relative seriousness of the violation as it relates to assuring the citizens of this state a high standard of professional care.
- b. The facts of the particular violation.
- c. Any extenuating circumstances or other countervailing considerations.
- d. Number of prior violations or complaints.
- e. Seriousness of prior violations or complaints.
- f. Whether remedial action has been taken.
- g. Any other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee, registrant, or permittee.

36.1(4) *Grounds for discipline.* The board may impose any of the disciplinary sanctions set out in subrule 36.1(2) when the board determines that the licensee, registrant, or permittee is guilty of the following acts or offenses:

a. 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 pharmacy, to operate a pharmacy doing business in this state, or to operate as a wholesale drug distributor doing business in this state, or in making application for a registration to practice as a pharmacist-intern, a pharmacy technician, or a pharmacy support person. It includes false representations of a material fact, whether by word or conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application, or attempting to file or filing with the board any false or forged diploma, certificate, affidavit, identification, or qualification in making application for a license or registration in this state.

b. Professional incompetency. Professional incompetency includes but is not limited to:

(1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of the pharmacist's practice.

(2) A substantial deviation by a pharmacist from the standards of learning or skill ordinarily possessed and applied by other pharmacists in the state of Iowa acting in the same or similar circumstances.

(3) A failure by a pharmacist to exercise in a substantial respect that degree of care which is ordinarily exercised by the average pharmacist in the state of Iowa acting under the same or similar circumstances.

(4) A willful or repeated departure from, or the failure to conform to, the minimal standard or acceptable and prevailing practice of pharmacy in the state of Iowa.

c. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of pharmacy or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

d. Habitual intoxication or addiction to the use of drugs. Habitual intoxication or addiction to the use of drugs includes, but is not limited to:

(1) The inability of a licensee or registrant to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

(2) The excessive use of drugs which may impair a licensee's or registrant's ability to practice with reasonable skill or safety.

e. Conviction of a felony related to the profession or occupation of the licensee or registrant, or a conviction of a felony that would affect the licensee's or registrant's ability to practice within the licensee's or registrant's profession. A copy of the record of conviction or a plea of guilty shall be conclusive evidence.

f. Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes, but is not limited to, a pharmacist having made deceptive or untrue representations as to competency to perform professional services which the pharmacist is not qualified to perform by virtue of training or experience.

g. Use of untrue or improbable statements in advertisements.

h. Distribution of drugs for other than lawful purposes. The distribution of drugs for other than lawful purposes includes, but is not limited to, the disposition of drugs in violation of Iowa Code chapters 124, 126, and 155A.

i. Willful or repeated violations of the provisions of Iowa Code chapter 147 or Iowa Code chapter 272C. Willful or repeated violations of these Acts include, but are not limited to, a pharmacist's, pharmacist-intern's, pharmacy technician's, or pharmacy support person's intentionally or repeatedly violating a lawful rule or regulation promulgated by the board of pharmacy or the state department of public health, violating a lawful order of the board in a disciplinary hearing, or violating the provisions of Title IV (Public Health) of the Code of Iowa.

j. Violating a statute or law of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, which statute or law relates to the practice of pharmacy or the distribution of controlled substances, prescription drugs, or nonprescription drugs.

k. Failure to notify the board within 30 days after a final decision entered by the licensing authority of another state, territory, or country which decision resulted in a license or registration revocation, suspension, or other disciplinary sanction.

l. Knowingly aiding, assisting, procuring, or advising another person to unlawfully practice pharmacy or to unlawfully perform the functions of a pharmacist-intern, a pharmacy technician, or a pharmacy support person.

m. Inability of a licensee or registrant to practice with reasonable skill and safety by reason of mental or physical impairment or chemical abuse.

n. Being adjudged mentally incompetent by a court of competent jurisdiction. Such adjudication shall automatically suspend a license or registration for the duration of the license or registration unless the board otherwise orders.

o. Submission of a false report of continuing education or failure to submit biennial reports of continuing education.

p. Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice court claim or action.

q. Failure to file the reports required by subrule 36.2(3) concerning acts or omissions committed by another licensee or registrant.

- r.* Willful or repeated malpractice.
- s.* Willful or gross negligence.
- t.* Obtaining any fee by fraud or misrepresentation.
- u.* Violating any of the grounds for revocation or suspension of a license or registration listed in Iowa Code sections 147.55, 155A.12, and 155A.15 or any of the rules of the board.
- v.* Practicing pharmacy without an active and current Iowa pharmacist license, operating a pharmacy without a current pharmacy license, operating a prescription drug wholesale facility without a current wholesale drug license, practicing as a pharmacist-intern without a current pharmacist-intern registration, assisting a pharmacist with technical functions associated with the practice of pharmacy without a current pharmacy technician registration except as provided in rule 657—3.3(155A), introductory paragraph, or assisting a pharmacist with nontechnical functions associated with the practice of pharmacy without a current pharmacy support person registration.
- w.* Attempting to circumvent the patient counseling requirements, or discouraging patients from receiving patient counseling concerning their prescription drug orders.
- x.* Noncompliance with a child support order or with a written agreement for payment of child support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J.
- y.* Student loan default or noncompliance with the terms of an agreement for payment of a student loan obligation as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 261 or default on a repayment or service obligation under any federal or state educational loan or service-conditional scholarship program upon certification by the program of such a default.
- z.* Engaging in any conduct that subverts or attempts to subvert a board investigation.
- aa.* Employing or continuing to employ as a practicing pharmacist any person whose Iowa pharmacist license is not current and active, employing or continuing to employ a person to assist a pharmacist with technical functions associated with the practice of pharmacy who is not currently registered as a pharmacy technician except as provided in rule 657—3.3(155A), introductory paragraph, or employing or continuing to employ a person to assist a pharmacist with nontechnical functions associated with the practice of pharmacy who is not currently registered as a pharmacy support person.
- ab.* Retaliatory action. Retaliating against a pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person for making allegations of illegal or unethical activities, making required reports to the board, or cooperating with a board investigation or survey.
- ac.* Failing to create and maintain complete and accurate records as required by state or federal law, regulation, or rule of the board.
- ad.* Violating the pharmacy or drug laws or rules of another state while under the jurisdiction of that state.
- ae.* Having a license to practice pharmacy issued by another state canceled, revoked, or suspended for conduct substantially equivalent to any of the grounds for disciplinary action in Iowa. A copy of the record from the state taking the disciplinary action shall be conclusive evidence of the action taken by that state.
- af.* Failure to comply with mandatory child or dependent adult abuse reporter training requirements.
- ag.* Failure to timely provide to the board or a representative of the board prescription fill data or other required pharmacy or controlled substances records.
- ah.* Nonpayment of a state debt as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 272D.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—36.2(155A,272C) Investigations.

36.2(1) General. The board may, upon receipt of a written or verbal complaint or upon its own motion pursuant to other evidence received by the board, review and investigate alleged acts or omissions that the board reasonably believes constitute cause under applicable law or administrative rules for licensee, registrant, or permittee discipline.

36.2(2) Reporting of judgments or settlements. Each licensee or registrant shall report to the board every adverse judgment in a malpractice action to which the pharmacy, pharmacist, pharmacist-intern,

pharmacy technician, or pharmacy support person is a party, and every settlement of a claim alleging malpractice. The report must be filed within 30 days from the date of the judgment or settlement.

36.2(3) Reporting of acts or omissions. Each licensee or registrant having firsthand knowledge of acts or omissions set forth in subrule 36.1(4) shall report to the board within 30 days of initially acquiring the information those acts or omissions committed by another person licensed to practice pharmacy or registered to practice as a pharmacist-intern, as a pharmacy technician, or as a pharmacy support person. The report shall include the name and other available information identifying the licensee or registrant and the date, time, and place of the incident.

36.2(4) Confidentiality of investigative files. Complaint files, investigation files, and all other investigation reports and investigative information in the possession of the board or its employees or agents that relate to licensee, permittee, or registrant discipline shall be privileged and confidential pursuant to Iowa Code section 272C.6(4).

36.2(5) Investigation of allegations. In order to determine if probable cause exists for a disciplinary hearing, the board, the executive director, or someone designated by the executive director shall cause an investigation to be made into the allegations of the complaint. The licensee, registrant, or permittee who is the subject of the complaint shall be given the opportunity to present to the investigator a position or defense respecting the allegations of the complaint prior to the commencement of a contested case.

36.2(6) Investigatory subpoena powers. The board is authorized by law to subpoena books, papers, records, and any other real evidence, whether or not privileged or confidential under law, to help determine whether a contested case proceeding (hearing) should be commenced.

36.2(7) Investigative report. Upon completion of the investigation, the investigator(s) shall prepare a report for the board's consideration. The report may contain the position or defense of the respondent, discuss jurisdiction, and set forth any legal arguments and authorities that appear applicable to the case.

36.2(8) Board consideration. The board shall review all investigations. Participation in the review shall not bar any board member from participating in any subsequent disciplinary proceeding.

a. Board action. After reviewing an investigation, the board may either institute a disciplinary proceeding by filing one or more statements of charges, send a confidential letter of education or administrative warning to the licensee, registrant or permittee, request additional investigation, or close the case without further investigation.

b. Confidential action. If the board determines that formal disciplinary action is not warranted, the board may send a confidential letter of education or administrative warning to the licensee, registrant or permittee. The purpose of a confidential letter of education or administrative warning is to alert the licensee, registrant or permittee to possible violations of Iowa law or board rules so that the licensee, registrant or permittee may address the issues. Confidential letters of education and administrative warnings do not constitute formal disciplinary action and are not public records. The board shall maintain a copy of the confidential letter of education or administrative warning in the confidential investigative file regarding the licensee, registrant or permittee. Confidential letters of education and administrative warnings may be used as evidence against a licensee, registrant or permittee in future administrative hearings.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—36.3(147,272C) Peer review committees.

36.3(1) Establish committee. The board may establish and register peer review committees.

36.3(2) Referral to committee. The board shall determine which complaints or other matters shall be referred to a peer review committee for investigation, review, and report to the board.

36.3(3) Services to committee. The board may provide investigatory and related services to a peer review committee upon request.

36.3(4) Investigation by committee. A peer review committee may determine the method to be used in making its investigation, or that it is unable to investigate the report upon a complaint and return the complaint, together with an explanation, to the board.

36.3(5) Confidentiality. A peer review committee shall observe the requirements of confidentiality imposed by Iowa Code section 272C.6.

36.3(6) Immunity from civil liability. Members of a peer review committee shall not be liable for acts, omissions, or decisions made in connection with service on a peer review committee. However, immunity from civil liability shall not apply if the act is done with malice.

36.3(7) Committee procedures. A peer review committee shall submit to the board for approval the procedures to be used for review, investigation, and handling of all complaints.

657—36.4(17A,124,124B,126,147,155A,272C) Disciplinary proceedings. The proceeding for revocation, suspension, or other disciplinary sanctions against a pharmacy license, a wholesale drug license, a pharmacy technician registration, a pharmacy support person registration, a pharmacist-intern registration, or a license to practice pharmacy, or the denial of or refusal to issue or renew a license or registration, or the suspension, denial, or revocation of a permit to handle precursor substances shall be substantially in accordance with the procedures set forth in 657—Chapter 35 and these rules, which are in addition to the procedures stated in Iowa Code chapter 17A and Iowa Code section 155A.16.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—36.5(17A,124,124B,126,147,155A,272C) Notice of disciplinary hearing.

36.5(1) Preparation of notice. The executive director shall prepare the notice of hearing upon direction to do so by the board upon a probable cause determination.

36.5(2) Contents. The notice of hearing shall contain the information set forth in 657—subrule 35.5(2).

36.5(3) Delivery. Delivery of the notice shall constitute the commencement of the contested case proceeding, and delivery may be executed by one of the methods provided for in 657—subrule 35.5(1).

36.5(4) Timely service – denial of renewal. Notice of a hearing involving denial of license, permit, or registration renewal shall be served no later than 30 days before the expiration of the license, permit, or registration.

36.5(5) Timely service – revocation or suspension. Notice of a hearing involving revocation or suspension of a license, permit, or registration shall be served no less than 30 days before the time set for the hearing.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—36.6(17A,124B,147,155A,272C) Informal settlement.

36.6(1) Negotiating parties.

a. A contested case may be resolved by informal settlement. The respondent or the board may initiate negotiation of an informal settlement.

b. The board chairperson may designate the executive director or one or more board members with authority to negotiate on behalf of the board.

36.6(2) Waiver of notice and opportunity to be heard. The decision to enter into informal settlement negotiations is voluntary on the part of the respondent. By entering into informal settlement negotiations, the respondent waives the right to seek disqualification of a board member pursuant to Iowa Code section 17A.17 and 657—35.9(17A) based on that board member's participation in the settlement negotiations. Upon initiation of negotiation, the assistant attorney general is authorized to discuss informal settlement with the board's designee. Consent to negotiation by the respondent also constitutes a waiver of notice and opportunity to be heard pursuant to Iowa Code section 17A.17 during informal settlement negotiation.

36.6(3) Board approval. All informal settlements are subject to approval of a majority of the full board. If the board fails to approve an informal settlement, it shall be of no force or effect to either party.

36.6(4) Participation of designee. A board member who is designated to act in negotiation of an informal settlement may review investigative material in the course of conducting the negotiation. The designated board member is not disqualified from participating in the adjudication of the contested case by virtue of reviewing the investigative material or having participated in negotiation discussions.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—36.7(272C) Appearance. The respondent shall have the right to appear before the board in person or by attorney at the respondent's expense.

657—36.8(17A,124B,147,155A,272C) Order of proceedings. Before testimony is presented, the record shall show the identity of any board members present, the presiding hearing officer, the primary parties and their representatives, and the fact that all testimony is being recorded.

Hearings before the board generally follow the order established by this rule.

1. The presiding officer may read the specification of charges and the answer thereto, or other responsive pleading, filed by the respondent prior to the hearing.

2. The assistant attorney general representing the public interest before the board may make an opening statement.

3. Each respondent shall be offered the opportunity to make an opening statement. A respondent may elect to reserve an opening statement until just prior to the presentation of evidence by the respondent.

4. Evidence is presented on behalf of the public.

5. Evidence is presented on behalf of the respondent(s).

6. Rebuttal evidence is presented on behalf of the public.

7. Rebuttal evidence is presented on behalf of the respondent(s).

8. The parties are offered the opportunity to make closing arguments, first on behalf of the public, then on behalf of the respondent, and then on behalf of the public.

657—36.9(272C) Confidentiality. At no time prior to the release of the final decision by the board shall any portion or the whole thereof be made public or be distributed to any persons other than the parties.

657—36.10(17A,272C) Notification of decision. All parties to a proceeding hereunder shall be promptly furnished with a copy of any final decision or order by one of the methods provided for in 657—subrule 35.5(1), or by telephone if necessary to ensure that the parties learn of the decision or order first.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—36.11(272C) Board decision. The board's decision and order to discipline a licensee, registrant, or permittee, or to revoke or suspend a license to practice pharmacy, a wholesale drug license, a license to operate a pharmacy, a registration to practice as a pharmacist-intern, a pharmacy technician, or a pharmacy support person, or a permit to handle precursor substances, shall remain in force and effect until the appeal is finally determined and disposed of upon its merit unless the board grants a stay of its decision as provided for in rule 657—35.28(17A).

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—36.12(17A,272C) Publication of decisions. Final decisions of the board relating to disciplinary proceedings are public records subject to Iowa Code chapter 22, examination of public records, and may be transmitted to the appropriate professional association and a newspaper of general circulation to be selected by the board.

657—36.13(17A,124B,147,155A,272C) Reinstatement. Any person whose license to practice pharmacy or to operate a pharmacy or whose wholesale drug license or permit to handle precursor substances or whose pharmacist-intern registration, pharmacy technician registration, or pharmacy support person registration has been revoked or suspended shall meet the following eligibility requirements for reinstatement:

36.13(1) Prerequisites. The individual shall satisfy all terms of the order of revocation or suspension or court proceedings as they apply to that revocation or suspension. If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur, or if the license, registration, or permit was voluntarily surrendered, an initial application for reinstatement

may not be made until one year has elapsed from the date of the board's order or the date of voluntary surrender.

36.13(2) *Pharmacist license revoked or surrendered—examinations required.* A person whose license to practice pharmacy was revoked or voluntarily surrendered must successfully pass the North American Pharmacist Licensure Examination (NAPLEX) or an equivalent examination as determined by NABP and the Multistate Pharmacy Jurisprudence Examination (MPJE), Iowa Edition.

36.13(3) *Proceedings.* The respondent shall initiate all proceedings for reinstatement by filing with the board an application for reinstatement of the license, registration, or permit. The application shall be docketed in the original case in which the license, registration, or permit was revoked, suspended, or surrendered. All proceedings upon petition for reinstatement, including all matters preliminary and ancillary thereto, shall be subject to the same rules of procedure as other cases before the board. The board and the respondent may informally settle the issue of reinstatement. The respondent may choose to have an informal reinstatement conference before the board, as provided in rule 657—36.14(17A,124B,147,155A,272C).

36.13(4) *Burden of proof.* An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the revocation or suspension no longer exists and that it will be in the public interest for the license, registration, or permit to be reinstated. The burden of proof to establish such facts shall be on the respondent.

36.13(5) *Order.* An order for reinstatement shall be based upon a decision that incorporates findings of facts and conclusions of law and shall be based upon the affirmative vote of a quorum of the board. This order shall be available to the public as provided in 657—Chapter 14.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—36.14(17A,124B,147,155A,272C) Informal reinstatement conference.

36.14(1) *Request.* Upon written request of the respondent and approval by the executive director of the board, an informal reinstatement conference may be held before the board.

36.14(2) *Confidentiality.* The conference shall be open to the public except as provided in Iowa Code chapter 21 and Iowa Code section 272C.6. Material submitted to the board regarding a licensee, registrant, or permittee subject to suspension or revocation and received prior to the filing of an application for reinstatement shall be deemed to be investigatory in nature and therefore confidential. If a request for an informal settlement conference is made and approved, all material submitted by the respondent to the board for its consideration shall be deemed public records and is not confidential. Upon filing a request for an informal reinstatement conference, the respondent consents to the provision of relevant materials to board members prior to the time of the informal reinstatement conference.

36.14(3) *Disposition.* After conducting an informal reinstatement conference, the board may issue a proposed order for reinstatement, may issue a proposed order denying reinstatement, or may order a formal hearing on the application.

36.14(4) *Appeal—formal hearing.* Upon appeal of a proposed order or upon the board's order for formal hearing, application for reinstatement shall be set for formal hearing subject to the same rules of procedure as other cases before the board. By consenting to the informal settlement conference, respondent waives any objection to any board member participating in a formal hearing by virtue of the board member's participation at the informal settlement conference. All materials submitted and statements made by the respondent at the informal settlement conference shall be admissible at a subsequent formal hearing.

36.14(5) *Final order.* A proposed order resulting from an informal reinstatement conference becomes the final decision of the board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in rule 657—35.26(17A,124B,126,147,155A,205,272C).

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

657—36.15(17A,124B,147,155A,272C) Voluntary surrender of a license, permit, or registration. The voluntary surrender of a license to practice pharmacy, a license to operate a pharmacy, a wholesale drug license, a permit to handle precursor substances, a pharmacy technician

registration, a pharmacy support person registration, or a pharmacist-intern registration shall be considered a revocation of license, permit, or registration. A request for reinstatement shall be handled under the terms established by rule 657—36.13(17A,124B,147,155A,272C).
[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—36.16(17A,124B,147,155A,272C) License, permit, or registration denial. Any request for a hearing before the board concerning the denial of a license, permit, or registration shall be submitted by the applicant in writing to the board by certified mail, return receipt requested, within 30 days of a mailing of a notice of denial of license, permit, or registration.

657—36.17(155A,272C) Order for mental or physical examination. A pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person who is licensed or registered by the board is, as a condition of licensure or registration, under a duty to submit to a mental or physical examination within a time period specified by order of the board. Such examination may be ordered upon a showing of probable cause and shall be at the expense of the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person.

36.17(1) Content of order. A board order for mental or physical examination shall include the following items:

a. A description of the type of examination to which the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person must submit.

b. The name and address of the examiner or treatment facility that the board has identified to perform the examination on the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person.

c. The time period in which the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person must schedule the required examination.

d. The amount of time in which the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person is required to complete the examination.

e. A requirement that the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person cause a report of the examination results to be provided to the board within a specified period of time.

f. A requirement that the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person communicate with the board regarding the status of the examination.

g. A provision allowing the pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person to request additional time to schedule or complete the examination or to request that the board approve an alternative examiner or treatment facility. The board shall, in its sole discretion, determine whether to grant such a request.

36.17(2) Objection to order. A licensee or registrant who is the subject of a board order and who objects to the order may file a request for hearing. The request for hearing shall specifically identify the factual and legal issues upon which the licensee or registrant bases the objection. The hearing shall be considered a contested case proceeding and shall be governed by the provisions of 657—Chapter 35. A contested case involving an objection to an examination order will be captioned in the name of Jane or John Doe in order to maintain the licensee's or registrant's confidentiality.

36.17(3) Closed hearing. Any hearing on an objection to the board order shall be closed pursuant to Iowa Code section 272C.6(4).

36.17(4) Order and reports—confidential. An examination order and any subsequent examination reports issued in the course of a board investigation are confidential investigative information pursuant to Iowa Code section 272C.6(4).

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—36.18(272C) Disciplinary hearings—fees and costs.

36.18(1) Definitions. As used in this chapter in relation to a formal disciplinary action filed by the board against a licensee or registrant:

“*Deposition*” means the testimony of a person pursuant to subpoena or at the request of the state of Iowa taken in a setting other than a hearing.

“*Expenses*” means costs incurred by persons appearing pursuant to subpoena or at the request of the state of Iowa for purposes of providing testimony on the part of the state of Iowa in a hearing or other official proceeding and shall include mileage reimbursement at the rate specified in Iowa Code section 70A.9 or, if commercial air or ground transportation is used, the actual cost of transportation to and from the proceeding. Also included are actual costs incurred for meals and necessary lodging.

“*Medical examination fees*” means actual costs incurred by the board in a physical, mental, chemical abuse, or other impairment-related examination or evaluation of a licensee or registrant when the examination or evaluation is conducted pursuant to an order of the board.

“*Transcript*” means a printed verbatim reproduction of everything said on the record during a hearing or other official proceeding.

“*Witness fees*” means compensation paid by the board to persons appearing pursuant to subpoena or at the request of the state of Iowa, for purposes of providing testimony on the part of the state of Iowa. For the purposes of this rule, compensation shall be the same as outlined in Iowa Code section 622.69 or 622.72 as the case may be.

36.18(2) *Hearing fee and recoverable costs.* The board may charge a fee not to exceed \$75 for conducting a disciplinary hearing that results in disciplinary action taken by the board against the license or registration. In addition to the fee, the board may recover from the licensee or registrant costs for the following procedures and personnel:

- a. Transcript.
- b. Witness fees and expenses.
- c. Depositions.
- d. Medical examination fees incurred relating to a person licensed or registered under Iowa Code chapter 147 or 169.

36.18(3) *Fees, costs are part of disciplinary order.* Fees and costs assessed by the board pursuant to subrule 36.18(2) shall be calculated by the board’s executive director and shall be entered as part of the board’s final disciplinary order. The board’s final disciplinary order shall specify the time period in which the licensee or registrant shall pay the assessed fees and costs.

36.18(4) *Board treatment of collected fees, costs.* Fees and costs collected by the board pursuant to subrule 36.18(2) shall be allocated to the expenditure category of the board in which the hearing costs were incurred. The fees and costs shall be considered repayment receipts as defined in Iowa Code section 8.2.

36.18(5) *Failure to pay assessed fees, costs.* Failure of a licensee or registrant to pay the fees and costs assessed herein within the time period specified in the board’s final disciplinary order shall constitute a violation of a lawful order of the board.

[ARC 9412B, IAB 3/9/11, effective 4/13/11]

These rules are intended to implement Iowa Code sections 17A.10 to 17A.23, 124.301, 124.304, 124B.12, 126.16 to 126.18, 155A.6, 155A.12, 155A.13, 155A.13A, 155A.15 to 155A.18, 155A.25, 205.11, 272C.3 to 272C.6, 272C.9, and 272C.10.

[Filed 4/22/99, Notice 3/10/99—published 5/19/99, effective 6/23/99]

[Filed 2/18/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]

[Filed 10/24/02, Notice 7/24/02—published 11/13/02, effective 12/18/02]

[Filed 7/15/03, Notice 4/16/03—published 8/6/03, effective 9/10/03]

[Filed 11/30/06, Notice 9/27/06—published 12/20/06, effective 1/24/07]

[Filed 3/5/08, Notice 12/19/07—published 3/26/08, effective 4/30/08¹]

[Filed 11/24/08, Notice 10/8/08—published 12/17/08, effective 1/21/09]

[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]

[Filed ARC 9412B (Notice ARC 9191B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]

¹ April 30, 2008, effective date of 36.1(4) “i,” “v,” and “aa” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.

CHAPTER 91
WEAPONS AND IOWA PROFESSIONAL PERMITS TO CARRY WEAPONS

[Prior to 5/9/07, see rules 661—4.1(724) to 661—4.12(17A,724)]

661—91.1(724) Definitions. The following definitions apply to rules in this chapter:

“Addicted to the use of alcohol” means physiological or psychological dependence on the continued use of alcohol, or a maladaptive pattern of alcohol use leading to significant occupational, educational, familial, social, legal, or health-related problems.

Alcohol addiction does not mean nonpathological alcohol use, such as social drinking or occasional or periodic intoxication not accompanied by disruption in social and family relationships, vocational or financial difficulties, or legal problems. Alcohol addiction also does not mean alcohol dependence with sustained full remission, as evidenced by a period of at least 12 months without instances or indicators of alcohol dependence or alcohol abuse. One or more instances of alcohol intoxication alone shall not constitute alcohol addiction, unless accompanied by alcohol dependence or a maladaptive pattern of alcohol use leading to significant occupational, educational, familial, social, legal, or health-related problems.

Any of the following shall create a presumption that a person is addicted to the use of alcohol:

1. Affirmation by the person that the person is addicted to the use of alcohol and has not achieved sustained full remission;

2. Treatment for alcohol dependence, abuse, or addiction within the last 12 months, not including follow-up treatment or attendance at support groups during a period of sustained full remission;

3. A diagnosis of alcohol dependence or alcohol abuse from a properly licensed medical or psychological professional in the past 12 months;

4. Two or more arrests, at least one of which resulted in a conviction, for unlawful use or possession of alcohol or other criminal act committed while under the influence of alcohol in the past 12 months;

5. Three or more arrests, at least one of which resulted in a conviction, for unlawful use or possession of alcohol or other criminal act committed while under the influence of alcohol in the past five years if the most recent arrest occurred in the past 12 months;

6. Disciplinary action taken by any employer or organization for prohibited use or possession of alcohol in the past 12 months;

7. Failure to successfully complete alcohol rehabilitation or treatment in the past 12 months;

8. One or more instances of founded child or dependent adult abuse related to alcohol use in the past five years;

9. A test of the person’s breath, blood, urine, or other bodily fluid which indicates that the person has engaged in unlawful acts involving alcohol, provided that the test was administered within the past 12 months; or

10. Documented reports or information from at least two credible sources that evidence a pattern of conduct indicating that the person is currently addicted to the use of alcohol as defined herein.

“Adjudicated as a mental defective” means a determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease:

1. Is a danger to the person’s self or to others; or

2. Lacks the mental capacity to contract or manage the person’s own affairs.

The term shall include:

- A finding of insanity by a court in a criminal case; and

- Those persons found incompetent to stand trial or found not guilty by reason of lack of mental responsibility.

“Applicant” means a person who is applying for a permit to carry weapons.

“Background check” means an inquiry through the IOWA system to NICS, the IOWA and the National Crime Information Center (NCIC) systems person files and the driver’s license file of the applicant as well as other available sources of information to be used to determine eligibility.

“Commissioner” means the commissioner of the Iowa department of public safety or, as applicable, the commissioner’s designee.

“Committed to a mental institution” means a formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily either as an inpatient or outpatient. The term includes commitment for mental defectiveness or mental illness. It also includes commitments for other reasons, such as for drug or alcohol abuse. The term does not include admission to a mental institution for observation or a voluntary admission to a mental institution.

“Crime punishable by imprisonment for a term exceeding one year” means any federal or state offense for which the maximum penalty, whether or not imposed, is capital punishment or imprisonment in excess of one year. The term shall not include any federal or state offenses pertaining to antitrust violations, unfair trade practices, restraints of trade, or other similar offenses relating to the regulation of business practices or any state offense classified by the laws of the state as a misdemeanor and punishable by a term of imprisonment of two years or less. What constitutes a conviction of such a crime shall be determined in accordance with the law of the jurisdiction in which the proceedings were held. Any conviction which has been expunged or set aside or for which a person has been pardoned or has had civil rights restored shall not be considered a conviction unless such pardon, expunction, or restoration of civil rights expressly provides that the person may not ship, transport, possess, or receive firearms, or unless the person is prohibited by the law of the jurisdiction in which the proceedings were held from receiving or possessing any firearms.

“Felony” means any crime punishable by imprisonment for a term exceeding one year as defined in this rule or any crime involving a firearm or explosive that is punishable by imprisonment for a term exceeding one year and is classified as a misdemeanor under the laws of this state.

“Firearm training documentation” means a photocopy of a certificate of completion or any similar document indicating completion of any firearm training program course; an affidavit from the instructor, school, organization or group that conducted or taught a firearm training program; a copy of or the display of an honorable discharge or general discharge under honorable conditions or Form DD-214 for personnel released or retired from active duty with the armed forces of the United States; or possession of a certificate of completion of basic training with a service record of successful completion of small arms training and qualification for active duty personnel in the armed forces of the United States. For a renewal application, firearm training documentation also includes documentation of qualifying on a firing range under the supervision of an instructor certified by the National Rifle Association or the Iowa law enforcement academy or another state’s department of public safety, state police department, or similar certifying body.

“Firearm training program” means any National Rifle Association handgun safety training course; any handgun safety training course available to the general public utilizing instructors certified by the National Rifle Association or the Iowa law enforcement academy or another state’s department of public safety, state police department, or similar certifying body; any handgun safety training course offered for security guards, investigators, special deputies, or any division or subdivision of a law enforcement or security enforcement agency approved by the Iowa department of public safety; or completion of small arms training while serving with the armed forces of the United States. Any person or entity seeking approval by the Iowa department of public safety for a handgun safety training course offered for security guards, investigators, special deputies, or any division or subdivision of a law enforcement or security enforcement agency, other than those certified by the National Rifle Association or the Iowa law enforcement academy or courses conducted by instructors certified by the National Rifle Association or the Iowa law enforcement academy, shall submit a detailed description of the course content to the commissioner for review. Any handgun safety training course submitted for review shall be reviewed by the commissioner to determine if the course is substantially equivalent to the Iowa law enforcement academy marksmanship qualification course.

“Identification documentation for an Iowa resident” means any of the following:

1. A driver’s license or nonoperator identification card that contains a photograph of the person and that has been issued by the Iowa department of transportation; or

2. A motor vehicle license or nonoperator identification card that contains a photograph of the person and that has been issued by a state other than Iowa and at least one current document indicating Iowa residency, including a residential lease agreement, utility bill, voter registration, tuition receipt for a college or university in Iowa, or other documentation that is acceptable to the officer issuing the permit and that indicates the intent of the person's presence in Iowa is something other than merely transitory in nature; or

3. A document which contains the name, place of residence, date of birth and photograph of the holder issued by or under the authority of the United States, a state or a political subdivision of a state and which is of a type intended or commonly accepted for the purpose of identification of individuals and at least one current document indicating Iowa residency, including a residential lease agreement, utility bill, voter registration, tuition receipt for a college or university in Iowa, or other documentation that is acceptable to the officer issuing the permit and that indicates the intent of the person's presence in Iowa is something other than merely transitory in nature; or

4. A motor vehicle license or nonoperator identification card that contains a photograph of the person and that has been issued by a state other than Iowa and a document indicating that the person is a member of the United States armed forces on active duty and whose permanent duty station is located in Iowa; or

5. A driver's license or nonoperator identification card that contains a photograph of the person and that has been issued by the Iowa department of transportation and an immigration document containing the alien registration number (ARN) of a permanent resident alien or nonimmigrant alien and documentation indicating that the person has resided in the state for at least 90 consecutive days prior to the person's making application. A nonimmigrant alien shall also be required to display a valid hunting license issued in any state, meet the requirements of an exception pursuant to 18 U.S.C. § 922(y)(2), or display a waiver granted by the United States Attorney General.

"Identification documentation for a nonresident" means a motor vehicle license or nonoperator identification card which has been issued by a state other than Iowa and which contains a photograph of the person to whom it was issued.

"IOWA system" means the Iowa on-line warrants and articles criminal justice information system operated by the Iowa department of public safety for use by law enforcement and criminal justice agencies in the exchange of criminal history and other criminal justice information.

"Misdemeanor crime of domestic violence" means an offense that:

1. Is a misdemeanor under federal or state law; and
2. Has, as an element, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by a current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabiting with or has cohabited with the victim as a spouse, parent, or guardian, or by a person similarly situated to a spouse, parent, or guardian of the victim.

"New application" means an application for an Iowa professional permit to carry weapons that is filed when the applicant does not currently hold an Iowa permit to carry weapons or when the applicant does not file the application at least 30 days prior to the expiration of a currently held Iowa permit to carry weapons.

"NICS" means the National Instant Criminal Background Check System established by the United States Attorney General pursuant to United States Code 18 U.S.C. § 922(t).

"Professional permit to carry weapons" means a permit to carry weapons issued to a person whose employment in a private investigation business or private security business licensed under Iowa Code chapter 80A, or whose employment as a peace officer, correctional officer with the Iowa department of corrections, private security officer, bank messenger or other person transporting property of a value requiring security, or whose employment in police work reasonably justifies that person's going armed. Property of value includes large quantities of cash transported in an armored car, negotiable instruments, gems, other high-value items transported by couriers, and other high-value property that may be vulnerable. Such a permit is valid only while the permitted person is engaged in the employment stated on the permit and while the person is traveling to and from that employment.

“*Qualifying on a firing range*” means successful completion of a course of live fire on a firing range under the supervision of an instructor certified by the National Rifle Association, the Iowa law enforcement academy, or another state’s department of public safety, state police department, or similar certifying body.

“*Renewal application*” means an application for an Iowa professional permit to carry weapons filed at least 30 days prior to the expiration of a currently held permit.

“*State employee*” means a person whose need to go armed arises out of employment by the state of Iowa. “State employee” includes a railroad special agent as described in Iowa Code chapter 80.

“*Unlawful user of or addicted to any controlled substance*” means a person who uses a controlled substance and has lost the power of self-control with reference to the use of the controlled substance or any person who is a current user of a controlled substance in a manner other than as prescribed by a licensed physician. Such use is not limited to the use of drugs on a particular day, or within a matter of days or weeks before, but rather that the unlawful use has occurred recently enough to indicate that the individual is actively engaged in such conduct. A person may be an unlawful current user of a controlled substance even though the substance is not being used at the precise time the person applies for an Iowa permit to carry weapons or seeks to acquire a firearm or receives or possesses a firearm. An inference of current use may be drawn from evidence of a recent use or possession of a controlled substance or a pattern of use or possession that reasonably covers the present time, e.g., a conviction for use or possession of a controlled substance within the past year; multiple arrests for such offenses within the past five years if the most recent arrest occurred within the past year; or persons found through a drug test to use a controlled substance unlawfully, provided that the test was administered within the past year. For a current or former member of the armed forces, an inference of current use may be drawn from recent disciplinary or other administrative action based on confirmed drug use, e.g., court-martial conviction, nonjudicial punishment, or an administrative discharge based on drug use or drug rehabilitation failure. [ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.2(724) Forms. The following forms, the use of which is required by provisions of this chapter, are provided by the commissioner to Iowa sheriffs:

1. Form WP1. Professional Permit to Carry Weapons
2. Form WP2. Nonprofessional Permit to Carry Weapons
3. Form WP3. Application for Annual Permit to Acquire Pistols or Revolvers
4. Form WP4. Annual Permit to Acquire Pistols or Revolvers
5. Form WP5. Application for Permit to Carry Weapons
6. Form WP6. Revocation/Cancellation of Permit to Carry/Permit to Acquire Weapons
7. Form WP7. Certified Peace Officer Permit to Carry Weapons
8. Form WP8. Reserve Peace Officer Permit to Carry Weapons
9. Form WP9. Authorization for Wallet-Size Permit to Carry Weapons, to be generated by the issuing officer including the type of permit, and, at a minimum, the individual identifiers of name and date of birth. A professional permit to carry weapons shall state the nature of employment requiring the holder to go armed.
10. Form WP10. Authorization for Wallet-Size Annual Permit to Acquire Pistols or Revolvers, to be generated by the issuing officer including the type of permit, and, at a minimum, the individual identifiers of name and date of birth, the residence of the permittee, and the effective date of the permit.
11. Form WP11. Nonprofessional Permit to Carry Weapons (issued to an Iowa resident who is serving on active duty in any branch of the United States military and whose permanent duty station is located in a state other than Iowa).

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.3(724) Federal and state prohibitions—permit to carry weapons.

- 91.3(1)** United States Code 18 U.S.C. § 922(g) prohibits the possession of any firearm by any person:
- a. Who has been convicted in any court of a crime punishable by imprisonment for a term exceeding one year; or
 - b. Who is a fugitive from justice; or

- c.* Who is an unlawful user of or addicted to any controlled substance; or
 - d.* Who has been adjudicated as a mental defective or who has been committed to a mental institution; or
 - e.* Who, being an alien, is illegally or unlawfully in the United States. Persons lawfully admitted to the United States as immigrant or nonimmigrant aliens must have resided in Iowa for at least 90 continuous days before becoming eligible for an Iowa permit to carry weapons. Additionally, nonimmigrant aliens must display a current valid hunting license issued in any state, meet the requirements of an exception pursuant to 18 U.S.C. § 922(y)(2), or display a waiver granted by the United States Attorney General; or
 - f.* Who has been discharged from the armed forces under dishonorable conditions; or
 - g.* Who, having been a citizen of the United States, has renounced the person's citizenship; or
 - h.* Who is subject to a court order that:
 - (1) Was issued after a hearing for which such person received actual notice and at which such person had an opportunity to participate;
 - (2) Restrains such person from harassing, stalking, or threatening an intimate partner of such person or child of such intimate partner or person or from engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child; and
 - (3) Includes a finding that such person represents a credible threat to the physical safety of such intimate partner or child or by its terms explicitly prohibits the use, attempted use, or threatened use of physical force against such intimate partner or child that would reasonably be expected to cause bodily injury; or
 - i.* Who has been convicted in any court of a misdemeanor crime of domestic violence.
- 91.3(2)** United States Code 18 U.S.C. § 922(n) prohibits the receiving of any firearm by any person:
- a.* Who is under indictment for a crime punishable by imprisonment for a term exceeding one year.
 - b.* Reserved.
- 91.3(3)** Iowa Code chapter 724 as amended by 2010 Iowa Acts, Senate File 2379, prohibits the issuance of an Iowa professional permit to carry weapons to any person:
- a.* Who is less than 18 years of age for a private security officer licensed by the Iowa department of public safety, or otherwise who is less than 21 years of age; or
 - b.* Who is addicted to the use of alcohol; or
 - c.* For whom probable cause exists to believe, based upon documented specific actions of the person, where at least one of the actions occurred within two years immediately preceding the date of the permit application, that the person is likely to use a weapon unlawfully or in such other manner as would endanger the person's self or others; or
 - d.* Who has been convicted of a felony in a state or federal court, or who has been adjudicated delinquent on the basis of conduct that would constitute a felony if committed by an adult; or
 - e.* Who is subject to a court order that:
 - (1) Was issued after a hearing for which such person received actual notice and at which such person had an opportunity to participate;
 - (2) Restrains such person from harassing, stalking, or threatening an intimate partner of such person or child of such intimate partner or person or from engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child; and
 - (3) Includes a finding that such person represents a credible threat to the physical safety of such intimate partner or child or by its terms explicitly prohibits the use, attempted use, or threatened use of physical force against such intimate partner or child that would reasonably be expected to cause bodily injury; or
 - f.* Who has been convicted in any court of a misdemeanor crime of domestic violence; or
 - g.* Who has, within the previous three years, been convicted of any serious or aggravated misdemeanor defined in Iowa Code chapter 708 not involving the use of a firearm or explosive.

[ARC 9238B, IAB 11/17/10, effective 1/1/11 (Editorial change: IAC Supplement 3/9/11)]

661—91.4(724) Application procedures for an Iowa professional permit to carry weapons.

91.4(1) A nonresident of Iowa or a state employee who is required by employment to go armed may apply to the commissioner for a professional permit to carry weapons. The applicant shall comply with all of the following:

- a. Submit a fully and accurately completed and signed application for permit to carry weapons.
- b. Submit firearm training documentation. For a new application, training may have occurred at any time prior to the submission of the application. For a renewal application, training must have occurred within the 12-month period prior to the expiration date displayed on the applicant's current permit.
- c. Submit the required fee:
 - (1) \$50 for a new application, or
 - (2) \$25 for a renewal application.
- d. Display identification documentation as defined in rule 661—91.1(724) or provide a photocopy thereof.

91.4(2) The commissioner will return an incomplete application to the applicant.

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.5(724) Issuance or denial of application for permit to carry weapons.

91.5(1) Upon receipt of a completed application, the commissioner shall conduct a background check to determine that issuance of a permit to the applicant is not prohibited pursuant to rule 661—91.3(724).

91.5(2) Within 30 days, the commissioner shall approve or deny an application submitted pursuant to subrule 91.4(1). The commissioner's failure to act within 30 days of receipt of a complete application shall result in an application's being deemed to have been approved.

91.5(3) A permit issued pursuant to this chapter may be delivered, at the discretion of the applicant, to the applicant by U.S. mail or may be picked up personally by the applicant or a person designated by the applicant.

91.5(4) In the event an application is denied pursuant to this chapter, the commissioner shall issue a written statement of the reasons for the denial.

91.5(5) The commissioner may conduct a background check annually on a person issued a permit to carry weapons pursuant to this chapter but such check shall not include a NICS inquiry.

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.6(724) Suspension or revocation of permit to carry weapons.

91.6(1) When the commissioner finds that a person who has been issued a permit to carry weapons has been arrested for a disqualifying offense or is the subject of proceedings that could lead to the person's ineligibility for such permit, the commissioner may immediately suspend the permit.

91.6(2) A permit holder shall be notified immediately of such suspension by personal service or certified mail. The suspension shall become effective upon the permit holder's receipt of such notice. If notified by personal service, the permit shall be surrendered to the person serving such notice for return to the commissioner. If notified by certified mail, the permit holder will be instructed to return the permit to the commissioner.

91.6(3) If the arrest or proceeding does not result in a disqualifying conviction or finding against the permit holder, the commissioner shall immediately reinstate the permit upon proof of the matter's final disposition and shall return the permit to the permit holder.

91.6(4) If the arrest or proceeding results in a disqualifying conviction or finding against the permit holder, the commissioner shall revoke the permit.

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.7(724) Appeals.

91.7(1) If the commissioner denies, suspends or revokes a professional permit to carry weapons for any reason other than the federal disqualifiers in subrule 91.3(1) or 91.3(2) or the reasons in paragraph 91.3(3) "e" or "f," the applicant or permit holder may file an appeal with an administrative law judge by

filing a copy of the denial, suspension, or revocation notice with a written statement that clearly states the applicant's reasons rebutting the denial, suspension, or revocation.

91.7(2) If the commissioner denies, suspends or revokes a professional permit to carry weapons solely for one or more of the federal disqualifiers in subrule 91.3(1) or 91.3(2) or the reasons in paragraph 91.3(3) "e" or "f," the applicant or permit holder may pursue relief of the NICS determination pursuant to Public Law 103-159.

91.7(3) The outcome of proceedings conducted pursuant to subrule 91.7(2) shall be binding on the commissioner.

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.8(724) Reports and remittance to the state.

91.8(1) Each sheriff shall remit to the commissioner, by the seventh working day of the month that follows the month in which one or more permits to carry a weapon were issued, information about such permits, including the permit holder's name, date of birth, NICS transaction number, type of permit issued and the portion of the fee to be remitted to the department as required by the Iowa Code. The reporting of issued permits to carry a weapon shall be in a format designated for that purpose.

91.8(2) Fees for each reporting period shall be remitted by the sheriff and shall be in the form of a check made payable to Iowa Department of Public Safety.

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

661—91.9(724) Offensive weapons as collector's items—method of classification. An offensive weapon, other than a machine gun, shall be classified by the commissioner as a collector's item when the firearm is so defined as a curio or relic in 27 CFR 478.11 as published April 1, 2010, in the Code of Federal Regulations.

[ARC 9238B, IAB 11/17/10, effective 1/1/11]

These rules are intended to implement Iowa Code chapter 724 as amended by 2010 Iowa Acts, Senate File 2357 and Senate File 2379.

[Filed 4/13/07, Notice 9/27/06—published 5/9/07, effective 7/1/07]

[Filed ARC 9238B (Notice ARC 9085B, IAB 9/22/10), IAB 11/17/10, effective 1/1/11]

[Editorial change: IAC Supplement 3/9/11]